MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR MEDICAL MARIJUANA REGULATION
MEDICAL MARIJUANA REGULATORY PROGRAM

PHYSICIAN CERTIFICATION FORM

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INSTRUCTIONS

This form does not constitute a prescription for medical marijuana.

This form should be completed in its entirety for qualifying patients who do not require more than the standard amount of four ounces of medical marijuana per month. *If a higher amount is required, please complete Physician Certification Form MO 580-3277.*

The date of the physician certification must be no earlier than thirty (30) days before the date the patient will apply for a patient identification card or renewal. Please see instructions below for further details regarding: [1] physician name, [2] license type, and [3] physician signature.

QUALIFYING PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM-DD-YYYY)

IS THE PATIENT 18 YEARS OR OLDER?
☐ Yes ☐ No

PHYSICIAN INFORMATION

PHYSICIAN NAME AS APPEARS ON LICENSE [1]	E-MAIL ADDRESS

LICENSE TYPE [2]	MISSOURI ISSUED LICENSE NUMBER	OFFICE PHONE NUMBER
☐ MD ☐ DO		

OFFICE ADDRESS	CITY	STATE	ZIP CODE	COUNTY

QUALIFYING PATIENT'S QUALIFYING MEDICAL CONDITION

☐ Cancer

☐ Epilepsy

☐ Glaucoma

☐ Intractable migraines unresponsive to other treatment

☐ A chronic medical condition that causes severe, persistent pain or persistent muscle spasms, including but not limited to those associated with multiple sclerosis, seizures, Parkinson's disease, and Tourette's syndrome **(Please specify underlying chronic medical condition)**: _____

☐ Debilitating psychiatric disorders, including, but not limited to, post-traumatic stress order, if diagnosed by a state licensed psychiatrist **(Diagnosing psychiatrist)**: _____

☐ Human immunodeficiency virus or acquired immune deficiency syndrome

☐ A chronic medical condition that is normally treated with a prescription medication that could lead to physical or psychological dependence, when a physician determines that medical use of marijuana could be effective in treating that condition and would serve as safer alternative to the prescription medication.
(Please specify chronic medical condition): _____

☐ A terminal illness **(Please specify the terminal illness)**: _____

☐ In the professional judgment of a physician, any other chronic, debilitating or other medical condition, including, but not limited to, hepatitis C, amyotrophic lateral sclerosis, inflammatory bowel disease, Crohn's disease, Huntington's disease, autism, neuropathies, sickle cell anemia, agitation of Alzheimer's disease, cachexia, and wasting syndrome **(Please specify debilitating disease or medical condition)**: _____

ATTESTATION AND AGREEMENT

I, _____, the physician:
(PRINT NAME)

1. In the case of a non-emancipated qualifying patient under the age of eighteen (18), have received the written consent of a custodial parent or legal guardian who will serve as a primary care giver for the qualifying patient.

   Initial: _____

2. Have met with and examined the qualifying patient. Date of Examination: _____

   Initial: _____

3. Have reviewed the qualifying patient's medical records or medical history and the qualifying patient's current medications and allergies to medications.

   Initial: _____

4. Have discussed with the qualifying patient, or the qualifying patient's custodial parent or legal guardian, the patient's current symptoms.

   Initial: _____

5. Have created a medical record for the qualifying patient regarding the meeting and am maintaining the qualifying patient's medical record as required in 334.097, RSMo.

   Initial: _____

6. Have discussed with the qualifying patient, or the qualifying patient's custodial parent or legal guardian, risks associated with medical marijuana including known contraindications applicable to the patient

   Initial: _____

7. Have discussed with the qualifying patient, or the qualifying patient's custodial parent or legal guardian, the risks of medical marijuana use to fetuses and the risks of medical marijuana use to breast feeding infants.

   Initial: _____

PHYSICIAN'S ATTESTATION

I, _____, in my professional opinion, believe the qualifying patient suffers from a qualifying medical condition as defined in 19 CSR 30-95.010. I attest that the information provided in this written certification is true and correct.

PHYSICIAN SIGNATURE [3]	DATE

[1] Physician name must be entered as it appears in the records of the Missouri Division of Professional Registration. Please contact medicalmarijuanainfo@health.mo.gov for more information.

[2] Physician is an individual who is licensed and in good standing to practice medicine or osteopathy under Missouri law. A license is in good standing if it is registered with the Missouri Board of Healing Arts as current, active, and not restricted in any way, such as by designation as temporary or limited. 19 CSR 30-95.010.

[3] Signature should be handwritten, rather than typed.