Issue Date:



**Certification Number** 

## OFFICIAL NEW YORK STATE MEDICAL CANNABIS PATIENT CERTIFICATION

|                                                                                                                                                                                             | Evniration Data  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| Duratitian on Infant                                                                                                                                                                        | Expiration Date: |
| Practitioner Information                                                                                                                                                                    |                  |
|                                                                                                                                                                                             |                  |
|                                                                                                                                                                                             |                  |
|                                                                                                                                                                                             |                  |
| DEA Registration:                                                                                                                                                                           |                  |
| Patient Information                                                                                                                                                                         |                  |
| First Name:                                                                                                                                                                                 |                  |
| Last Name:                                                                                                                                                                                  |                  |
| DOB:                                                                                                                                                                                        |                  |
| Address:                                                                                                                                                                                    |                  |
|                                                                                                                                                                                             |                  |
| Phone:                                                                                                                                                                                      |                  |
| Email:                                                                                                                                                                                      |                  |
| Dosing Recommendations                                                                                                                                                                      |                  |
| Recommendations/Limitations:                                                                                                                                                                |                  |
|                                                                                                                                                                                             |                  |
|                                                                                                                                                                                             |                  |
|                                                                                                                                                                                             |                  |
| As the averability of new adaptive Letters to the fall average                                                                                                                              |                  |
| As the practitioner named above, I attest to the following:  I am caring for this patient's serious condition;                                                                              |                  |
| By training and/or experience, I am qualified to treat the serious condition as doc                                                                                                         |                  |
| <ul> <li>In my professional opinion and based on my review of past treatments, the patient is<br/>benefit from the primary or adjunctive treatment with medical cannabis for the</li> </ul> |                  |
| This certification will be provided to the patient and a copy of this certification will be                                                                                                 |                  |
|                                                                                                                                                                                             |                  |
|                                                                                                                                                                                             |                  |
| Electronically signed by:                                                                                                                                                                   | on:              |
|                                                                                                                                                                                             |                  |
|                                                                                                                                                                                             |                  |
|                                                                                                                                                                                             |                  |

FALSE STATEMENTS MADE HEREIN ARE PUNISHABLE AS A CLASS A MISDEMEANOR PURSUANT TO PENAL LAW § 210.45. ISSUANCE OF A CERTIFICATION WHEN (i) THE RECIPIENT HAS NO MEDICAL NEED FOR IT, OR (ii) IT IS FOR A PURPOSE OTHER THAN A CERTIFIED MEDICAL USE AS DEFINED IN THE CANNABIS LAW IS PUNISHABLE AS A CLASS E FELONY PURSUANT TO PENAL LAW § 179.10.

This certification must be provided to the patient, or his or her caregiver where appropriate. The certified patient and his or her designated caregiver(s) will need this certification in conjunction with their active patient or designated caregiver registry identification card when purchasing medical cannabis products from a registered organization's dispensing facility.

Step by step instructions for patient registration can be found on the following pages and should be included with this certification. Instructions are also available on the Medical Cannabis Program website at: <a href="https://www.cannabis.ny.gov">www.cannabis.ny.gov</a>.



## **Patient Registration Instructions**

