Colorado Department of Public Health and Environment

Medical Marijuana Registry

PHYSICIAN CERTIFICATION

Instructions: Please complete all the information required on this form OR provide relevant portions of the patient's medical record that contain all the information required on this form. Sign the form, and keep a copy in the patient's medical record. The patient will submit this certification along with his or her application for a Medical Marijuana Registry identification card. This does not constitute a prescription for marijuana. You may contact the Registry at (303) 692-2184 if you have any questions or concerns.

PATIENT INFORMATION	
NAME (LAST, FIRST, MI):	DATE OF BIRTH:
PHYSICIAN INFORMATION	
NAME (LAST, FIRST, MI):	TELEPHONE NUMBER:
MAILING ADDRESS:	FAX NUMBER:
CITY, STATE, AND ZIP CODE:	PHYSICIAN LICENSE NUMBER DR-

PHYSICIAN'S STATEMENT

The above-named patient has been diagnosed with and is currently undergoing treatment for the following chronic debilitating medical condition: (Check appropriate boxes.)

1. ❑ Cancer
2. ❑ Glaucoma
3. ❑ HIV or AIDS positive

OR A medical condition or treatment that produces, for this patient, one or more of the following and which, in the physician's professional opinion, may be alleviated by the medical use of marijuana.

4. ❑ Cachexia
5. ❑ Severe pain
6. ❑ Severe nausea
7. ❑ Seizures (including those characteristic of epilepsy)
8. ❑ Persistent muscle spasms (including those characteristic of multiple sclerosis)

Comments:

I hereby certify that I am a physician duly licensed in good standing to practice medicine in Colorado, and that I have a bona fide physician-patient relationship with the above-named patient. I have assessed this patient's medical history and current medical condition, and I conclude that this patient may benefit from the medical use of marijuana. This assessment is not a prescription for the use of marijuana.

PHYSICIAN'S SIGNATURE:	DATE: