

OMMP Application Tips

Remember to include a copy of your Photo ID.

⚠️ Copies of **Photo ID** for Patient, Caregiver, and Grower must be included with the application.



An Application is only valid when an Attending Physician Statement (APS) is received. If we do not receive a **COMPLETE** application, we cannot issue cards.

If you or someone else will be growing your medical marijuana, the Grower/Growsite information **MUST BOTH** be completed. If you will **ONLY** be using **dispensaries** and no medical marijuana will be grown by you or for you, leave the grower/growsite sections blank.

Need help with your application?

Detailed instructions are included with your application.

Application Form Instructions

INFORMATION - REQUIRED
Information is required and this section must be completely filled out. All requirements must be met if the Patient is under the age of 18.

CAREGIVER INFORMATION - OPTIONAL
Patient chooses to have a Caregiver, this section must be completely filled out. Caregiver is not required if the Patient is 18 or older.

ROWER/GROWSITE INFORMATION - OPTIONAL
Patient chooses to have a Grower/Growsite, this section must be completely filled out. The Patient chooses to be designated as either a Grower or a Growsite. A dispensary must conduct a criminal history check on every Grower per ORS 475.304(9)(a). An additional fee is required if the designated Grower is not the Patient.

FEES - REQUIRED

0.00	No reduced fee proof is submitted. No Grower/Growsite is listed and the Patient is a Grower.
0.00	No reduced fee proof is submitted. A Grower/Growsite is listed and the Patient and Grower are different people.
0.00	Current proof of Oregon Supplemental Nutrition Assistance Program (SNAP) submitted. No Grower/Growsite is listed or the Patient is his/her own Grower.
0.00	Current proof of Oregon Supplemental Nutrition Assistance Program (SNAP) submitted. Grower/Growsite is listed and the Patient and Grower on the appn are different people.
\$110.00	Current proof of Oregon Health Plan receipt eligibility is submitted. No Grower/Growsite or the Patient is his/her own Grower.
\$50.00	Current proof of Oregon Health Plan receipt eligibility is submitted. Grower/Growsite or the Patient is his/her own Grower.
\$100.00	Current proof of Oregon Health Plan receipt eligibility is submitted. The Patient and Grower listed on the application are different people.
\$20.00	Current proof of Supplemental Security Income (SSI) receipt eligibility is submitted. Grower/Growsite or the Patient is his/her own Grower.
\$70.00	Current proof of Supplemental Security Income (SSI) receipt eligibility is submitted. Grower/Growsite or the Patient is his/her own Grower.
\$70.00	Current proof of Supplemental Security Income (SSI) receipt eligibility is submitted. Grower/Growsite or the Patient is his/her own Grower.

APPLICATION FORM Type or print legibly. Do not alter this form or use white-out.

PATIENT - REQUIRED
LEGAL NAME (Last, First, MI):
MAILING ADDRESS:
CITY:
STATE: ZIP: COUNTY:
PHOTO ID # AND ISSUING AGENCY (Enclose Copy):
DATE OF BIRTH: PHONE:
 Male Female

CAREGIVER - OPTIONAL (Complete ONLY if you have a Caregiver)
LEGAL NAME (Last, First, MI):
MAILING ADDRESS:
CITY:
STATE: ZIP: COUNTY:
PHOTO ID # AND ISSUING AGENCY (Enclose Copy):
DATE OF BIRTH: PHONE:
 Male Female

GROWER/GROWSITE - OPTIONAL (Complete ONLY if you have a Grower/Growsite)
LEGAL NAME (Last, First, MI):
MAILING ADDRESS:
CITY:
STATE: ZIP: COUNTY:
PHOTO ID # AND ISSUING AGENCY (Enclose Copy):
DATE OF BIRTH: PHONE:
 Male Female

GROWSITE ADDRESS:
CITY: STATE: Oregon ZIP: COUNTY:

FEES - REQUIRED The correct fee must be enclosed. If you are unsure please contact the OMMP.

PATIENT IS HIS/HER OWN GROWER, AND:	PATIENT IS DESIGNATING GROWER OTHER THAN HIS/HERSELF, AND:
Submits no reduced fee proof: \$200.00	Submits no reduced fee proof: \$250.00
Submits current SNAP proof: \$60.00	Submits current SNAP proof: \$110.00
Submits current OHP proof: \$50.00	Submits current OHP proof: \$100.00
Submits current SSI proof: \$20.00	Submits current SSI proof: \$70.00
Vet 100% disability proof: \$20.00	Vet 100% disability proof: \$70.00

OMMP FEES ARE NON-REFUNDABLE. Enclose check or money order payable to OMMP. This form must be sent with the payment. Do not staple or tape. See reverse for information on documentation required for fee types.

PATIENT SIGNATURE & DATE - REQUIRED I TESTIFY THAT THE ABOVE INFORMATION IS TRUE.
PATIENT SIGNATURE: DATE:

⚠️ Make sure the Physician's information is **LEGIBLE**. If we can't read the name of your doctor, the application process will be delayed.

Make sure your physician checks an applicable medical condition. At least one must be checked.

⚠️ The APS must be **dated within 90 days** or the date your application is received.

Need some help figuring out **fees**?

Reduced fee qualifications and required documentation are listed on the second page of the application.

Growsite fee: If someone **other than you** is growing your medicine, then a **\$50 Growsite fee** is required in addition to your application fee.

⚠️ Don't forget to sign!

⚠️ Don't forget to get your physician's signature!

Attending Physician's Statement
Instructions: Please complete all sections of this form in order to comply with the Oregon Medical Marijuana Act OR provide relevant portions of the patient information required on this form. This does not constitute a prescription. If you need this document in an alternate format, please call (971) 325-7272. **This form must be received by the OMMP within 90 days of the physician's signature. You cannot renew more than three months prior to your current card expiration.

PATIENT INFORMATION
PATIENT NAME (LAST, FIRST, MI):
MAILING ADDRESS:
CITY, STATE AND ZIP CODE: PATIENT INFORMATION

PHYSICIAN INFORMATION
PHYSICIAN NAME: MD/DO #:
MAILING ADDRESS: TELEPHONE:
CITY, STATE AND ZIP CODE:

PHYSICIAN'S STATEMENT

1. Malignant neoplasm (Cancer)

2. Glaucoma

3. Postive status for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)

4. Post-Traumatic Stress Disorder (PTSD)

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):
a. Cachexia
b. Severe pain
c. Severe nausea
d. Seizures, including but not limited to seizures caused by epilepsy
e. Persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis

6. Debilitating Medical Condition. Check all appropriate boxes:
I hereby certify that I am a physician duly licensed to practice medicine in Oregon under ORS Chapter 677. I am primarily responsible for the care and treatment of the above-named patient. The above-named patient has been diagnosed with the above debilitating medical condition(s). 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: