

Extension Request Form

- Please type or print legibly.
- The OMMP must receive this form **before** your current card expires to be eligible for an extension.
- The Patient may have **ONE** 30-day extension granted every 3 years.
- Extension Requests are processed at a priority level.
- You will receive a response in writing once your request has been processed.

Please type or print legibly.

PATIENT – REQUIRED	
LEGAL NAME (Last, First, MI):	DATE OF BIRTH:
MAILING ADDRESS:	PHONE:

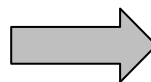
Reason for Extension Request – REQUIRED

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PATIENT SIGNATURE & DATE – REQUIRED

PATIENT SIGNATURE:	DATE:
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Mail or fax completed request form to:



OHA/OMMP

PO Box 14450

Portland, OR 97293-0450

Fax: 971-673-1278