Medical Marijuana Program
P.O. Box 47852 | Olympia, WA 98504-7852
Telephone: 360-236-4819 | Fax: 360-236-2901

Washington State Medical Marijuana Authorization Form

Patient and Designated Provider Information			
Full Legal Name of Patient		Full Legal Name of Designated Provider (if any)	
Street Address		Designated Provider Street Address	
City	State	City	State
Patient's Date of Birth	ZIP Code	Designated Provider's Date of Birth	ZIP Code

Authorizing Healthcare Practitioner Information	
Name of Healthcare Practitioner (as appears on license)	Healthcare Practitioner License No. (Ex. – MD00001111)
Business Street Address for Healthcare Practitioner	City, State and ZIP Code for Healthcare Practitioner
Telephone number for Healthcare Practitioner where this authorization can be verified during normal business hours	

Attestation of Healthcare Practitioner

I am licensed in the state of Washington and have diagnosed the above named patient as having the following terminal or debilitating medical condition that is severe enough to significantly interfere with the patient's activities of daily living and ability to function, and can be objectively assessed and evaluated (check all that apply):

- ☐ Cancer
- ☐ HIV
- ☐ Epilepsy or other seizure disorder
- ☐ Spasticity disorder
- ☐ Intractable pain
- ☐ Posttraumatic stress disorder
- ☐ Glaucoma
- ☐ Crohn's disease
- ☐ Multiple sclerosis
- ☐ Hepatitis C
- ☐ Chronic renal failure requiring hemodialysis
- ☐ Traumatic brain injury
- ☐ A disease that results in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms or spasticity

I further attest that I have performed an in-person examination of the above named patient and assessed his or her medical history and medical condition. I have advised this patient about the potential risks and benefits of the medical use of marijuana. It is my professional opinion that this patient may benefit from the medical use of marijuana.

Healthcare Practitioner Signature	
Date Issued	Expiration Date

OPTIONAL: In my professional opinion, the medical needs of this patient exceed the presumptive number of plants allowed by law. I recommend this patient be allowed to grow up to plants (not to exceed 15) in his or her domicile for his or her personal use. (Note: This provision applies only after July 1, 2016, and requires the patient and designated provider, if any, to be entered into the medical marijuana authorization database and hold a recognition card.)

Health Care Practitioner Signature (if recommending additional plants)

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Patient/Designated Provider Notification
An authorization for the medical use of marijuana does not provide protection from arrest unless the patient and designated provider, if any, are entered into the medical marijuana authorization database and hold a recognition card. An authorized patient or designated provider may not: • Sell, donate, or otherwise supply the patient's marijuana to another person. • Use or display marijuana in a manner or place that is open to the view of the general public. • Grow, possess, or use marijuana on federal property. • Grow more than 15 plants in any one housing unit even if multiple qualifying patients or designated providers reside in the housing unit. • Grow, store, produce, or process marijuana or marijuana-infused products if any portion of such activity can be readily seen by normal unaided vision or readily smelled from a public place or the private property of another housing unit.
Patient/Designated Provider Attestation
Patient: I hereby attest that I have discussed the risks and benefits of the medical use of marijuana with my healthcare practitioner. I understand some of the risks may include possible long-term effects to the brain in the areas of memory, coordination, and cognition; impairment of the ability to drive or operate heavy machinery; physical or psychological dependence; and respiratory damage if smoked. I further attest that I have read chapter 69.51A RCW and understand the legal requirements of being a patient. OR Designated provider: I hereby attest that I am over the age of 21 and agree to serve as the designated provider for the patient identified on this form. I understand I can serve as the designated provider for only one patient at a time. I further understand that I can stop serving as designated provider for this patient by revoking the designation in writing. The revocation must be signed, dated, and provided to the patient and the medical marijuana authorization database administrator if I am entered into the database. I understand 14 days must elapse before I can begin serving as the designated provider for a different patient. I further attest that I have read chapter 69.51A RCW and understand the legal requirements of being a designated provider.

Signature of Patient or Designated Provider	Date

NOTE – In order to be valid this authorization must be:

- Fully completed and printed by the authorizing healthcare practitioner. Every field must be filled unless it is described as "optional." If a designated provider is not identified, those fields must be marked N/A.
- Printed on tamper-resistant paper as defined in RCW 69.51A.010.
- Written on this form (or a subsequent version) for **NEW** authorizations and renewals beginning July 24, 2015.
- Written on this form (or a subsequent version) for **ALL** authorizations beginning July 1, 2016.

Authorizations expire after one year for adult patients and six months for patients under the age of 18. The authorizing healthcare practitioner may indicate an earlier expiration date. A copy must be kept in the patient's medical record.

The patient and designated provider, if any, must obtain individual authorizations from the authorizing healthcare practitioner. It is not sufficient for the designated provider to possess a copy of the patient's authorization.

For questions contact the Medical Marijuana Program at medicalmarijuana@doh.wa.gov or (360) 236-4819, or visit the Department of Health's website at www.doh.wa.gov/medicalmarijuana.