



MEDICAL MARIJUANA PHYSICIAN CERTIFICATION

PHYSICIAN INFORMATION

FOR ALL QUALIFYING PATIENTS

Physician's Name:	
Arizona License Number:	Type: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NMD/ND <input type="checkbox"/> MD(H)/DO(H)

PHYSICIAN INFORMATION ON FILE WITH LICENSING BOARD

Office Address:	
Telephone Number:	Email Address:

QUALIFYING PATIENT INFORMATION

Patient's Name:	Date of Birth:
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CHECK ONE OR MORE BOXES TO INDICATE QUALIFYING PATIENT'S DEBILITATING MEDICAL CONDITION

<input type="checkbox"/> Acquired immune deficiency syndrome (AIDS)	<input type="checkbox"/> Agitation of Alzheimer's disease
<input type="checkbox"/> Amyotrophic lateral sclerosis (ALS)	<input type="checkbox"/> Cancer
<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Human immunodeficiency virus (HIV)	<input type="checkbox"/> Hepatitis C

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

<input type="checkbox"/> Cachexia or wasting syndrome	<input type="checkbox"/> Severe and chronic pain
<input type="checkbox"/> Severe nausea	<input type="checkbox"/> Seizures, including those characteristic of epilepsy
<input type="checkbox"/> 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:

- Have made or confirmed a diagnosis of a debilitating medical condition, as defined in [A.R.S. § 36-2801](#), for the qualifying patient.
Initial: _____
- 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: _____
- Have conducted an in-person 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: _____ Initial: _____
- 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: _____
- 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: _____
- Have referred the qualifying patient to a dispensary. YES NO If YES, 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