



**STATE OF NEW HAMPSHIRE**  
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
***DIVISION OF PUBLIC HEALTH SERVICES***  
***THERAPEUTIC CANNABIS PROGRAM***

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## Card Deactivation Request Form

*Please type or print clearly.*

***To be completed by Qualifying Patient:***

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Registry ID Card #: \_\_\_\_\_

I am requesting deactivation of my Therapeutic Cannabis Registry ID Card.

I understand that to re-activate my card, I will have to re-apply to the program by submitting a new Patient Application, Written Certification from my provider, and application fee.

\_\_\_\_\_  
*Signature of Qualifying Patient*

\_\_\_\_\_  
*Date*