Arkansas Department of Health

Medical Marijuana Physician Written Certification

Patient Information

First Name	MI	Last Name

Street Number and Street Name (or PO Box)

Unit Number	Unit Type (Apt, Unit, Suite, etc.)

City	State	Zip Code

Date of Birth (MM/DD/YYYY)	Under the age of 18?	Physically Disabled?
	☐ Yes ☐ No	☐ Yes ☐ No

_____ I hold a valid, unrestricted, existing license to practice as a medical physician or osteopathic physician in Arkansas.

_____ It is my professional opinion, after having completed an in-person assessment of the patient's medical history and current medical condition in the course of a physician patient relationship, the patient has a qualifying medical condition identified below.

Select the qualifying medical condition(s):

- ☐ Cancer
- ☐ Glaucoma
- ☐ Positive status for human immunodeficiency virus/ acquired immune deficiency syndrome
- ☐ Hepatitis C
- ☐ Amyotrophic lateral sclerosis
- ☐ Tourette's syndrome
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Post-traumatic stress disorder
- ☐ Severe arthritis
- ☐ Fibromyalgia
- ☐ Alzheimer's disease
- ☐ Cachexia or wasting syndrome
- ☐ Peripheral neuropathy
- ☐ Intractable pain, which is pain that has not responded to ordinary medications, treatment or surgical measures for more than six (6) months
- ☐ Severe nausea
- ☐ Seizures, including without limitation those characteristic of epilepsy
- ☐ Severe and persistent muscle spasms, including without limitation those characteristic of multiple sclerosis

Issue Registry Card for: ☐ 12 Months ☐ Less than 12 months ___ Months ___ Weeks

Physician Information

First Name	MI	Last Name	Suffix

Arkansas Medical License Number	DEA Number

Address

Unit Number	Unit Type (Apt, Unit, Suite, etc.)

City	State	Zip Code

Phone	I do hereby attest that this information is true, accurate and complete. Signature	Date

Patient Authorization

The information in this certification is correct and as the patient or parent, custodian, legal guardian, by signing I indicate I am aware of this diagnosis and medical marijuana physician written certification and authorize the Arkansas Department of Health to verify as warranted

Signature	☐ Patient ☐ Parent ☐ Custodian ☐ Legal Guardian	Date

Print Name