<u>PATIENT REGISTRATION FORM</u>

Patient Name (Last, First, Middle) ____________________________________ **DOB:** _____________

PA Marijuana ID#: ______________________________

Serious Medical Condition: ____

PDMP Checked by Physician **YES** **NO**

CONSENT FOR CERTIFICATION
I hereby authorize Physician to Certify me for Medical Marijuana in the Commonwealth of Pennsylvania.

____ ___________________
PATIENT AND/OR GUARDIAN SIGNATURE **DATE:**

CONSENT FOR CERTIFICATION FOR MONOR/INCAPACITATED PATIENTS
I hereby authorize Physician to Certify_________________________________. Patient is unable to consent for Certification because he/she is a minor child/other__________________________________.

X___________________________________	X_______________________	X_______________________
SIGNATURE OF GUARDIAN	**NAME OF GUARDIAN**	**WITNESS SIGNATURE**

DATE: ______________________

MEDICARE PATIENTS <u>(MUST COMPLETE AN ABN FORM)</u>