ATTENDING PHYSICIAN'S STATEMENT-NEW APPLICATION
Montana Medical Marijuana Program

Instructions: Please complete all sections of this form in order to comply with the registration requirements of the Montana Medical Marijuana Act. **This does not constitute a prescription for marijuana.**

PATIENT INFORMATION

PATIENT NAME (LAST,FIRST, M.I.):_____

DATE OF BIRTH: _____TELEPHONE NUMBER: _____

MAILING ADDRESS: _____

CITY: _____STATE: _____ ZIP CODE: _____

PHYSICIAN'S INFORMATION

PHYSICIAN NAME: (PLEASE PRINT LEGIBLY): _____

PHYSICIAN'S MONTANA LICENSE NUMBER: _____

MAILING ADDRESS:_____TELEPHONE NUMBER: _____

CITY: _____STATE:_____ZIP CODE: _____

PHYSICIAN'S STATEMENT

Medical Marijuana may be used for debilitating medical conditions. Please specify patient's condition by checking all appropriate boxes:

[ ] 1. Cancer, Glaucoma, or Positive status for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome. (AIDS)

[ ] 2. A chronic or debilitating disease or medical condition or it's treatment that produces one or more of the following for this patient:

[ ] a. Cachexia or wasting syndrome

[ ] b. Severe or chronic pain

[ ] c. Severe nausea

[ ] d. Seizures, including but not limited to seizures caused by epilepsy

[ ] e. Severe or Persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis or Crohn's Disease

[ ] Other symptoms caused by above conditions (specify):_____

_____

_____

_____

I hereby certify that I am a physician duly licensed to practice medicine in Montana under MCA Title 37, Chapter 3. It is my professional opinion that after having completed a full assessment of the afore named patient's medical history and current medical condition, made in the course of a bona fide physician/patient relationship, that this patient has a debilitating medical condition as listed above. The potential benefits of medical marijuana will likely outweigh the health risks for this patient. (Please give original to patient to be forwarded with the application packet to the Department.)

PHYSCIAN'S SIGNATURE_____**DATE**_____