OKLAHOMA MEDICAL MARIJUANA AUTHORITY
PHYSICIAN RECOMMENDATION FORM

ADULT PATIENTS
(age of 18 or older)

*This form is to be completed by an Oklahoma Board Certified Physician and **returned to the patient** for submission with his or her online patient license application. This form also can 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 (check 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 – *(as on file with the licensing board)*

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 # _____

Certifying Board(s): _____

PHYSICIAN ATTESTATION *[OAC 310:681-2-1(c)(4)(E)]* ***By my signature below I attest to the following:***

- 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)]*

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: _____