ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

MARIJUANA PROGRAM PATIENT ATTESTATION

I, _____ , attest that:

I will not divert marijuana to any individual who or entity that is not allowed to possess marijuana pursuant A.R.S. Title 36, Chapter 28.1 and that the information provided in the application is true and correct.

_____ _____

Signature Date Signed

Arizona Department of Health Services (AZDHS) Patient Application Form

*** PLEASE WRITE CLEARLY – ANY INPUT ERRORS WILL DELAY YOUR CARD

□ New Patient

□ Renewal Patient: Current Card #: _____ Exp Date: _____

First Name: _____ Last Name: _____

Middle Name (optional): _____ Suffix: _____
Top of Form

Date of Birth: _____ Gender: Male □ Female □

ID Type: □ Driver's License □ Other ID Number: _____Issue Date: _____

Residence Street Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address (required): _____

□ Check if Mailing Address is the SAME as Residential. If not, write mailing address below:

Mailing Address_____

City: _____ County: _____ State: _____ Zip Code: _____

□ *Check if Caregiver is being designated. If NO caregiver, leave the * answers empty.

*First Name _____ *Last Name _____ *Date of Birth _____

*Male □ *Female □ *Residence Street Address: _____

*City: _____ *County: _____ *State: _____ *Zip Code: _____

□ Check if you're requesting to cultivate. You must live more than 25 miles from a dispensary.

□ Check if you receive Food Benefits (SNAP). If you're eligible for SNAP assistance, your application fee will be reduced from $150 to $75. You must have a food benefits card with your name on it, or your acceptance of benefits letter.

I certify that the information provided is accurate and complete, and I give my permission to process my AZDHS application for a Medical Marijuana ID card.

Signature: _____ Date: _____

Health Questionnaire

Date of Birth: _____ Height: _____ Weight: _____

Gender □ Male □ Female If female, are you currently pregnant? □ Yes □ No

List the medical conditions for which you would like to use medical marijuana:

_____

_____

Treatments: check any treatments you have used for your condition:
□ Prescribed Medicine □ Physical Therapy □ Chiropractic □ Massage
□ Herbal Therapy □ Counseling □ Exercise □Acupuncture □ New Diet

Primary Care Provider Physician Name: _____ Date Last Seen:_____

Physician Address: _____

List Prescription Medications. Include strength and dosing: _____

_____

Non-Prescription Supplements: _____

Allergies to Medications: _____

_____

Hospitalization / Surgical history and dates: _____

_____

Medical Marijuana History

Have you been evaluated by another physician for Medical Marijuana? □ Yes □ No
If yes, write the name of the practice, doctor, and date seen:_____

_____

How often do you use marijuana: ____ times/day _____ times/week _____ times/month

What is your preferred method of using Marijuana? □ Smoke □ Vaporize □ Edible

□ Topical / Lotion □ Tincture □ Juice Other: _____

How effective is Marijuana for your condition on a scale from 1-10: _____

I understand that the information I've been asked to provide is for the diagnosis and treatment of the medical condition for which I'm seeking the physician today. I certify that the information I provided is accurate and complete and offered only for the purpose of gaining treatment of my medical condition.

_____ _____ _____
Print Name Signature Date

Patient Acknowledgement

Instructions: Please read and initial each line.

I understand that:

_____ The attending physician, staff, and/or representative of this medical provider are neither providing, dispensing, nor encouraging me to obtain medical marijuana.

_____ The attending physician, staff, and/or representative of this medical provider are addressing specific aspects of my medical car and are in no way establishing themselves as my primary care physician/provider.

_____ Should an approval be made for my medicinal use of cannabis, there is a renewal date specified by the state. It is my responsibility to see the physician to access the possible continuance of cannabis use beyond the term of approval.

_____ I acknowledge that I am a resident of Arizona; I am at least 18 years of age and have not misrepresented any information to the medical provider.

_____ I acknowledge that I am not recording any portion of my visit with the medical provider nor do I possess any recoding equipment. I understand the medical provider does not approve of such action. I further acknowledge that without express written consent from the medical provider, it is illegal to film or record in this office with video camera, cell phone, or any other recording devices, including still image, video, or audio. Any such action is a direct violation of HIPAA regulations and patient/doctor confidentiality.

_____ I acknowledge that it was my decision to become a patient of this medical provider and am in now way being coerced to do so.

_____ I acknowledge that marijuana, even if used for medical purposes, is illegal under federal law and has been placed on Schedule 1 by the US FDA. As such, marijuana is considered to have no medical benefit and a significant potential for abuse. I assume all responsibility for any violation of federal law.

_____ _____

Print Name Date

_____

Patient Signature

Informed Consent and Release from Liability

Please read the next 2 pages and initial each line.

I understand the following:

_____ I am being evaluated for a physician's recommendation and certification for medical marijuana. The physician will make this recommendation based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain this certification, and it is my intent to use marijuana only as needed for the treatment of my medical condition, and not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use, sale/purchase and/or distribution of marijuana.

_____ I must be an Arizona resident and over 18 years of age to obtain an approval or recommendation for the use of cannabis under Arizona law. If I am under 18 years of age I must have parental consent and authorization for the use of medical marijuana.

_____ The federal government has classified marijuana as a Schedule 1 controlled substance. Schedule 1 controlled substances are defined, in part, as having (1) high potential for abuse, (2) no currently accepted medical treatments 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 Arizona, which have modified their state laws to treat marijuana as a medicine.

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

_____ The use of marijuana can affect coordination, motor skills, and cognition; the ability to think, judge, and reason. While using marijuana I should not drive, operate heavy machinery, or engage in any activities that require me to be alert and/or respond quickly. I understand that if I drive while under the influence of marijuana, I understand that I can be arrested for a DUI (driving under the influence).

_____ Possible 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, 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 marijuana may increase eating, alter my perception of time and space and impair my judgment.

_____ I understand that using marijuana while under the influence of alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

_____ The risks, benefits, and drug interactions of marijuana are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with this physician, and my primary physician, before using marijuana, and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating physician(s).

_____ Individuals may develop a tolerance to, and/or dependence on marijuana. I understand that if I require increasingly higher doses to achieve the same benefit, I could be developing a dependency on marijuana, and should seek medical assistance.

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

_____ If the medical provider subsequently learns that the information I have furnished is false or misleading, the recommendation for marijuana may no longer be valid. I agree to promptly meet with the medical provider and/or provide additional information in the event of any inaccuracies or misstatements in the information I have provided.

Furthermore, I undersigned (including my heirs or anyone acting on my behalf) hold this medical provider and his/her principles. Agents, employees, and management, harmless and release them from any liability resulting in any way whatsoever from my use or marijuana. This release of liability includes, but is not limited to, any bodily or psychology injury, whether known or unknown, as well as legal and/or employment problems resulting from use of marijuana.

_____ _____

Print Name Date

_____

Patient Signature