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.*

TYPE OR PRINT LEGIBLY.

A	PATIENT INFORMATION	
	PATIENT NAME:	DATE OF BIRTH:
	MAILING ADDRESS:	TELEPHONE #:
	CITY, STATE AND ZIP CODE:	
	E-MAIL ADDRESS:	

B	PHYSICIAN INFORMATION	
	PHYSICIAN NAME:	MD/DO #:
	MAILING ADDRESS:	TELEPHONE #:
	CITY, STATE AND ZIP CODE:	

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 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