PHYSICIAN RECOMMENDATION FORM - FIRST PHYSICIAN

Minor Patient License *Under the age of 18*

OKLAHOMA Medical Marijuana Authority

INSTRUCTIONS

1. This form is to be completed by a physician licensed and in good standing in the State of Oklahoma.
2. The parent/legal guardian must submit this form with the minor patient online license application.
3. Patients under the age of 18 must have two forms dated within 30 days of each other, and the second recommendation form must be dated within 30 days of the application submission date

CLEAR FORM PRINT

Patient Information

The physician recommendation is for a: ◯ **2 Year License** ◯ **60-Day Temporary License**

First Name _____ Middle Name _____ Last Name _____ Suffix _____ Date of Birth (mm/dd/yyyy) _____

Current Physical Street Address _____ APT# _____ City _____ State _____ ZIP _____

Proof of Identity *(select one):* ◯ OK Driver's License ◯ U.S. Passport / U.S. Photo I.D. ◯ OK I.D. Card ◯ Tribal I.D. Card ◯ Birth Certificate

MEDICAL CONDITIONS *(optional section)* - **I recommend the use of medical marijuana for the patient named above for the following condition(s):**

1. Specific ICD-10-CM: _____ _____ _____ . _____ _____ _____ _____ Description: _____

1. Specific ICD-10-CM: _____ _____ _____ . _____ _____ _____ _____ Description: _____

1. Specific ICD-10-CM: _____ _____ _____ . _____ _____ _____ _____ Description: _____

CERTIFICATION OF NECESSITY OF A CAREGIVER *(optional section)* **A physician signature is required to certify the need for a caregiver.**

- I certify the patient/applicant is homebound or does not have the capability to self-administer or purchase medical marijuana due to a developmental disability or a physical or cognitive impairment;
- I believe the patient/applicant would benefit from having a caregiver with a caregiver's license designated to manage the patient's medical marijuana on the patient's behalf; and
- By signing below, I recognize the patient may identify a caregiver of his or her choosing to assist with the purchase, application and administration of medical marijuana.

Physician Signature (required if applicable): _____ Date: _____

Physician Information

First Name _____ Middle Name _____ Last Name _____ Suffix _____ Phone Number _____

Office Address (address must match address on licensure board site) _____ City _____ State _____ ZIP _____

Licensing Entity:
- ☐ OK Board of Medical Licensure & Supervision
- ☐ OK State Board of Osteopathic Examiners
- ☐ OK Podiatric Medical Examiners Board

Medical License # _____

NPI# _____

PHYSICIAN ATTESTATION **By my signature below, I attest to the following:**

- I hold a valid, unrestricted and existing license to practice in the State of Oklahoma as a doctor of medicine, doctor of osteopathic medicine, or podiatric physician;
- I have established a medical record for the patient/applicant and a bona fide physician-patient relationship with the patient/applicant;
- I have determined the presence of a medical condition(s) for which the patient/applicant is likely to receive therapeutic or palliative benefit from the use of medical marijuana;
- I am recommending a medical marijuana license for the patient/applicant according to the accepted standards a reasonable and prudent physician would follow for recommending or approving any medication.
- I have verified the patient/applicant's identity as indicated; and
- The information in this recommendation form is true and correct.

Physician Signature (required): _____ Date: _____

PHYSICIAN RECOMMENDATION FORM - SECOND PHYSICIAN

Minor Patient License *Under the age of 18*

OKLAHOMA Medical Marijuana Authority

INSTRUCTIONS

1. This form is to be completed by a physician licensed and in good standing in the State of Oklahoma (see further instructions below) within 30 days of the date the first recommendation form was signed.
2. The parent/legal guardian must submit this form with the minor patient online license application.
3. Patients under the age of 18 must have two forms dated within 30 days of each other, and the second recommendation form must be dated within 30 days of the application submission date.

CLEAR FORM PRINT

Patient Information

The physician recommendation is for a: ◯ **2 Year License** ◯ **60-Day Temporary License**

First Name _____ Middle Name _____ Last Name _____ Suffix _____ Date of Birth (mm/dd/yyyy) _____

Current Physical Street Address _____ APT# _____ City _____ State _____ ZIP _____

Proof of Identity *(select one):* ◯ OK Driver's License ◯ U.S. Passport / U.S. Photo I.D. ◯ OK I.D. Card ◯ Tribal I.D. Card ◯ Birth Certificate

MEDICAL CONDITIONS *(optional section)* - **I recommend the use of medical marijuana for the patient named above for the following condition(s):**

1. Specific ICD-10-CM: _____ _____ _____ . _____ _____ _____ _____ Description: _____

1. Specific ICD-10-CM: _____ _____ _____ . _____ _____ _____ _____ Description: _____

1. Specific ICD-10-CM: _____ _____ _____ . _____ _____ _____ _____ Description: _____

CERTIFICATION OF NECESSITY OF A CAREGIVER *(optional section)* **A physician signature is required to certify the need for a caregiver.**

- I certify the patient/applicant is homebound or does not have the capability to self-administer or purchase medical marijuana due to a developmental disability or a physical or cognitive impairment;
- I believe the patient/applicant would benefit from having a caregiver with a caregiver's license designated to manage the patient's medical marijuana on the patient's behalf; and
- By signing below, I recognize the patient may identify a caregiver of his or her choosing to assist with the purchase, application and administration of medical marijuana.

Physician Signature (required if applicable): _____ Date: _____

Physician Information

First Name _____ Middle Name _____ Last Name _____ Suffix _____ Phone Number _____

Office Address (address must match address on licensure board site) _____ City _____ State _____ ZIP _____

Licensing Entity:
- ☐ OK Board of Medical Licensure & Supervision
- ☐ OK State Board of Osteopathic Examiners
- ☐ OK Podiatric Medical Examiners Board

Medical License # _____

NPI# _____

PHYSICIAN ATTESTATION **By my signature below, I attest to the following:**

- I hold a valid, unrestricted and existing license to practice in the State of Oklahoma as a doctor of medicine, doctor of osteopathic medicine, or podiatric physician;
- I have established a medical record for the patient/applicant and a bona fide physician-patient relationship with the patient/applicant;
- I have determined the presence of a medical condition(s) for which the patient/applicant is likely to receive therapeutic or palliative benefit from the use of medical marijuana;
- I am recommending a medical marijuana license for the patient/applicant according to the accepted standards a reasonable and prudent physician would follow for recommending or approving any medication.
- I have verified the patient/applicant's identity as indicated; and
- The information in this recommendation form is true and correct.

Physician Signature (required): _____ Date: _____