

## Arkansas Department of Health

## **Medical Marijuana Physician Written Certification**



Patient Information								
First Name		MI	Last Nar	ne				
Street Number and Street Name (or PO B	ox)							
	- ,							
Unit Number	Unit Type	(Apt, Unit, Su	uite, etc.)					
City				State	Zip Code			
Data (Dist) (MANA/DD (MANA)					District Di	1. 1 12		
Date of Birth (MM/DD/YYYY)	Ye	age of 18?	П	•	Physically Di	sabledr	□ No	
		3		J	L res		NO	
I hold a valid, unrestr Arkansas, and have b  It is my professional o and current medical o	een issued a region opinion, after have condition in the c	stration from stration from the strategy of th	om U.S. D leted an in	EA to prescri	be controlle ssment of tl	ed substanc	es. medical	history
medical condition ide	ntified below.							
elect the qualifying medical cond	lition(s):							
Cancer Glaucoma								
=	or human immund	deficiency	y virus/ aco	quired immur	ne deficienc	y syndrome		
Hepatitis C								
Amyotrophic late								
Tourette's syndr	ome							
Ulcerative colitis	i							
Post-traumatic s								
☐ Severe arthritis								
Severe arthritis Fibromyalgia								
	ase							
Fibromyalgia								
Fibromyalgia Alzheimer's dise	ting syndrome							
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Fibromyalgia Alzheimer's dise Cachexia or was	ting syndrome opathy which is pain tha	t has not r	responded	to ordinary r	nedications,	treatment	or surgica	ıl measur
Fibromyalgia Alzheimer's dise Cachexia or was' Peripheral neuro Intractable pain, more than six (6 Severe nausea	ting syndrome opathy which is pain tha ) months			·		treatment	or surgica	ıl measur
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Print Name