# NYS State Medical Marijuana Authorization Form

**Please Fill out Applicable Area for Patient or Designated Caregiver**

## PATIENT INFORMATION

**Date_____**

**(PLEASE PRINT)**

**FULL LEGAL NAME OF PATIENT: _____**

**STREET ADDRESS: _____**

**CITY: _____**

**STATE: _____**

**ZIP CODE: _____**

**PHONE: (  ) _____**

**PATIENTS DATE OF BIRTH: _____/_____/_____**



PAYNE ORGANIC GREEN INC.
Support@payneorganicgreen.com Tel: 516-400-7070 Fax: 516-706-9580

# NYS State Medical Marijuana Authorization Form

## DESIGNATED CAREGIVER INFORMATION

**Date_____**

**(PLEASE PRINT)**

**FULL NAME OF DESIGNATED CAREGIVER _____**

**DESIGNATED CAREGIVER'S DATE OF BIRTH _____/_____/_____**

**DESIGNATED CAREGIVER'S STREET ADDRESS _____**

**CITY _____**

**STATE _____**

**ZIP CODE _____**

**PHONE (  ) _____**

**DESIGNATED CAREGIVER'S DATE OF BIRTH _____/_____/_____**



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## AUTHORIZING HEALTHCARE PRACTITIONER INFORMATION

**NAME OF HEALTHCARE PRACTITIONER (AS APPEARS ON LICENSE)**

**_____**

**HEALTHCARE PRACTITIONER LICENSE NO. _____**

**HEALTHCARE PROVIDER STREET ADDRESS: _____**

**CITY _____ STATE _____ ZIP CODE _____**

**HEALTHCARE PROVIDER TELEPHONE NUMBER FOR HEALTHCARE PRACTITIONER WHERE THIS AUTHORIZATION CAN BE VERIFIED DURING NORMAL BUSINESS HOURS PHONE (  ) _____**

**ATTESTATION OF HEALTHCARE PRACTITIONER I AM LICENSED IN THE STATE OF NEW YORK AND HAVE DIAGNOSED THE ABOVE NAMED PATIENT AS HAVING THE FOLLOWING TERMINAL OR DEBILITATING MEDICAL CONDITION THAT IS SEVERE ENOUGH TO SIGNIFICANTLY INTERFERE WITH THE PATIENT'S ACTIVITIES OF DAILY LIVING AND ABILITY TO FUNCTION, AND CAN BE OBJECTIVELY ASSESSED AND EVALUATED (CHECK ALL THAT APPLY):**

- **Cancer**
- **HIV positive**
- **Aids**
- **Amyotrophic lateral sclerosis (ALS)**
- **Parkinson disease**
- **Multiple sclerosis**
- **Post traumatic stress disorder (PTSD)**
- **Epilepsy**
- **Inflammatory bowel disease**
- **Neuropathy**
- **Chronic pain**
- **Huntington's disease**
- **Damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity**



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**PATIENTS MUST ALSO HAVE ONE OF THE FOLLOWING ASSOCIATED OR COMPLICATING CONDITIONS: CACHEXIA OR WASTING SYNDROME, SEVERE OR CHRONIC PAIN, SEVERE NAUSEA, SEIZURES, OR SEVERE OR PERSISTENT MUSCLE SPASMS.**

**I FURTHER ATTEST THAT I HAVE PERFORMED AN IN-PERSON EXAMINATION OF THE ABOVE NAMED PATIENT AND ASSESSED HIS OR HER MEDICAL HISTORY AND MEDICAL CONDITION. IT IS MY PROFESSIONAL OPINION THAT THIS PATIENT MAY BENEFIT FROM THE MEDICAL USE OF MARIJUANA.**

**HEALTHCARE PRACTITIONER SIGNATURE _____**

**DATE ISSUED _____ EXPIRATION DATE _____**



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## DISCLAIMER / NOTIFICATION

**By signing this agreement you acknowledge that you have read, understand and agree to abide by the laws of New York State governing the Medical Marijuana program as a patient or a designated caregiver. Certified patients and designated caregivers must always carry their registry ID card whenever they possess approved medical marijuana products. • Medical marijuana products may not be transported outside of New York State. • New York State does not accept certifications or registry ID cards from other states. • A certified patient or designated caregiver who has been issued a registry ID card must notify the Medical Marijuana Program of any change in his or her name, address, or if he or she no longer has the serious condition noted on the card within ten (10) business days of such change. An authorization for the medical use of marijuana does not provide protection from arrest unless the patient and designated provider, if any, are entered into the medical marijuana authorization database and hold a recognition card. An authorized patient or designated provider may not: Sell, Donate, or otherwise supply the patient's Marijuana to another person, Use or Display Marijuana in a manner or place that is open to the view of the general public, Grow, possess, or use Marijuana or Federal property, Grow, store, produce, or process marijuana or marijuana-infused products if any portion of such activity can be readily seen by normal unaided vision or readily smelled from a public place or the private property of another housing unit.**

**Signature** _____



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