

GOVERNMENT OF THE DISTRICT OF COLUMBIA

Department of Health

Health Regulation and Licensing Administration



Medical Marijuana Program

Dispensary

Physician Affidavit Form

The undersigned physician applicant for a Medical Marijuana Dispensary attests to the fact that I understand that I am prohibited under the regulations governing the District's Medical Marijuana Program from recommending the use of medical marijuana to a patient for participation in the District of Columbia Medical Marijuana Program.

Signature of Applicant: _____

Print Name: _____

Company Name: _____

Title: _____

Date: _____

Subscribed and sworn to before me this _____ day of _____, 20____.

My commission expires _____

Notary Signature and Seal: _____