

Attending Provider's Statement Oregon Medical Marijuana Program

Instructions: Please complete all sections of this form 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.

If you need this document in an alternate format, please call (971) 673-1234.

****This form must be received by the OMMP within 90 days of the provider's signature date.****

****You cannot renew more than three months prior to your current card expiration date.****

Print legibly.

A Patient information	
Patient name:	Date of birth:
Mailing address:	Phone number:
City, state and ZIP:	
B Provider information	
Medical license type: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> PA <input type="checkbox"/> CNS <input type="checkbox"/> CRNA <input type="checkbox"/> NP <input type="checkbox"/> ND	
Provider name:	License number:
Mailing address:	Phone number:
City, state and ZIP:	
C Debilitating medical condition	
Check all 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. A degenerative or pervasive neurological condition	
<input type="checkbox"/> 5. Post-Traumatic Stress Disorder (PTSD)	
6. 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, a physician assistant, a nurse practitioner, a clinical nurse specialist, a certified registered nurse anesthetist, or a naturopathic physician as defined in OAR 333-008-0010. I have primary responsibility 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. <u>This is not a prescription for the use of medical marijuana.</u>	
Provider's signature:	Date: