OREGON HEALTH AUTHORITY

Attending Provider's Statement

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. **Print legibly.** 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.*
****Patient cannot renew more than 90 days prior to the expiration date of the patient's current card.****

Section A: Patient information

Patient name: _____ Date of birth: _____
Mailing address: _____ Phone number: _____
City, state and ZIP: _____

Section B: Provider information

Medical license type: ☐ MD ☐ DO ☐ PA ☐ CNS ☐ CRNA ☐ NP ☐ ND
Provider name: _____ License number: _____
Mailing address: _____ Phone: _____
City, state and ZIP: _____

Section 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, a physician associate, 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. **This is not a prescription for the use of medical marijuana.**

Provider signature: _____ **Date:** _____

Patient mail attending provider's statement to: OHA/OMMP PO Box 14450 Portland, OR 97293-0450

200-63264_OHA 9265 (01/2025)