ATTENDING PHYSICIAN’S STATEMENT
Oregon Medical Marijuana Program

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.

<table>
<thead>
<tr>
<th>PATIENT INFORMATION</th>
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<tbody>
<tr>
<td><strong>PATIENT NAME:</strong></td>
</tr>
<tr>
<td><strong>DATE OF BIRTH:</strong></td>
</tr>
<tr>
<td><strong>MAILING ADDRESS:</strong></td>
</tr>
<tr>
<td><strong>TELEPHONE #:</strong></td>
</tr>
<tr>
<td><strong>CITY, STATE AND ZIP CODE:</strong></td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>PHYSICIAN INFORMATION</th>
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<tbody>
<tr>
<td><strong>PHYSICIAN NAME:</strong></td>
</tr>
<tr>
<td><strong>MD/DO #:</strong></td>
</tr>
<tr>
<td><strong>MAILING ADDRESS:</strong></td>
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<td><strong>CITY, STATE AND ZIP CODE:</strong></td>
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<tr>
<th>DEBILITATING MEDICAL CONDITION</th>
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<tbody>
<tr>
<td>Check all appropriate boxes:</td>
</tr>
<tr>
<td>1. Malignant neoplasm (Cancer)</td>
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<tr>
<td>2. Glaucoma</td>
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<tr>
<td>3. Positive status for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)</td>
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<tr>
<td>4. A degenerative or pervasive neurological condition</td>
</tr>
<tr>
<td>5. Post-Traumatic Stress Disorder (PTSD)</td>
</tr>
<tr>
<td>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):</td>
</tr>
<tr>
<td>a. Cachexia</td>
</tr>
<tr>
<td>b. Severe pain</td>
</tr>
<tr>
<td>c. Severe nausea</td>
</tr>
<tr>
<td>d. Seizures, including but not limited to seizures caused by epilepsy</td>
</tr>
<tr>
<td>e. Persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis.</td>
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<tr>
<td>Comments:</td>
</tr>
</tbody>
</table>

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

OHA 9265 (Rev.04/19)