Oregon Health Authority

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: ☐ MD ☐ DO ☐ PA ☐ CNS ☐ CRNA ☐ NP ☐ ND

Provider name:	License number:
Mailing address:	Phone number:
City, state and ZIP:	

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 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. This is not a prescription for the use of medical marijuana.

Provider's signature:	**Date:**