

**Montana Marijuana Program**  
**PHYSICIAN STATEMENT for a DEBILITATING MEDICAL CONDITION**

Registered cardholder applicants with a debilitating medical condition must use this form when applying for the Montana Marijuana Program Registry. *A medical doctor or doctor of osteopathy* must complete this form for the registered cardholder applicant.  
***Only original Physician's Statements are accepted- Do not send a copy.***  
**Completion of this form does not constitute a prescription for marijuana.**

**PHYSICIAN AND PATIENT: READ THIS CHECKLIST BEFORE SENDING THIS FORM TO THE DEPARTMENT**

- ✓ The physician completing this form must address questions one, two and three in PART B in the space provided or in attached documentation.
- ✓ A patient application is also required with this form. A patient application can be found at [www.dphhs.mt.gov/marijuanaprogram](http://www.dphhs.mt.gov/marijuanaprogram) under "Forms".

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_  
Last First MI

**This information must match the information on file with the Montana Board of Medical Examiners:**

Physician's Name: \_\_\_\_\_ Montana License Number: \_\_\_\_\_

Street Address, City, State, Zip (physician's office): \_\_\_\_\_

Mailing address, City, State, Zip: \_\_\_\_\_

Physician's Telephone Number: \_\_\_\_\_ Business Email: \_\_\_\_\_

Is any of the information above new information that needs to be updated in the Marijuana System?

Yes  No

**Initial one or two below:**

1. I am the patient's treating physician and this patient has been under my ongoing medical care as part of a bona fide professional relationship \_\_\_\_\_  
OR;
2. I am the patient's referral physician \_\_\_\_\_

**Please indicate the condition for which you are recommending marijuana (circle letter). You may circle more than one condition:**

- a. Cancer, glaucoma or positive status for human immunodeficiency virus, or acquired immune deficiency syndrome when the condition or disease results in symptoms that seriously and adversely affect the patient's health status;
- b. Cachexia or wasting syndrome
- c. Intractable nausea or vomiting
- d. Epilepsy or an intractable seizure disorder
- e. Multiple sclerosis
- f. Chron's disease
- g. Painful peripheral neuropathy
- h. A central nervous system disorder resulting in chronic, painful spasticity or muscle spasms
- i. Admittance into hospice care

NOTE: A chronic pain diagnosis requires a PHYSICIAN'S STATEMENT for a CHRONIC PAIN DIAGNOSIS

**In a statement or in attached documentation:**

1. Specify the patient's debilitating medical condition. Describe the condition, why it is debilitating and to what extent it is debilitating.
2. Describe medications, procedures and other medical options used to treat the condition and state that these options have not been effective.
3. List restrictions to the patient's activities due to the use of marijuana.

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Specify the time period for which the use of marijuana would be appropriate (not to exceed one year).

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**In signing this form, I certify:**

- a. I am a physician duly licensed to practice medicine in Montana under MCA Title 37, Chapter 3.
- b. I am this patient’s treating physician and I have assumed primary responsibility for providing management and routine care of this patient.
- c. Having completed a full assessment of the patient’s medical history and current condition, in the course of the medical care and supervision I have provided, this patient has a debilitating medical condition as described above.
- d. I have reviewed all prescription and non-prescription medications and supplements used by this patient, and have considered the potential drug interaction with marijuana.
- e. I have a reasonable degree of certainty that this patient’s condition would benefit from the use of marijuana and the potential benefits of marijuana will likely outweigh the health risks for this patient.
- f. I have described the potential risks and benefits of the use of marijuana to this patient.
- g. I will continue to serve as this patient’s treating physician and will supervise the use of marijuana and evaluate the efficacy of the treatment.
- h. The information provided in this written certification is true and correct.

Physician’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Give the original form to the patient**