# 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.****

PLEASE TYPE OR PRINT LEGIBLY.

## 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: | MD/DO #: |
|---|---|
| MAILING ADDRESS: | TELEPHONE #: |
| CITY, STATE AND ZIP CODE: | |

## C PHYSICIAN'S STATEMENT

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. Agitation due to Alzheimer's Disease
- ☐ 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. This is not a prescription for the use of medical marijuana.

| **PHYSICIAN'S SIGNATURE:** | **DATE:** |
|---|---|
| | |

PATIENT MAIL ATTENDING PHYSICIAN'S STATEMENT TO:

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