ADULT PATIENTS
(age of 18 or older)
2 YEAR

OKLAHOMA MEDICAL MARIJUANA AUTHORITY
PHYSICIAN RECOMMENDATION FORM

INSTRUCTIONS:
1. This form is to be completed by a physician licensed and in good standing in the State of Oklahoma.
2. The patient must submit this form with his or her online patient license application.
3. Patients must submit their application within 30 days of the date the form is signed.
4. This form can also be used to certify the patient's need for a caregiver.

PATIENT INFORMATION

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

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

PATIENT 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: _____
2. Specific ICD-10-CM: ____ ____ ____ . ____ ____ ____ ____ Description: _____
3. Specific ICD-10-CM: ____ ____ ____ . ____ ____ ____ ____ Description: _____

PHYSICIAN INFORMATION

First Name _____ Middle Name _____ Last Name _____ Suffix _____ Phone # _____

Office Address _____ City _____ State _____ Zip _____

LICENSING ENTITY:

☐ Oklahoma Board of Medical Licensure & Supervision
☐ Oklahoma State Board of Osteopathic Examiners

Medical License # _____

NPI # _____

PHYSICIAN ATTESTATION *[OAC 310:681-2-1(c)(4)(E)] 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, or doctor of osteopathic medicine;
- 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: _____

(Optional) CERTIFICATION OF NECESSITY OF CAREGIVER *[OAC 310:681-2-1(c)(4)(E)(iv)]*

CLEAR FORM PRINT FORM

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: _____

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