PHYSICIAN RECOMMENDATION FORM

Adult Patient License

Age 18 or older

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 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

The physician recommendation is for a: (•) 2 Year License ( ) 60-Day Temporary License

Name First 8	Name Middle 8	Name Last 8	Name suffix 8	Date of Birth 8
First Name	Middle Name	Last Name	Suffix	Date of Birth (mm/dd/yyyy)

Address Street 6	Address apt 6	Address city 8	Address State 8	Address zip 8
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

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: ICD 43 ICD 44 ICD 45 . ICD 46 ICD 47 ICD 48 ICD 49 Description: Description 7

1. Specific ICD-10-CM: ICD 50 ICD 51 ICD 52 . ICD 53 ICD 54 ICD 55 ICD 56 Description: Description 8

1. Specific ICD-10-CM: ICD 57 ICD 58 ICD 59 . ICD 60 ICD 61 ICD 62 ICD 63 Description: Description 9

CERTIFICATION OF NECESSITY OF A CAREGIVER Hello World! **n signature is required to certify the need for a caregiver.**

- I certify the patient/applicant is homebound or does not have the capabilit… 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): Walt Disney Date: Date physician signed 5

Physician Information

Name First 9	Name Middle 9	Name Last 9	Name suffix 9	Date of Birth 9
First Name	Middle Name	Last Name	Suffix	Phone Number

Address office 3	Address city 9	Address State 9	Address zip 9
Office Address (address must match address on licensure board site)	City	State	ZIP

Licensing Entity:
- [x] OK Board of Medical Licensure & Supervision
- [ ] OK State Board of Osteopathic Examiners
- [ ] OK Podiatric Medical Examiners Board

Medical License # Medical License Number 3

NPI# NPI Number 3

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): Walt Disney Date: Date physician signed 6