ARIZONA DEPARTMENT OF HEALTH SERVICES
LICENSING

MEDICAL MARIJUANA PHYSICIAN CERTIFICATION
PHYSICIAN INFORMATION
FOR ALL QUALIFYING PATIENTS

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

☐ 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 checked, please review and attest item 6)***

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 PHYSICIAN:
(PRINT NAME)

1. Have made or confirmed diagnosis of a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient.
   Initial: _____
2. Have established a medical record for the qualifying patient and am maintaining the qualifying patient's medical record as required in A.R.S. § 12-2297.
   Initial_____
3. Have conducted a physical examination of the qualifying patient within the last 90 calendar days appropriate to the qualifying patient's presenting symptoms and the debilitating medical condition I diagnosed or confirmed.
   Date of Examination (mm/dd/yyyy):_____Initial_____
4. Have reviewed the qualifying patient's medical records, including medical records from other treating physicians from the previous 12 months; the qualifying patient's responses to conventional medications and medical therapies; and the qualifying patient's profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database.
   Initial: _____
5. Have explained the potential risks and benefits of the medical use of marijuana to the qualifying patient, or if applicable, the qualifying patient's custodial parent or legal guardian.
   Initial: _____
6. Have reviewed evidence documenting that the patient is currently undergoing conventional treatment for PTSD *(PTSD patients only)*.
   Initial: _____
7. 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: _____
8. I have addressed the potential dangers to fetuses caused by smoking or ingesting marijuana while pregnant or to infants while breastfeeding. I have also informed the patient that the use of marijuana during pregnancy may result in a risk of being reported to the Department of Child Safety during pregnancy or at the birth of the child by persons who are required to report.
   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 (mm/dd/yyyy)