PLEASE READ AND SIGN IN THE SPACE PROVIDED BELOW THAT YOU UNDERSTAND AND AGREE TO EACH ITEM.

I UNDERSTAND THAT MEDICAL MARIJUANA IS CONSIDERED MEDICINE AND IS TO BE USED IN THE POTENTIAL TREATMENT OF THE SUFFERING CAUSED BY SERIOUS AND DEBILITATING MEDICAL CONDITIONS, AS DETERMINED THE MARYLAND MEDICAL CANNABIS COMMISION. THESE CONDITIONS INCLUDE**:** A CHRONIC OR DEBILITATION DISEASE OR MEDICAL CONDITION THAT RESULTS IN A PATIENT BEING ADMITTED INTO HOSPICE OR RECEIVING PALLIATE CARE; OR A CHRONIC OR DEBILITAING DISEASE OR MEDICAL CONDITION OR THE TREATMENT OF A CHRONIC OR DEBILITATING DISEASE OR MEDICAL CONDITION THAT PRODUCES: 1. CACHEXIA, ANOREXIA, OR WASTING SYNDROME; 2. SEVERE OR CHRONIC PAIN; 3. SEVERE NAUSEA; 4. SIZURES; OR 5. SEVERE OR PERSISTANT MUSCLE SPASMS; OR 6. ANY OTHER CHRONIC CONDITION FOR WHICH TREATMENT OPTIONS HAVE FAILED AND YOUR SYMPTOMS MAY BE RELIEVED WITH MEDICAL MARIJUANA.

I AGREE TO NOTIFY THE STAFF NURSE PRACTIONER IF I:

HAVE BEEN PRESCRIBED OR AM TAKING PRESCRIPTION MEDICATION FOR THIS CONDITION; HAVE EVER HAD DEPRESSIVE OR SUICIDAL SYMPTOMS/THOUGHTS, EXPERIENCED PSYCHOSIS OR ANY OTHER MENTAL ILLNESS; AM CURRENTLY USING HERBS, SUPPLEMENTS OR OTHER MEDICATIONS; EXPERIENCE DISRUPTIONS IN MY SLEEP PATTERNS; LOSE INTEREST IN MY REGULAR/USUAL ACTIVITIES; BEGIN EXPERIENCING RESPIRATORY PROBLEMS OR OTHER ISSUES, AND WILL DISCONTINUE THE USE OF MEDICAL MARIJUANA UNTIL FURTHER NOTICE. THE NURSE PRACTITIONER, STAFF, INDEPENDENT CONTRACTORS, AND ASSOCIATES ARE NOT ADDRESSING SPECIFIC ASPECTS OF MY MEDICAL CARE AND, UNLESS OTHERWISE STATED, ARE IN NO WAY ESTABLISHING THEMSELVES AS MY PRIMARY CARE PROVIDER. FURTHERMORE, THE NURSE PRACTITIONER, STAFF, INDEPENDENT CONTRACTORS, AND ASSOCIATES ARE NOT ADVISING THAT I DISCONTINUE TREATMENT OR MEDICATION THAT I CURRENTLY TAKE. I GIVE MY CONSENT TO HAVE MY NAME, DATE OF VISIT, AND OTHER REQUIRED INFORMATION TO LAW ENFORCEMENT FOR LEGAL VERIFICATION OF MY RECOMMENDATION AS NEEDED (IN THE SITUATION WHERE I MAY NEED TO PROVE MY CARD EXISTS YET DO NOT, FOR WHATEVER REASON, HAVE IT AVAILABLE).

PATIENT SIGNATURE: _____ DATE: _____/_____/_____ (or parent/guardian)

PRINTED PATIENT NAME: _____