Appendix

State's Exhibit 3

Arizona Department of Health Services

MEDICAL MARIJUANA PHYSICIAN CERTIFICATION

PHYSICIAN INFORMATION

FOR ALL QUALIFYING PATIENTS

Physician's Name:	
Arizona License Number:	Type: ☐ MD ☐ DO ☐ NMD/ND ☐ 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:

CHECK ONE OR MORE BOXES TO INDICATE QUALIFYING PATIENT'S DEBILITATING MEDICAL CONDITION

☐ Acquired immune deficiency syndrome (AIDS)	☐ Agitation of Alzheimer's disease
☐ Amyotrophic lateral sclerosis (ALS)	☐ Cancer
☐ Crohn's disease	☐ Glaucoma
☐ Human immunodeficiency virus (HIV)	☐ Hepatitis C

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 those characteristic of epilepsy

☐ 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