MEDICAL CANNABIS PHYSICIANS

Intake Forms

for

New Patients

Revised 1/31/2018

IMPORTANT: All pages must be completed and returned to our office prior to your scheduled appointment. If you have any questions regarding these forms, please contact us prior to your appointment so we may assist you. Incomplete forms may delay medical cannabis treatments.

MEDICAL CANNABIS
PHYSICIANS

This is the Medical Cannabis Physicians patient intake questionnaire. To be considered for medical Marijuana, all information must be provided:

Name_____ Date_____ DOB_____
Address_____
County_____
Fl Drivers License #_____
Height_____Weight_____
SSN _____Phone #_____
Email address_____
Primary Care Physician and phone number_____

Reason for cannabis treatment (circle one or more)

Muscle Spasms •Seizures •Cancer •Glaucoma •Crohn's Disease •HIV/AIDS •PTSD •ALS
•Parkinson's Disease •Multiple Sclerosis •Terminal illness •Severe Nausea •Paraplegia
•Quadriplegia •Chronic Pain •Other debilitating illness (explain)_____

Please list symptoms you experience, frequency, severity and duration

	Symptom	Frequency	Severity	Duration
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Please list all treatments you've tried, how long was each treatment attempted, and outcomes of each treatment

	Treatment	Duration	Outcome
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Do you smoke cigarettes? y/n how much _____ how many years_____
Do you drink alcohol? y/n how much_____ how often_____
Do you use illegal drugs? y/n type_____ How often_____
Please list all your medical illnesses:

1._____	5._____	9._____
2._____	6._____	10._____
3._____	7._____	11._____
4._____	8._____	12._____

Please list all current medications dosage and how many times a day

	Name of Medication	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Please list any allergies:

MEDICAL CANNABIS PHYSICIANS

Consent Form

A qualified physician may not delegate the responsibility of obtaining written informed consent to another person. The qualified patient or the patient's parent or legal guardian if the patient is a minor must initial each section of this consent form to indicate that the physician explained the information and, along with the qualified physician, must sign and date the informed consent form.

I,_____(Print Patient Name), understand that Medical Cannabis is offered as treatment for specific medical conditions and/or symptoms as designated by the Florida Department of Health, Office of Compassionate Use.

PLEASE INITIAL EACH SECTION

____ I understand that Dr. Varesh Patel is a qualified physician who is registered with the Office of Compassionate Use and may order medical cannabis for my medical use if he feels I qualify as a patient who could benefit from this medical decision.

___I understand that Dr. Patel is not implying or suggesting that medical cannabis should be a substitute for any other treatment prescribed by another physician.

___I understand that I may not seek medical cannabis from any other physician while being a registered patient with Dr. Patel.

___Medical marijuana is not regulated by the USFDA and therefore may contain unknown quantities of active ingredients, impurities and/or containments.

___I am aware that a notice of compliance has not been issued under the Food and Drug Administration's regulations concerning the safety and effectiveness of marijuana as a drug. I understand the significance of this fact.

___I am aware that medical marijuana has not been approved under federal regulations, and I understand that medical marijuana has not been deemed legal under federal law.

___I understand the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified. I accept such risk.

___I agree that if I am a female patient that I will contact my attending physician if I become or think about becoming pregnant. I acknowledge that the use of medical marijuana creates pass-through problems to a fetus during pregnancy and to a baby during breastfeeding.

___I should not drive a vehicle while using medical marijuana and that I can get a DUI for driving under the influence.

___I understand that Dr. Patel will register my case with the Florida Department of Health, Compassionate Use Registry and he will submit the treatment plan quarterly to the institution as designated by the legislature for the State of Florida for research purposes on the efficacy of medical cannabis to help treat patients.

___I understand that I may fill the order placed by Dr. Patel at any qualified dispensing organization. The dispensary will verify identity of the patient as well as the existence of an order in the Registry of Compassionate Use, a maximum of seventy (70) day supply is allowed.

___I understand that when treatment is discontinued, Dr. Patel will deactivate my registration with the Compassionate Use Registry.

The Federal Government's classification of marijuana as a Schedule I controlled substance.

___The federal government has classified marijuana as a Schedule I controlled substance. Schedule I substances are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in states, such as Florida, which have modified their state laws to treat marijuana as a medicine.

___When in the possession or under the influence of medical marijuana, the patient or the patient's caregiver must have his or her medical marijuana use registry identification card in his or her possession at all times.

The approval and oversight status of marijuana by the Food and Drug Administration.

___Marijuana has not been approved by the Food and Drug Administration for marketing as a drug. Therefore, the "manufacture" of marijuana for medical use is not subject to any federal standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients, which may vary in potency, impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

The potential for addiction.

___Some studies suggest that the use of marijuana by individuals may lead to a tolerance to, dependence on, or addiction to marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I should contact Dr. Varesh Patel.

The potential effect that marijuana may have on a patient's coordination, motor skills, and cognition, including a warning against operating heavy machinery, operating a motor vehicle, or engaging in activities that require a person to be alert or respond quickly.

___The use of marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. Driving under the influence of cannabis can double the risk of crashing, which escalates if alcohol is also influencing the driver. While using medical marijuana, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly and I should not participate in activities that may be dangerous to myself or others. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."

The potential side effects of medical marijuana use.

___Potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, may affect the production of sex hormones that lead to adverse effects, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of medical marijuana may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment. Many medical authorities claim that use of medical marijuana, especially by persons younger than

25, can result in long-term problems with attention, memory, learning, drug abuse, and schizophrenia.

___I understand that using marijuana while consuming alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

___I agree to contact Dr. Varesh Patel if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact Dr. Varesh Patel if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

The risks, benefits, and drug interactions of marijuana.

___Signs of withdrawal can include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

___Symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to contact Dr. Varesh Patel immediately or go to the nearest emergency room.

___Numerous drugs are known to interact with marijuana and not all drug interactions are known. Some mixtures of medications can lead to serious and even fatal consequences. I agree to follow the directions of Dr. Varesh Patel regarding the use of prescription and non-prescription medication. I will advise any other of my treating physician(s) of my use of medical marijuana.

___Marijuana may increase the risk of bleeding, low blood pressure, elevated blood sugar, liver enzymes, and other bodily systems when taken with herbs and supplements. I agree to contact Dr. Varesh Patel immediately or go to the nearest emergency room if these symptoms occur.

___I understand that medical marijuana may have serious risks and may cause low birthweight or other abnormalities in babies. I will advise Dr. Varesh Patel if I become pregnant, try to get pregnant, or will be breastfeeding.

The current state of research on the efficacy of marijuana to treat the qualifying conditions set forth in this section.

___Cancer:

- There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for cancers, including glioma.

  There is evidence to suggest that cannabinoids (and the endocannabinoid system more generally) may play a role in the cancer regulation processes. Due to a lack of recent, high quality reviews, a research gap exists concerning the effectiveness of cannabis or cannabinoids in treating cancer in general.

- There is conclusive evidence that oral cannabinoids are effective antiemetics in the treatment of chemotherapy-induced nausea and vomiting.

  There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for cancer-associated anorexia-cachexia syndrome and anorexia nervosa.

___Epilepsy:

- There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for epilepsy.

  Recent systematic reviews were unable to identify any randomized controlled trials evaluating the efficacy of cannabinoids for the treatment of epilepsy.

  Currently available clinical data therefore consist solely of uncontrolled case series, which do not provide high-quality evidence of efficacy. Randomized trials of the efficacy of cannabidiol for different forms of epilepsy have been completed and await publication.

___Glaucoma:

- There is limited evidence that cannabinoids are an ineffective treatment for improving intraocular pressure associated with glaucoma.

Lower intraocular pressure is a key target for glaucoma treatments. Non- randomized studies in healthy volunteers and glaucoma patients have shown short-term reductions in intraocular pressure with oral, topical eye drops, and intravenous cannabinoids, suggesting the potential for therapeutic benefit. A good-quality systemic review identified a single small trial that found no effect of two cannabinoids, given as an oromucosal spray, on intraocular pressure. The quality of evidence for the finding of no effect is limited. However, to be effective, treatments targeting lower intraocular pressure must provide continual rather than transient reductions in intraocular pressure. To date, those studies showing positive effects have shown only short-term benefit on intraocular pressure (hours), suggesting a limited potential for cannabinoids in the treatment of glaucoma.

___Positive status for human immunodeficiency virus AND acquired immune deficiency syndrome:

- There is limited evidence that cannabis and oral cannabinoids are effective in increasing appetite and decreasing weight loss associated with HIV/AIDS.

There does not appear to be good-quality primary literature that reported on cannabis or cannabinoids as effective treatments for AIDS wasting syndrome.

___Post-traumatic stress disorder:

- There is limited evidence (a single, small fair-quality trial) that nabilone is effective for improving symptoms of posttraumatic stress disorder.

A single, small crossover trial suggests potential benefit from the pharmaceutical cannabinoid nabilone. This limited evidence is most applicable to male veterans and contrasts with non-randomized studies showing limited evidence of a statistical association between cannabis use (plant derived forms) and increased severity of posttraumatic stress disorder symptoms among individuals with posttraumatic stress disorder. There are other trials that are in the process of being conducted and if successfully completed, they will add substantially to the knowledge base.

___Amyotrophic lateral sclerosis:

- There is insufficient evidence that cannabinoids are an effective treatment for symptoms associated with amyotrophic lateral sclerosis.

Two small studies investigated the effect of dronabinol on symptoms associated with ALS. Although there were no differences from placebo in either trial, the sample sizes were small, the duration of the studies was short, and the dose of dronabinol may have been too small to ascertain any activity. The effect of cannabis was not investigated.

___**Crohn's disease:**

- There is insufficient evidence to support or refute the conclusion that dronabinol is an effective treatment for the symptoms of irritable bowel syndrome.

Some studies suggest that marijuana in the form of cannabidiol may be beneficial in the treatment of inflammatory bowel diseases, including Crohn's disease.

___**Parkinson's disease:**

- There is insufficient evidence that cannabinoids are an effective treatment for the motor system symptoms associated with Parkinson's disease or the levodopa- induced dyskinesia.

Evidence suggests that the endocannabinoid system plays a meaningful role in certain neurodegenerative processes; thus, it may be useful to determine the efficacy of cannabinoids in treating the symptoms of neurodegenerative diseases. Small trials of oral cannabinoid preparations have demonstrated no benefit compared to a placebo in ameliorating the side effects of Parkinson's disease. A seven-patient trial of nabilone suggested that it improved the dyskinesia associated with levodopa therapy, but the sample size limits the interpretation of the data. An observational study demonstrated improved outcomes, but the lack of a control group and the small sample size are limitations.

___**Multiple sclerosis:**

- There is substantial evidence that oral cannabinoids are an effective treatment for improving patient-reported multiple sclerosis spasticity symptoms, but limited evidence for an effect on clinician-measured spasticity.

Based on evidence from randomized controlled trials included in systematic reviews, an oral cannabis extract, nabiximols, and orally administered THC are probably effective for reducing patient-reported spasticity scores in patients with MS. The effect

appears to be modest. These agents have not consistently demonstrated a benefit on clinician-measured spasticity indices.

___**Medical conditions of same kind or class as or comparable to the above qualifying medical conditions:**

- The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy of marijuana to treat the patient's medical condition.

- Terminal conditions diagnosed by a physician other than the qualified physician issuing the physician certification

- The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy of marijuana to treat the patient's terminal condition.

___**Chronic nonmalignant pain:**

- There is substantial evidence that cannabis is an effective treatment for chronic pain in adults.

The majority of studies on pain evaluated nabiximols outside the United States. Only a handful of studies have evaluated the use of cannabis in the United States, and all of them evaluated cannabis in flower form provided by the National Institute on Drug Abuse. In contrast, many of the cannabis products that are sold in state-regulated markets bear little resemblance to the products that are available for research at the federal level in the United States. Pain patients also use topical forms.

While the use of cannabis for the treatment of pain is supported by well- controlled clinical trials, very little is known about the efficacy, dose, routes of administration, or side effects of commonly used and commercially available cannabis products in the United States.

That the patient's de-identified health information contained in the physician certification and medical marijuana use registry may be used for research purposes

___The Department of Health submits a data set to The Medical Marijuana Research and Education Coalition for each patient registered in the medical marijuana use registry that includes the patient's qualifying medical condition and the daily dose amount and forms of marijuana certified for the patient

___I have had the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified. I acknowledge that Dr. Varesh Patel has informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana.

By signing this document, I voluntarily agree that all my questions have been addressed; benefits and risks have been discussed. I understand no fees associated with care or obtaining medical cannabis can be applied to any insurance plan, according to Florida State Law. Myself or my legal representative prior to evaluation of treatment will pay all fees.

Print name: _____

Or legal representative: _____

Signature: _____

Date: _____

Witness: _____

Print name: _____

Date: _____

MEDICAL CANNABIS
PHYSICIANS

Cancellation Policy

We at Medical Cannabis Physicians/ Dr. Varesh Patel value your business and care greatly about your health. One of our primary concerns is maintaining our appointment schedule so that we may be available to our patients. In order for us to do so, it is crucial that once scheduled, you promptly notify our office of any change in your appointment needs.

For these reasons, we have established a policy to assess a $75.00 fee to reserve your NP Cannabis appointment which will be applied to your first visit. However, if you miss your appointment this fee is non--refundable.

We appreciate your cooperation in this matter so that we may provide you with the best possible care.

I understand the above fee for the NP Cannabis appointment and that it is non-refundable if I should miss my appointment.

Signed _____ Date:_____

Signature of Witness _____

MEDICAL CANNABIS PHYSICIANS

Disclosure Form

I hereby authorize _____ to disclose the following information from the health records of:
Patient Name _____ Date of Birth _____ SS# _____
Address _____
I authorize this information to be released to and used by Medical Cannabis Physicians/ Dr. Varesh Patel for the purpose of treatment, payment, and/or healthcare operations unless otherwise specified as follows:
_____

Covering the period of health care: From _____ to _____

Information to be disclosed:

Complete health records
Records from previous physicians
Billing information
Progress notes-Most recent date
Operative reports-Most recent date
Consultation reports-Most recent date
Radiology reports-Most recent date
Pathology reports-Most recent date
Laboratory tests-Most recent date
Photographs, video tapes
Digital or other images
Other (please specify)
_____
_____

I understand that by signing this form, I give special authorization allowing the release of any information from my health record regarding acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) infection, behavioral health service/psychiatric care, or treatment for alcohol and/or drug abuse unless otherwise specified as follows:

The practice *will not* receive payment or other remuneration from a third party in exchange for using or disclosing PHI.
I understand that HIPPA regulations and Florida law require that information contained in my medical records be held in strict confidence and not be released without my written authorization. The authorizations I sign on this page will remain in effect until I request in writing that my authorizations be revoked, which I may do at any time. I understand that a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I also have the right to receive a copy of this authorization upon my request.

The practice/facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information authorized herein. I understand that authorizing the release of this health information is voluntary, and that I may refuse to sign this authorization. I am not required to sign this form to assure treatment. I understand I may inspect or copy the information to be used or released, as provided in CFR 164.524. I understand any release of information carries with it the potential for an unauthorized re-release and the information may not be protected by federal confidentiality rules.

Signed _____Patient/Guardian Date:_____

Signature of Witness _____

DR. VARESH PATEL/MEDICAL CANNABIS PHYSICIANS

1400 S. Orlando Ave
Winter Park, FL 32789
info@MCPFL.com
(407) 647-4008

PATIENT INFORMATION SHEET

MEDICAL CANNABIS PHYSICIANS

NAME: _____ GENDER: _____ DOB: _____ DATE: _____
ALLERGIES: _____

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

_____ _____ _____
_____ _____ _____
_____ _____ _____

PERSONAL MEDICAL HISTORY: (Please circle all that apply)

ADHD	COPD/ Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arrhythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: _____	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Last Menstrual Period	Date: _____	Normal Abnormal
Colonoscopy	Yes/No Date:____	Normal Abnormal
Mammogram	Yes/No Date:____	Normal Abnormal
Dexa (Bone Density)	Yes/No Date:____	Normal Abnormal
Pap	Yes/No Date:____	Normal Abnormal

Other medical problems not listed above:

_____

Surgical History: Please list all prior surgeries and approximate dates performed.

_____ _____
_____ _____

SOCIAL / CULTURAL HISTORY:

Education Level: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Are there any vision problems that affect your communication? ☐Yes ☐ No

Are there any hearing problems that affect your communication? ☐Yes ☐ No

Are there any limitations to understanding or following instructions (either written or verbal)? ☐Yes ☐ No

Current Living Situation (Check all that apply):

☐ Single Family Household ☐ Multi-generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other: _____

Continued on other side.

Smoking/ Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/day: _____ Number of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Never Type: _____

Are you sexually active? ☐Yes ☐ No

Are there any personal problems or concerns at home, work, or school you would like to discuss? ☐Yes ☐ No

Are there any cultural or religious concerns you have related to our delivery of care? ☐Yes ☐ No

Are there any financial issues that directly impact your ability to manage your health? ☐Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Comments (Please feel free to comment on any answers marked "yes" above):

_____

_____

FAMILY HISTORY:

FATHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

MOTHER: Living: Age _____ Deceased: Age _____

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: _____	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: _____

SIBLINGS:

_____

_____

List other medical providers you see on a regular basis (i.e. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc.)

_____

_____

Patient Signature: _____ Date: _____

MEDICAL CANNABIS PHYSICIANS

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize my health care provider_____(insert name) to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name:_____

Address:_____

Purpose: I authorize the release of my health information for the following specific purpose: _____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]

- ☐ Only the following records or types of health information: _____.

Term: I understand that this Authorization will remain in effect:

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**

- From the date of this Authorization until the_____day of_____, 20___.
- Until the Provider fulfills this request.
- Until the following event occurs:_____

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at Medical Cannabis Physicians of Florida. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to Medical Cannabis Physicians of Florida at the address listed below. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the office for answers to my questions about the privacy of my health information at 1400 S. Orlando Ave, Winter Park FL 32789, or by telephone at 407-647-4008

_____
Print Name

_____ _____ _____
Signature Date Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Name of Guardian/ Representative Legal Relationship Date Witness

Medical Marijuana Use Registry Identification Card Application Instructions for Qualified Patients

In order to apply for a Medical Marijuana Use Registry Identification Card each patient must: be a Florida resident, be diagnosed with a qualifying condition, and must have been added to the Compassionate Use Registry (and received a Compassionate Use Registry Patient Identification Number) by a physician licensed under Chapter 458 or Chapter 459, Florida Statutes, to receive low-THC cannabis, medical cannabis, or a cannabis delivery device from an authorized Florida dispensing organization.

NEW PATIENT APPLICATIONS MUST INCLUDE ALL OF THE FOLLOWING

- A completed application. By providing your email address, you consent to the Department contacting you through the email address, including the provision of a temporary verification email.
- A copy of your Florida driver license or Florida identification card, or other proof of residency listed below
- A $75 check or money order (application fee) made out to Florida Department of Health.
- A full-face, passport-type 2x2 inches in size, color photograph taken within the 90 days immediately preceding application

  Minor applications must **also** include:

  - A designated legal representative and Medical Marijuana Use Registry Identification Card Legal Representative Application
  - A copy of the parent's or designated legal representative's proof of residency

PROOF OF RESIDENCY

Patients must submit a copy of a valid Florida driver license or Florida identification card. If the patient does not possess a valid Florida driver license or Florida identification card, they may submit a copy of a utility bill in the patients's name including a Florida address, or a Florida voter registration card. The name and address on the documents provided for residency must match the name and address in this application.

For minor patients, the parent or designated legal representative must submit proof of residency of the parent or designated legal representative.

RENEWAL APPLICATIONS

All Medical Marijuana Use Registry Identification Cards expire 1 year after the date of the physician's initial order. Submit renewal applications 45 days before your card expires. Renewal applications CANNOT be used to purchase low-THC cannabis, medical cannabis, or a cannbis delivery device.

LEGAL REPRESENTATIVE

If you are signing on behalf of the qualified patient in the application, you must provide proof of legal representation. A legal representative means the qualified patient's parent, legal guardian acting pursuant to a court's authorization as required under section 744.3215(4), Florida Statutes, health care surrogate acting pursuant to the qualified patient's written consent or a court's authorization as required under section 765.113, Florida Statutes, or an individual who is authorized under a power of attorney to make health care decisions on behalf of the qualified patient.

NOTICE ON THE COLLECTION, USE, OR RELEASE OF SOCIAL SECURITY NUMBERS

Florida law requires that public agencies provide individuals with a written statement identifying the state or federal law governing the collection, use, or release of social security numbers for each purpose for which the public agency collects an individual's social security number. The collection of social security numbers by the Florida Department of Health is either specifically authorized by law or imperative for the performance of the Florida Department of Health's duties and responsibilities as prescribed by law. This notice is provided pursuant to Subsection 119.071(5)(a), Florida Statutes. For the Compassionate Use Registry Identification Card Qualified Patient Application, social security numbers are collected and used for identification purposes to ensure that the number identifier assigned to the qualified patient is unique and matches the identity of the qualified patient, as authorized by sections 119.071(5)(a)2. and 119.071(5)(a)6., Florida Statutes. Social security numbers collected for this purpose will remain confidential.

KEEP THESE INSTRUCTIONS AND A COPY OF YOUR COMPLETED APPLICATION FOR FUTURE REFERENCE.

ELECTRONIC APPLICATION:

Expedite your application by applying online at

https://mmuregistry.flhealth.gov/

MAIL COMPLETED APPLICATION TO:

Office of Medical Marijuana Use
PO Box 31313
Tampa, FL 33631-3313

QUESTIONS?

Please call 800-808-9580 for assistance

Medical Marijuana Use Registry Patient Identification Card

Qualified Patient Application

☐ **Initial Application** ☐ **Renewal Application** ☐ **Minor Application**

Mail Completed Application to: Office of Medical Marijuana Use PO Box 31313 Tampa, FL 33631-3313	Patient Registry ID #:_____

Patient Information					
First Name		Last Name			Middle Initial
Date of Birth	Social Security Number		Address		
City	Apt/Ste #		State	Zip Code	County
Telephone	Email (optional to receive communication, including a temporary verification)				

Patient Passport Photo	
STAPLE 2"x 2" STAPLE STAPLE 2"x 2" STAPLE Attach a color photograph taken within 90 days of registration	Submit a full-face, passport-type, color photograph of the patient taken within the 90 days immediately preceding registration, and 2x2 inches in size. The image size measured from the bottom of your chin to the top of your head (including hair) should not be less than 1 inch, and not more than 1 3/8 inches. The photograph must be color, clear, with a full front view of your face, and printed on photo quality paper with a plain light (white or off-white) background. The photograph must be taken in normal street attire, without a hat, head covering, or dark glasses unless a signed statement is submitted by the applicant verifying the item is worn daily for religious purposes or a signed doctor's statement is submitted verifying the item is used daily for medical purposes. Headphones, "bluetooth", or similar devices must not be worn in the passport photograph. Any photograph retouched so that your appearance is changed is unacceptable. A snapshot, most vending machine prints, and magazine or full-length photographs are unacceptable.

Designate a Legal Representative *(if applicable)*		
Legal Representative First Name	Legal Representative Last Name	Legal Representative Date of Birth

I hereby certify the above information to be accurate and complete and no one other than me, or my legal representative, is submitting this request on my behalf.	
Patient or Legal Representative Name *(Print)*	
Patient or Legal Representative Signature	Date

Medical Marijuana Use Registry Identification Card Application Instructions for Legal Representatives

A legal representative means the qualified patient's parent, legal guardian acting pursuant to a court's authorization as required under section 744.3215(4), Florida Statutes, health care surrogate acting pursuant to the qualified patient's written consent or a court's authorization as required under section 765.113, Florida Statutes, or an individual who is authorized under a power of attorney to make health care decisions on behalf of the qualified patient.

LEGAL REPRESENTATIVE APPLICATION MUST INCLUDE ALL OF THE FOLLOWING

- A completed application. By providing your email address, you consent to the Department contacting you through the email address, including the provision of a temporary verification email.
- A copy of the proof of legal representation
- A $75 check or money order (application fee) made out to Florida Department of Health.
- A full-face, passport-type 2x2 inches in size, color photograph taken within the 90 days immediately preceding application.

RENEWAL APPLICATIONS

All Medical Marijuana Use Registry Identification Cards expire 1 year after the date of the physician's initial order. Submit renewal applications 45 days before your card expires. Renewal applications CANNOT be used to purchase low-THC cannabis, medical cannabis, or a cannbis delivery device.

NOTICE ON THE COLLECTION, USE, OR RELEASE OF SOCIAL SECURITY NUMBERS

Florida law requires that public agencies provide individuals with a written statement identifying the state or federal law governing the collection, use, or release of social security numbers for each purpose for which the public agency collects an individual's social security number. The collection of social security numbers by the Florida Department of Health is either specifically authorized by law or imperative for the performance of the Florida Department of Health's duties and responsibilities as prescribed by law. This notice is provided pursuant to Subsection 119.071(5)(a), Florida Statutes. For the Compassionate Use Registry Identification Card Qualified Patient Application, social security numbers are collected and used for identification purposes to ensure that the number identifier assigned to the qualified patient is unique and matches the identity of the qualified patient, as authorized by sections 119.071(5)(a)2. and 119.071(5)(a)6., Florida Statutes. Social security numbers collected for this purpose will remain confidential.

KEEP THESE INSTRUCTIONS AND A COPY OF YOUR COMPLETED APPLICATION FOR FUTURE REFERENCE.

ELECTRONIC APPLICATION:

Expedite your application by applying online at https://mmuregistry.flhealth.gov/

MAIL COMPLETED APPLICATION TO:

Office of Medical Marijuana Use
PO Box 31313
Tampa, FL 33631-3313

QUESTIONS?

Please call 800-808-9580 for assistance

Medical Marijuana Use Registry Identification Card

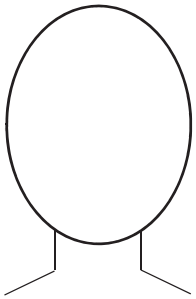
Legal Representative Application

☐ **Initial Application** ☐ **Renewal Application**

Mail Completed Application to: Office of Medical Marijuana Use PO Box 31313 Tampa, FL 33631-3313	Patient Registry ID #:_____

Patient Information				
First Name	Last Name			Middle Initial
Date of Birth	Social Security Number	Address		
City	Apt/Ste #	State	Zip Code	County
Telephone	Email (optional to receive communication, including a temporary verification)			

Legal Representative Information				
First Name	Last Name			Middle Initial
Date of Birth	Social Security Number	Address		
City	Apt/Ste #	State	Zip Code	County
Telephone	Email (optional to receive communication, including a temporary verification)			

Legal Representative Passport Photo	
STAPLE 2"x 2" STAPLE  Attach a color photograph taken within 90 days of registration STAPLE 2"x 2" STAPLE	Submit a full-face, passport-type, color photograph of the legal representative taken within the 90 days immediately preceding registration, and 2x2 inches in size. The image size measured from the bottom of your chin to the top of your head (including hair) should not be less than 1 inch, and not more than 1 3/8 inches. The photograph must be color, clear, with a full front view of your face, and printed on photo quality paper with a plain light (white or off-white) background. The photograph must be taken in normal street attire, without a hat, head covering, or dark glasses unless a signed statement is submitted by the applicant verifying the item is worn daily for religious purposes or a signed doctor's statement is submitted verifying the item is used daily for medical purposes. Headphones, "bluetooth", or similar devices must not be worn in the passport photograph. Any photograph retouched so that your appearance is changed is unacceptable. A snapshot, most vending machine prints, and magazine or full-length photographs are unacceptable.

I hereby certify the above information to be accurate and complete and no one other than me is submitting this request on my behalf.	
Legal Representative Name *(Print)*	
Legal Representative Signature	Date