



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.****

PRINT LEGIBLY.

A PATIENT INFORMATION	
PATIENT NAME:	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 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 (<i>check all that apply</i>):	
<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 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