

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_ M/F:\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, OH Zip:\_\_\_\_\_\_\_\_

Driver’s License #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone:\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Medical Condition/s which qualifies you for medical marijuana under Ohio Law:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Medical Record: with the above qualifying diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Must be within the last 12 months)*

Physician’s Name/Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List of Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of Surgeries with approximate dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Required Ohio Medical Marijuana Registry information:**

Special status: Terminal Y/N

Veteran Y/N or Social Security Disability Y/N

(must have documentation for VA or SSD)

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Must have to be registered with the Ohio Medical Marijuana Registry

Name (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please place a check next to any conditions you have been diagnosed with or are currently experiencing:

\_\_ Appetite changes \_\_ Acquired Immune Deficiency Syndrome (AIDS)

\_\_ Bowel Movement Changes \_\_ Amyotrophic Lateral Sclerosis (ALS)

\_\_ Intestinal Cramps \_\_ Cachexia

\_\_ Loss of Weight \_\_ Cancer

\_\_ Nausea \_\_ Chronic Pain

\_\_ Vomiting \_\_ Chronic Traumatic Encephalopathy (CTE)

\_\_ Asthma \_\_ Epilepsy of Other Seizure Disorder

\_\_ COPD/Emphysema \_\_ Fibromyalgia

\_\_ Glaucoma

\_\_ Hepatitis C

\_\_ Heart Disease \_\_ Inflammatory Bowel Disease

\_\_ High Blood Pressure \_\_ Crohn's Disease

\_\_ On Blood Thinning Medication \_\_ Ulcerative Colitis

\_\_ Diabetes \_\_ Multiple SClerosis

\_\_ Parkinson’s Disease

\_\_ Positive for HIV

\_\_ Kidney Disease \_\_ PTSD

\_\_ Liver Disease \_\_ Sickle Cell Anemia

\_\_ Liver Fibrosis \_\_ Spinal Cord Injury or Disease

\_\_ Skin Rashes \_\_ Tourette’s Syndrome

\_\_ Traumatic Brain Injury

\_\_ Anxiety

\_\_ Bipolar Disease

\_\_ Depression

\_\_ Schizophrenia

\_\_ Sleep Disturbances

\_\_ Hallucinations

Reasons for taking current medications:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Negative side effects from medications you are taking or have taken in the past:

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The benefits you hope to obtain or have received from cannabis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Consent and Waiver of Liability

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree not to make any legal claim or complaint or commence any proceeding against Dr. BJ. Sidari, D.O., CTR and Moral Medical Justification, LLC (hereinafter referred to as “Physician”), in providing me with a physician recommendation for medical marijuana to be used as an affirmative defense/recommendation to a violation of Ohio law section 2925.11 or section 2925.141 in relation to Ohio House Bill 523 / Ohio Medical Marijuana Control Program, effective September 8, 2016.

***I hereby attest that I have read and understand the following statements by initialing on each line:***

\_\_\_I understand that Marijuana is Cannabis, and that the terms are often used interchangeably.

\_\_\_The recommendation under Ohio House Bill 523 does not guarantee protection from arrest.

\_\_\_The recommendation can be raised against charges in a court of law. Although some law enforcement officers may use discretion, it is possible that I can be arrested prior to asserting my affirmative defense/recommendation in court.

\_\_\_If I use my recommendation documentation in another state (such as Michigan), I will be subjected to the laws of that state while I am present in their jurisdiction.

\_\_\_I am hereby giving voluntary informed consent to treatment with medical cannabis. The Physician has sufficiently explained the current state of knowledge in the medical community of the effectiveness of treatment of my condition with medical cannabis, and the potential risks and side effects. I understand that there are other treatment options and I am not obligated to seek treatment from this physician.

\_\_\_I release the Physician from any and all actions, causes of actions, claims, complaints, and demands for damages, loss of life, injury, economic or employment loss, positive results on drug screens, damage to reputation or character, termination or service/care by another healthcare professional, or whatsoever arising directly or indirectly as a result of the physician recommendation, and my use of medical marijuana.

\_\_\_I hereby affirm I am assuming all risks associated with the use of medical cannabis, both foreseeable and unforeseeable, that may occur now or anytime in the future.

\_\_\_I consent to the use of my treatment plan and medical information to be used in private research and publication by any private company or public institution performing research on safety and efficacy of cannabis, or by Moral Medical Justification, LLC.

\_\_\_The Federal Food and Drug Administration (FDA) approves all scheduled drugs prescribed by physicians. Cannabis is not an FDA approved medication. The use of cannabis in any form has not been evaluated by the FDA. The use of marijuana is not intended to diagnose, treat, or cure any disease. The recommendation of a qualifying condition by this physician does not constitute a prescription to use medical cannabis. My decision to use cannabis should not be based solely on this physician recommendation. I, the patient, am advised to consult with my primary care physician, private legal counsel, and perform my own independent research before using medical cannabis.

\_\_\_The Physician cannot write a prescription for cannabis and has no control over the content of the medication. I understand the effects or the adverse risks of whichever cannabis product I decide to consume vary from patient to patient. Furthermore, the Physician may not be able to provide me with thoroughly researched conclusions regarding all the potential benefits and adverse risks of cannabis use for my particular qualifying medical condition. The scientific research on cannabis is incomplete and does not meet the high requirements for all other medicines approved by the FDA.

\_\_\_The Physician, will give a written recommendation for medical cannabis use. Ohio law HB 523 allows for a patient to possess a 90-day supply of medication. I (the patient) am solely responsible for administering marijuana as my condition warrants, as determined on the basis of my own judgment and am solely responsible for all the consequences.

\_\_\_Cannabis is generally tolerated well by patients. Any side effects tend to be mild and temporary, usually lasting one week or less as patients adjust. Common side effects include irritated throat, dry mouth, elevated heart rate, mild time and space disorientation, mild euphoria, a general sense of well-being, and in some instances drowsiness and decreased motivation. Any side effects must be reported to the Physician at the quarterly follow up or renewal, or as needed during the interim. There is a very rare, but potentially serious, side effect known as “First Dose Psychosis” that may occur with initial exposure to cannabis.

\_\_\_The Physician shall deactivate the patient’s recommendation when treatment is discontinued. I acknowledge that the Physician will immediately revoke my recommendation if I am arrested for, charged with, and/or convicted of any cannabis related activities. I acknowledge that the Physician will not testify on my behalf for a medical necessity defense related to any criminal cannabis charges or other criminal or civil matters. Revocation of the physician recommendation will represent an immediate termination of the patient-physician relationship. Furthermore, I release the Physician from all subpoenas interrogatories, attestations, or testimonies related to any criminal cannabis charges or other criminal or civil matters.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient / Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Physician Date



**Recommendations**

I certify the information provided to the Physician is true and accurate to the best of my knowledge.

***Any person who fraudulently submits false, misleading, or inaccurate information to the Physician for the purpose of receiving a medical marijuana recommendation by such Physician commits a misdemeanor under Ohio law, may be subject to prosecution, and will have the recommendation revoked.***

I additionally certify that I have been given actual Notice and understand that, notwithstanding the Ohio House Bill 523/ Ohio Medical Marijuana Control Program: (please ***initial*** each line.)

\_\_\_Cannabis is a prohibited Schedule I controlled substance under federal law; the program does not provide any immunity from or affirmative defense to arrest or prosecution under federal law;

\_\_\_Participation in the program is permitting only to the extent provided by the strict requirements of the program;

\_\_\_Any activity not sanctioned by the program may be a violation of state or federal law and could result in arrest, conduction, or incarceration;

\_\_\_Growing, distributing or possessing cannabis in any capacity, except through a federally approved research program, may be a violation of state or federal law and could result in arrest, conviction, or incarceration;

\_\_\_Use of medical cannabis, or possessing a marijuana patient recommendation or registry card, may affect an individual’s ability to receive or retaining federal or state licensure and other areas;

\_\_\_Restrictions for Use & Administration: Under the program, patients are prohibited from smoking medical cannabis. Patients cannot use or administer the product on any form of public transportation, in any public place, in their place of employment if restricted by his or her employer, in a state correctional institution, on the grounds of a preschool/primary school/secondary school, on a school bus or in a vehicle, aircraft or motorboat.

\_\_\_Participation in the program does not authorize any person to violate federal law or state law.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

**HIPAA Compliant Authorization**

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I hereby authorize you to release and discuss any and all medical health treatment records and information that you have in your possession regarding my health condition, including but not limited to my health history, my health treatment, your findings regarding my health, records of consultations that I have had, records of medication prescribed for me, X-rays taken of me, to the physicians, hospitals, and other facility treating me for the purpose of providing medical advice and treatment (I understand a covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization when the prohibition on conditioning of authorizations in 45 CFR164.508 {b}{4} applies) I am providing this authorization voluntarily and have not been required to give it to obtain treatment. I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it before it is delivered. If I do not revoke it, this Authorization will expire one year after the date on which I signed it. I understand that information disclosed through this Authorization may be subject to redisclosure and no longer protected by the privacy protections associated with HIPPA and 45 CFR 164.508. This document shall be governed by the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Pub L No 104-191. However, I intend it to be honored in any jurisdiction where it is presented and for other jurisdictions to refer to Ohio law and HIPPA to interpret and determine the validity and enforceability of this document. Photocopies or facsimile reproductions of this signed authorization shall be treated as original counterparts.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_