

ATTENDING PHYSICIAN'S STATEMENT **Oregon Medical Marijuana Program**

Office use only: OBME

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) 673-1234

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

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

TYPE OR PRINT LEGIBLY.

A	PATIENT INFORMATION	
	PATIENT NAME:	DATE OF BIRTH:
	MAILING ADDRESS:	TELEPHONE #:
	CITY, STATE AND ZIP CODE:	
	E-MAIL ADDRESS:	
B	PHYSICIAN INFORMATION	
	PHYSICIAN NAME:	MD/DO #:
	MAILING ADDRESS:	TELEPHONE #:
	CITY, STATE AND ZIP CODE:	
C	DEBILITATING MEDICAL CONDITION	
	Check all appropriate boxes:	
	☐ 1. Malignant neoplasm (Cancer)	
	☐ 2. Glaucoma	
	☐ 3. Positive status for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)	
	☐ 4. A degenerative or pervasive neurological condition	
	☐ 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):	
	☐ 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.	
	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 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>		
PHYSICIAN'S SIGNATURE: DATE:		

PATIENT MAIL ATTENDING PHYSICIAN'S STATEMENT TO:

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