PHYSICIAN RECOMMENDATION FORM - FIRST PHYSICIAN

Minor Patient License Under the age of 18



INSTRUCTIONS

- 1. This form is to be completed by a physician licensed and in good standing in the State of Oklahoma.
- 2. The parent/legal guardian must submit this form with the minor patient online license application.
- 5. Patients under the age of 18 must have two forms dated within 30 days of each other, and the second recommendation form must be dated within 30 days of the application subission date

Proof of Identity (select one): OK Driver's License U.S. Passport / U.S. Photo I.D. OK I.D. Card Tribal I.D. Card MEDICAL CONDITIONS (optional section) - I recommend the use of medical marijuana for the patient named above for the 1. Specific ICD-10-CM:	rent Physical Street Address APT# City State Zip of of Identity (select one): OK Driver's License U.S. Passport / U.S. Photo I.D. OK I.D. Card Tribal I.D. Card Birth Certificate DICAL CONDITIONS (optional section) - I recommend the use of medical marijuana for the patient named above for the following condition(s): Description: Description: Description: Description: Description: RTIFICATION OF NECESSITY OF A CAREGIVER (optional section) A physician signature is required to certify the need for a caregiver. antity the patienthypicant is homebound or does not have the capability to self administer or purchase medical marijuana due to a developmental disability or a physical or antivor impairment. Careful Physician Signature is required to certify the need for a caregiver. Physician Signature (required if applicable): Date: Date: hysician Information Example Middle Name Last Name Suffix Phone Number OK State Board of Medical Licensure & Supervision Medical License ## OK State Board of Osteopathic Examiners OK Podiatric Medical Examiners Board NPI# VSICIAN ATTESTATION by my signature below, lattest to the following: and a variety medical consideration and abone fire physical-special relationship with the purchase, application or patientic physician, see established and and board fire physician patient elements behalf, and only the patients of the patient physician see established and and administration of medicine, or position proprieties and weather physician see established and and board fire physician patient elements with the purchase, application or position physician, see established and and administration of medicine, or position proprieties and physician see established and and board fire physician patient elements with the patient-physican patient elements with the patient-physican conservation of medicine proprieties or position physician physician seed established and an addition physician patient elements position and a board fire physician patient elements with the patient-physi		ecommendation is for a:	2 Year License	eu-Day Iem	porary License	
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Office Address (address must match address on licensure board site) City Stat	OK State Board of Osteopathic Examiners OK Podiatric Medical Examiners Board NPI# VSICIAN ATTESTATION By my signature below, I attest to the following: India valid, unrestricted and existing license to practice in the State of Oklahoma as a doctor of medicine, doctor of osteopathic medicine, or podiatric physician; have established a medical record for the patient/applicant and a bona fide physician-patient relationship with the patient/applicant; have determined the presence of a medical condition(s) for which the patient/applicant is likely to receive therapeutic or palliative benefit from the use of medical marijuana; the recommending a medical marijuana license for the patient/applicant according to the accepted standards a reasonable and prudent physician would follow for recommending of a proving any medication. Nave verified the patient/applicant's identity as indicated; and	`				_ Date:	
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OK Podiatric Medical Examiners Board NPI#	nold a valid, unrestricted and existing license to practice in the State of Oklahoma as a doctor of medicine, doctor of osteopathic medicine, or podiatric physician; nave established a medical record for the patient/applicant and a bona fide physician-patient relationship with the patient/applicant; nave determined the presence of a medical condition(s) for which the patient/applicant is likely to receive therapeutic or palliative benefit from the use of medical marijuana; are recommending a medical marijuana license for the patient/applicant according to the accepted standards a reasonable and prudent physician would follow for recommending or proving any medication. The patient of the	Physician Ir First Name Office Address (address)	Middle Name ress must match address on licensure board OK Board of Medical Licensure & Super	Tast Name disite) City Vision Medical License		Suffix	Phone Number
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approving any medication. I have verified the patient/applicant's identity as indicated; and The information in this recommendation form is true and correct.		Physician Ir First Name Office Address (address (address) Licensing Entity: PHYSICIAN ATT I hold a valid, unrestri I have established a n I have determined the I am recommending approving any medic I have verified the pate	Middle Name Tess must match address on licensure board OK Board of Medical Licensure & Super OK State Board of Osteopathic Examine OK Podiatric Medical Examiners Board TESTATION By my signature below, I at cted and existing license to practice in the State of nedical record for the patient/applicant and a bona e presence of a medical condition(s) for which the a medical marijuana license for the patient/application. tient/applicant's identity as indicated; and	Last Name d site) City vision Medical License NPI# test to the following: Oklahoma as a doctor of medicine if ide physician-patient relationshi patient/applicant is likely to receive	e, doctor of osteopathic p with the patient/appli e therapeutic or palliativ	Suffix State State c medicine, or podiatric icant; ve benefit from the use	Phone Number ZIP physician; e of medical marijuana;

PHYSICIAN RECOMMENDATION FORM - SECOND PHYSICIAN

Minor Patient License Under the age of 18



INSTRUCTIONS

- 1. This form is to be completed by a physician licensed and in good standing in the State of Oklahoma (see further instructions below) within 30 days of the date the first recommendation form was signed.
- The parent/legal guardian must submit this form with the minor patient online license application.
- Patients under the age of 18 must have two forms dated within 30 days of each other, and the second recommendation form must be dated within 30 days of the application subission date.

Patient Info	rmation				
The physician recommendation is for a:		2 Year License	60-Day Temporary License		
First Name	Middle Name	Last Name		Suffix [Pate of Birth (mm/dd/yyyy)
Current Physical Stre	et Address	APT# City		State	ZIP
Proof of Identity (sel	ect one): OK Driver's License	U.S. Passport / U.S. Photo I.D.	OK I.D. Card	Tribal I.D. Card	Birth Certificate
MEDICAL CONDIT	TIONS (optional section) - I recommen	d the use of medical marijuana	for the patient name	ed above for the fol	lowing condition(s):
1. Specific ICD-10-CM	·		Description:		
1. Specific ICD-10-CM	·		_ Description:		
1. Specific ICD-10-CM	:		_ Description:		
I certify the patient/ap cognitive impairment; I believe the patient/a; By signing below, I recognitions.	OF NECESSITY OF A CAREGIN plicant is homebound or does not have the ca pplicant would benefit from having a caregive ognize the patient may identify a caregiver of mature (required if applicable):	apability to self-administer or purchaser with a caregiver's license designate f his or her choosing to assist with the	se medical marijuana due ed to manage the patient e purchase, application ar	e to a developmental di 's medical marijuana o nd administration of me	sability or a physical or n the patient's behalf; and edical marijuana.
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Physician In	formation				
First Name	Middle Name	Last Name		Suffix	Phone Number
Office Address (addre	ess must match address on licensure b	pard site) City		State	ZIP
Licensing Entity:	OK Board of Medical Licensure & Su	pervision Medical Licen:	se #		
	OK State Board of Osteopathic Exan	niners			
	OK Podiatric Medical Examiners Boa	ard NPI#			
PHYSICIAN ATT	ESTATION By my signature below,	I attest to the following:			
I hold a valid, unrestric I have established a m I have determined the I am recommending a approving any medica I have verified the pati	ted and existing license to practice in the Sta edical record for the patient/applicant and a b presence of a medical condition(s) for which medical marijuana license for the patient/ap	te of Oklahoma as a doctor of medici pona fide physician-patient relationsl the patient/applicant is likely to recei	nip with the patient/applic ve therapeutic or palliativ	cant; ve benefit from the use	of medical marijuana;
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New Physician Signature	gnature (required):			_ Date:	