ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

MEDICAL MARIJUANA REVIEWING PHYSICIAN CERTIFICATION REVIEWING PHYSICIAN INFORMATION

Physician's Name:	
Arizona Issued License Number:	Type: ☐ MD ☐ DO ☐ NMD/ND ☐ MD(H)/DO(H)
Physician Office Address:	
Physician Telephone Number:	Physician Email Address:
Minor Qualifying Patient Name:	Minor Qualifying Patient Date of Birth:

☐ Acquired immune deficiency syndrome (AIDS) ☐ Amyotrophic lateral sclerosis (ALS) ☐ Crohn's disease
☐ Human immunodeficiency virus (HIV) ☐ Agitation of Alzheimer's disease ☐ Cancer ☐ Glaucoma ☐ Hepatitis C
☐ Post-Traumatic Stress Disorder (PTSD)

IF A CHRONIC OR DEBILITATING DISEASE OR MEDICAL CONDITION OR THE TREATMENT FOR A CHRONIC OR DEBILITATING DISEASE OR MEDICAL CONDITION CAUSES:

☐ Cachexia or wasting syndrome ☐ Severe and chronic pain ☐ Severe nausea ☐ Seizures, including epilepsy characteristic
☐ Severe or persistent muscle spasms, including those characteristic of multiple sclerosis

IF ANY CONDITION ABOVE IS CHECKED, INDICATE THE UNDERLYING CHRONIC OR DEBILITATING DISEASE OR MEDICAL CONDITION:

I, _____, THE REVIEWING PHYSICIAN:
(PRINT NAME)

- Have conducted a comprehensive review of the qualifying patient's medical records from other physicians treating the qualifying patient.

  Initial: _____

- If the qualifying patient has been referred to a dispensary, I have disclosed to the qualifying patient, or if applicable, the qualifying patient's custodial parent or legal guardian, any personal or professional relationship I have with the dispensary.

  Initial: _____

PHYSICIAN'S ATTESTATION

I, _____, in my professional opinion believe that the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient's medical use of marijuana to treat or alleviate the qualifying patient's debilitating medical condition. I attest that the information provided in this written certification is true and correct.

_____ _____

Physician's Signature Date Signed