



# Request for Removal or Revocation from Medical Cannabis Database

## Instructions

Completely fill out this form, get it notarized below, and mail to the Medical Cannabis Database Administrator at: CloudPWR LLC, PO Box 2032, Post Falls, ID, 83877. The database administrator will review your request and notify you via email with confirmation of removal or revocation from the Medical Cannabis Database. Note: Though the Medical Cannabis Recognition Card for you and/or your designated provider will be de-activated, your information will be retained in the database for five years for state tax exemption auditing per [RCW 69.51A.230\(6\)](#).

## Your Information

Recognition Card Number:		Today's Date:	
Full Name (last, first, middle initial):		Date of Birth:	
E-mail Address:		Phone Number:	
Street Address:			
City:	State:	Zip Code:	
<input type="checkbox"/> I am a Patient <input type="checkbox"/> I am a Designated Provider <input type="checkbox"/> I am Both			

## I Request to (choose all that apply):

<input type="checkbox"/> Remove myself as a patient in the medical cannabis database.
<input type="checkbox"/> Remove myself as a designated provider in the medical cannabis database. Patient's First and Last Name: Patient's Date of Birth: Patient's Recognition Card # (listed under your photo on your recognition card):
<input type="checkbox"/> Revoke my designated provider in the medical cannabis database. Designated Provider First and Last Name: Designated Provider Date of Birth:

**Signature of Requestor** (to be signed in front of a notary public)

## Notary Public Use Only

Subscribed and sworn to before me in the County of \_\_\_\_\_, State of \_\_\_\_\_,  
 This day of \_\_\_\_\_, 20\_\_\_\_.  
 Notary Public \_\_\_\_\_  
 My commission expires: \_\_\_\_\_  
 Signature: \_\_\_\_\_

## Database Administrator Use Only

Received by:	Removed/Revoked on:	E-mail notice sent on:
--------------	---------------------	------------------------