

# 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 and holds a recognition card.

**I. Patient and Designated Provider Information** **Issue Type (check one):**      **Initial**      **Renewal**

<b>1</b>	Patient's Full Name: (same as state-issued ID)	Date of Birth:		
<b>2</b>	Street address: (No P.O. Box)	City:	State: WA	Zip:
<b>3</b>	Does the patient have a designated provider (DP)? <b>(check one below)</b> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span><b>Yes</b>, patient sign's <b>item 6</b> below, unless they are a minor (under age 18)</span> <span><b>No</b>, continue to <b>Section II</b></span> </div>			
<b>4</b>	DP or Parent/Legal Guardian's Name:	Date of Birth:		
<b>5</b>	Street address: (No P.O. Box)	City:	State: WA	Zip:
<b>6</b>	I am an adult patient (18 and older) and agree the person named above will serve as my designated provider. <b>Patient Signature:</b> _____ <b>Date:</b> _____ (RCW 69.51A.010(4))			

**II. Healthcare Practitioner Information**

<b>7</b>	Healthcare Practitioner's Name (as it appears on license):	WA License Number: (Example: MD000011110):			
<b>8</b>	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):**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Chronic Renal Failure Requiring Hemodialysis | <input type="checkbox"/> Crohn's Disease        |
| <input type="checkbox"/> Epilepsy/Other Seizure Disorder   | <input type="checkbox"/> Glaucoma                                     | <input type="checkbox"/> Hepatitis C            |
| <input type="checkbox"/> HIV   | <input type="checkbox"/> Intractable Pain                             | <input type="checkbox"/> Multiple Sclerosis     |
| <input type="checkbox"/> Posttraumatic Stress Disorder   | <input type="checkbox"/> Spasticity Disorder                          | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> 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** \_\_\_\_\_