

## ATTENDING PHYSICIAN'S STATEMENT --- NEW APPLICATION

### Oregon Medical Marijuana Program

**Instructions:** Please complete all required information in order to comply with the registration requirements of the Oregon Medical Marijuana Act **OR** provide relevant portions of the patient's medical record containing all information required on this form. **This does not constitute a prescription for marijuana.**

If you need this document in an alternative format, please call: 503-731-4002 x 233

A	PATIENT INFORMATION	
	PATIENT NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:
	MAILING ADDRESS:	TELEPHONE NUMBER: (   )
	CITY, STATE AND ZIP CODE:	

B	PHYSICIAN INFORMATION	
	PHYSICIAN NAME: (Please Print <u>Legibly</u> )	
	MAILING ADDRESS:	TELEPHONE NUMBER: (   )
	CITY, STATE AND ZIP CODE:	

C	PHYSICIAN'S STATEMENT	
	<b>Debilitating Medical Condition: Check appropriate boxes</b>	
	<input type="checkbox"/> 1. Malignant neoplasm (Cancer)	
	<input type="checkbox"/> 2. Glaucoma	
	<input type="checkbox"/> 3. Positive status for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)	
	<input type="checkbox"/> 4. Agitation due to Alzheimer's Disease	
	5. A medical condition or treatment for a medical condition that produces for a specific patient	
	one or more of the following: (check all that apply)	
	<input type="checkbox"/> a. Cachexia	
	<input type="checkbox"/> b. Severe pain	
	<input type="checkbox"/> c. Severe nausea	
	<input type="checkbox"/> d. Seizures, including but not limited to seizures caused by epilepsy	
	<input type="checkbox"/> e. Persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis	
	Comments:	
	I hereby certify that I am a physician duly licensed to practice medicine in Oregon under ORS Chapter 677. I have primary responsibility for the care and treatment of the above-named patient. The above-named patient has been diagnosed with a debilitating medical condition, as listed above. Marijuana used medically may mitigate the symptoms or effects of this patient's condition. <u>This is not a prescription for the use of medical marijuana.</u>	
	<b>PHYSICIAN'S SIGNATURE:</b>	<b>DATE:</b>

MAIL ATTENDING PHYSICIAN'S STATEMENT TO:

DHS/OMMP  
PO Box 14450  
Portland, OR 97293-0450

