OKLAHOMA MEDICAL MARIJUANA AUTHORITY

PHYSICIAN TERMINATION OF PATIENT LICENSE FORM

This form is for recommending physicians who wish to notify OMMA that a patient no longer meets the requirements for the use of medical marijuana. The patient's license will be terminated upon successful submission of this form by the recommending physician.

NOTE: Please provide complete, accurate contact information. OMMA will need to verify the information in this form with the recommending physician. If OMMA is unable to verify the information, the patient license will not be terminated.

INSTRUCTIONS: Please email this form to OMMAPhysicians@ok.gov; or mail to: PO Box 262266, OKC, OK 73126-2266

PATIENT INFORMATION - Request for Termination of License

First Name | Middle Name | Last Name | Suffix | Date of Birth (mm/dd/yy)

Is the patient a Minor under the age of 18? ◯ NO ◯ YES If YES, both recommending physicians must complete this form in order to terminate the license.

PHYSICIAN INFORMATION

First Name | Middle Name | Last Name | Suffix

Office Address | City | State | Zip

Email Address | Phone Number

Medical License Number | NPI Number

PHYSICIAN ATTESTATION

By my signature below I attest to the following:

- I am the physician who signed the above named patient's recommendation form;
- I understand submission of this form will result in the termination of the patient's license and that the patient will not be refunded the license application fee;
- The patient no longer meets the requirements for the continued use of medical marijuana;
- I understand that the associated caregiver license(s) will also be terminated; and
- OMMA will notify the patient of his or her license termination, along with a copy of this form.

Physician Signature *(required)*: _____ Date: _____