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 – *Enter information as on file with the licensing board. To assist OMMA in verifying your board certification, please make sure you have notified your relevant licensing entity of your board certification.*

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: ______

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