City and County of San Francisco

Department of Public Health

Medical Cannabis Voluntary
Identification Card Program

Health & Safety Code 11362.5

PHYSICIAN'S STATEMENT

This certifies that Lauren O'Neill is a patient under my medical care and
print patient's name

supervision for the treatment of Chronic Fibromyalgia Pains

I have discussed the medical benefits and risks of cannabis use with the patient as a treatment for these medical conditions. (Select one below)

☒ I recommend medical cannabis use for my patient. ☐ I do not object to medical cannabis use for my patient.

If my patient chooses to use cannabis therapeutically, I will continue to monitor his/her medical condition and to provide advice on his/her progress.

This letter is for use by my patient and the San Francisco Department of Public Health (SFDPH). I understand that I may be contacted by the SFDPH to verify the information in this letter. My patient authorizes me to discuss his/her medical condition and the contents of this letter with the SFDPH for verification purposes only.

I understand that the SFDPH will return this form to my patient and that the SFDPH will not retain any copies of this form.

Patient: _____ Signature

Physician: _____ Signature

(Roger) Stephen Ellis MD
Name (print)

(CA): G-40749
CA License No.

(415)-681-0823
Telephone No.

450 Sutter Street, Suite # 1415
Street Address

San Francisco, CA 94108
City/Zip Code

Optional: _____ N.P./P.A. Signature

_____ N.P./P.A. Name (print)

Date of Statement: _____

Time Period Covered

☐ 1 month ☐ 2 months ☐ 6 months ☒ Other 1 year

ISSUED
DEC 19 2009
R. STEPHEN ELLIS, M.D.

PRIMARY CAREGIVER CERTIFICATION

Health and Safety Code 11362.5

I, Lauren O'Neil do hereby certify that
Patient's Name

Christopher Robison
Caregiver's Name

10/15/1970
Date of Birth of Caregiver

1222 35th AVE, SF CA 94122
Caregiver's Address

UG143899
CDL or ID of Caregiver

is my primary caregiver. He or she consistently assumes, on my behalf, responsibility for my housing, health or safety.

Patient's Signature

12/19/09
Date

DEC 19 2009

Christopher D. Robison
Caregiver's Signature

12/19/2009
Date

DEC 19 2009

I am aware the above named patient is in need of caregiver assistance.
The above named caregiver is providing assistance to the above named patient pursuant to Health and Safety Code 11362.5

(Roger) Stephen Ellis MD
Physician's Name (printed)

450 Sutter St. - # 1415 San Francisco CA 94108
Address

DEC 19 2009

Phone
(415)-681-0823

Physician's Signature

(CA): G-40749
License #

Date

For Cooperative Verification Purposes Only

Verification Information was provided by _____ on ___/___/___

Time_____ Staff Name_____ Staff Signature_____

Patient Member Number _____

M.D Specified Exp.Date:_____

08/21/06