

ATTENDING PHYSICIAN'S STATEMENT – NEW APPLICATION
Oregon Medical Marijuana Act Program

Instructions: Please complete all sections of this form 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 alternate format, please call (971) 673-1226

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

B PHYSICIAN INFORMATION	
PHYSICIAN NAME: (Please print <u>legibly!</u>)	
MAILING ADDRESS:	TELEPHONE #: ()
CITY, STATE AND ZIP CODE:	

C PHYSICIAN'S STATEMENT	
Debilitating Medical Condition: Check appropriate boxes.	
<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.	
This is not a prescription for the use of medical marijuana.	
PHYSICIAN'S SIGNATURE:	DATE:

MAIL ATTENDING PHYSICIAN'S STATEMENT TO:

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

