Clear Form

Washington State Medical Cannabis Authorization

This form must be completed and signed by the authorizing practitioner or delegate. This authorization form is **not** a prescription and does not provide protection from arrest unless the qualifying patient and their designated provider is also entered in the medical cannabis authorization database by a certified consultant and receives a recognition card.

I. Patient and Designated Provider Information

Issue Type (check one): ☐ **Initial** ☐ **Renewal**

1	Patient's Full Name: (same as state-issued ID)		Date of Birth:	
2	Street address: (No P.O. Box)	City:	State: WA	Zip:
3	Does the patient have a designated provider (DP)? (**check one below**) ☐ **Yes**, patient sign's **item 6** below, unless they are a minor (under age 18) ☐ **No**, continue to **Section II**			
4	DP or Parent/Legal Guardian's Name:		Date of Birth:	
5	Street address: (No P.O. Box)	City:	State: WA	Zip:
6	I am an adult patient (18 and older) and agree the person named above will serve as my designated provider. **Patient Signature:** _____ **Date:**_____ (RCW69.51A.010(11))			

II. Healthcare Practitioner Information

7	Healthcare Practitioner's Name (as it appears on license):			WA License Number: (Example: MD000011110):	
8	Office/Clinic Address (No P.O. Box)	City:	State:	Zip:	Phone:

III. In signing this form, I certify and recommend the following:

9. I am a Washington State licensed healthcare practitioner and allowed to authorize my patients to use cannabis for medical purposes under RCW 69.51A.010. In my professional opinion, as the treating healthcare practitioner, the above named patient may benefit from the medical use of cannabis for the qualifying condition(s) below **(check all that apply):**

- ☐ Cancer
- ☐ Chronic Renal Failure Requiring Hemodialysis
- ☐ Crohn's Disease
- ☐ Epilepsy/Other Seizure Disorder
- ☐ Glaucoma
- ☐ Hepatitis C
- ☐ HIV
- ☐ Intractable Pain
- ☐ Multiple Sclerosis
- ☐ Posttraumatic Stress Disorder
- ☐ Spasticity Disorder
- ☐ Traumatic Brain Injury
- ☐ A disease that results in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms or spasticity

10. In my professional opinion, the above named patient is eligible for a compassionate care renewal of their authorization form and registration in the medical cannabis authorization database per RCW 69.51A.030 (**check one):**

☐ **Yes,** is eligible (Patient's DP may renew database registration on the their behalf) ☐ **No**, is not eligible

11. By issuing this authorization, I understand a patient or their designated provider on the patient's behalf, may grow up to four plants within their domicile. If entered into the database, the patient (or designated provider) may grow up to six plants within their domicile. In my professional opinion, I have determined the patient's medical needs exceed the amounts provided and recommend additional plants **(check one below):**

☐ **Yes,** I recommend _____ number of plants (enter 6-15) ☐ **No** recommendations

12. This authorization was issued _____ (today's date) and needs to be renewed before _____ (expiration date*)
*Adult patient authorizations may be valid for up to one year from issue date; up to six months for minor patients.

13. Practitioner's Signature _____ **Date signed** _____

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

WASHINGTON STATE RCW 69.51A.030 MEDICAL CANNABIS