

Washington State Medical Cannabis Authorization

This form must be completed and signed by the authorizing practitioner.

This authorization form is **not** a prescription.

I. Patient and Designated Provider Information **Issue Type (check one):** _____ **Initial - must be in person**
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)? (a patient under 18 must have a parent or guardian as DP) 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: _____ (RCW 69.51A.010(11))			

II. Healthcare Practitioner Information

7	Healthcare Practitioner's Name (as it appears on license):		WA License Number: (Example: MD00001111):		
8	Office/Clinic Address (No PO Box)	City	State:	Zip:	Phone:

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

I am a WA State licensed healthcare practitioner allowed to authorize the use of cannabis for medical purposes under RCW 69.51A.030. In my professional opinion, the above-named patient may benefit from the medical use of cannabis.

9. Qualifying Conditions.

The above-named patient has one or more qualifying conditions as defined in RCW 69.51A.010(24).

- Cancer
- PTSD
- Hepatitis C
- A disease that results in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms or spasticity
- HIV
- Intractable Pain
- Traumatic Brain Injury
- Multiple Sclerosis
- Glaucoma
- Epilepsy/Seizure Disorder
- Spasticity Disorder
- Crohn's Disease

10. Compassionate care eligibility. In my professional opinion, the above-named patient is eligible for a compassionate care renewal of their registration in the medical cannabis registry and recognition card. RCW 69.51A.030(2)(c)(iv):

Yes (Patient's DP may renew patient's card on their behalf)

No, not eligible for compassionate care renewal

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

Yes, if patient is entered in registry, I authorize _____ plants (enter 7-15)

No additional plants authorized

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

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