Medical Marijuana Authorization Form

Washington State Department of Health

This authorization does not provide protection from arrest unless the qualifying patient or designated provider is also entered in the medical marijuana authorization database and holds a recognition card.

Patient Information and Attestation

Full Legal Name:		Date of Birth:	
Street Address:	City:	State: **WA**	Zip:

I hereby attest that I have discussed the risks and benefits of the medical use of marijuana with my healthcare practitioner. I understand some of the risks may include possible long-term effects to the brain in the areas of memory, coordination, and cognition; impairment of the ability to drive or operate heavy machinery; physical or psychological dependence; and respiratory damage if smoked. I understand that I may revoke my designated provider (if applicable) at any time in writing. I have read chapter 69.51A RCW and understand the legal requirements of being a patient.

Patient Signature: _____ Date: _____

Designated Provider Information and Attestation (If any – Mark N/A in each box if not applicable)

Full Legal Name:		Date of Birth:	
Street Address:	City:	State: **WA**	Zip:

I hereby attest that I am over the age of 21 and agree to serve as the designated provider for the patient identified on this form. I understand I may serve as the designated provider for only one patient at a time. I can stop serving as designated provider for this patient by revoking the designation in writing. The revocation must be signed, dated, and provided to the patient and the medical marijuana authorization database administrator if I am entered into the database. I understand 14 days must go by before I may begin serving as the designated provider for a different patient. I have read chapter 69.51A RCW and understand the legal requirements of being a designated provider.

Designated Provider Signature: _____ Date: _____

Authorizing Healthcare Practitioner Information and Attestation

Name of Healthcare Practitioner: (as it appears on license)	Healthcare Practitioner License Number: (Ex: MD00001111)		
Office Address:	City:	State:	Zip:

Phone Number: (Where authorization can be verified during normal business hours)

I am licensed in the state of Washington and have diagnosed the above named patient as having the following terminal or debilitating medical condition that is severe enough to significantly interfere with the patient's activities of daily living and ability to function, and can be objectively assessed and evaluated (check all that apply):

- ☐ Cancer
- ☐ Chronic Renal Failure Requiring Hemodialysis
- ☐ Crohn's Disease
- ☐ Epilepsy or Other Seizure Disorder
- ☐ Glaucoma
- ☐ Hepatitis C
- ☐ HIV
- ☐ Intractable Pain
- ☐ Multiple Sclerosis
- ☐ Posttraumatic Stress Disorder
- ☐ Spasticity Disorder
- ☐ Traumatic Brain Injury
- ☐ A disease that results in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms or spasticity

I further attest that I have performed an in-person examination of the above named patient and assessed his or her medical history and medical condition. I have advised this patient about the potential risks and benefits of the medical use of marijuana. It is my professional opinion that this patient may benefit from the medical use of marijuana.

Healthcare Practitioner Signature: _____ Issue Date: _____

Authorization Expiration Date: (Maximum from issue date of six months for minors and one year for adults) _____

Additional Plant Authorization (Optional)

This provision is valid only if the person is entered into the authorization database and possesses a recognition card. A second signature is required if authorizing additional plants. Authorization must not exceed 15 plants.

Healthcare Practitioner Attestation: In my professional opinion, the medical needs of this patient exceed the presumptive number of plants allowed by law of 4 plants with just an authorization form or 6 plants if entered in the database. I recommend this patient or their designated provider be allowed to grow in his or her domicile up to _____ plants for the patient's personal use.

Healthcare Practitioner Signature: (second signature only required if recommending additional plants)

_____

WASHINGTON STATE RCW 69.51A.030 MEDICAL MARIJUANA