Print Form

Arizona Department of Health Services

MEDICAL MARIJUANA PHYSICIAN CERTIFICATION

REVIEWING PHYSICIAN INFORMATION

Physician's Name:	
Arizona License Number:	Type: ☐ MD ☐ DO ☐ NMD/ND ☐ MD(H)/DO(H)

PHYSICIAN INFORMATION ON FILE WITH LICENSING BOARD

Office Address:	
Telephone Number:	Email Address:

QUALIFYING PATIENT UNDER 18 YEARS OF AGE INFORMATION

Patient's Name:	Date of Birth:

CHECK ONE OR MORE BOXES TO INDICATE QUALIFYING PATIENT'S DEBILITATING MEDICAL CONDITION

☐ Acquired immune deficiency syndrome (AIDS)	☐ Agitation of Alzheimer's disease
☐ Amyotrophic lateral sclerosis (ALS)	☐ Cancer
☐ Crohn's disease	☐ Glaucoma
☐ Human immunodeficiency virus (HIV)	☐ Hepatitis C

IF A CHRONIC OR DEBILITATING DISEASE OR MEDICAL CONDITION OR THE TREATMENT FOR A CHRONIC OR DEBILITATING DISEASE OR MEDICAL CONDITION CAUSES:

☐ Cachexia or wasting syndrome	☐ Severe and chronic pain
☐ Severe nausea	☐ Seizures, including those characteristic of epilepsy

☐ Severe or persistent muscle spasms, including those characteristic of multiple sclerosis

IF ANY CONDITION ABOVE IS CHECKED, INDICATE THE UNDERLYING CHRONIC OR DEBILITATING DISEASE OR MEDICAL CONDITION:

I, _____, THE REVIEWING PHYSICIAN:
(PRINT NAME)

- Have conducted a comprehensive review of the qualifying patient's medical records from other physicians treating the qualifying patient.

  YES ☐ NO ☐ Initial: _____

- Have referred the qualifying patient to a dispensary. YES ☐ NO ☐ If YES, I have disclosed to the qualifying patient or, if applicable, the qualifying patient's custodial parent or legal guardian any personal or professional relationship I have with the dispensary.

  YES ☐ NO ☐ Initial: _____

PHYSICIAN'S ATTESTATION

I, _____, in my professional opinion believe that the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient's medical use of marijuana to treat or alleviate the qualifying patient's debilitating medical condition. I attest that the information provided in this written certification is true and correct.

_____ _____

Physician's Signature Date Signed