Medical Marijuana Program
WRITTEN DOCUMENTATION OF PATIENT'S MEDICAL RECORDS
(Please Print)

Note to Attending Physician: This is not a mandatory form. If used, this form will serve as written documentation from the attending physician, stating that the patient has been diagnosed with a serious medical condition and that the medical use of marijuana is appropriate. A copy of this form must be filed in the attending physician's medical records for the patient. If the patient chooses to apply for a Medical Marijuana Identification card through the county health department or its designee, the agency will call the attending physician to verify the information contained on this form, in accordance with Health & Safety Code, Section11362.72 (a)(3).

Attending physician name	California medical license number

Service mailing address (number, street)	Office telephone number ( )

City	State	ZIP code	Office fax number ( )

Licensed by *(check one)*:

☐ Medical Board of California   ☐ Osteopathic Medical Board of California

_____ is a patient under the medical care and supervision of the above

Patient's name

named physician who has diagnosed the patient with one or more of the following medical conditions:

1. Acquired Immune Deficiency Syndrome (AIDS)
2. Anorexia
3. Arthritis
4. Cachexia
5. Cancer
6. Chronic pain
7. Glaucoma
8. Migraine
9. Persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis
10. Seizures, including, but not limited to, seizures associated with epilepsy
11. Severe nausea
12. Any other chronic or persistent medical symptom that either:
    a. Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990.
    b. If not alleviated, may cause serious harm to the patient's safety or physical or mental health

ATTENDING PHYSICIAN STATEMENT:

This patient has been diagnosed with one or more of the foregoing medical conditions and the use of medical marijuana is appropriate.

Attending physician's signature	Telephone number	Date

Original—Patient   Copy—Patient's File

CDPH 9044 (1/09)