LICENSING AND REGULATORY AFFAIRS
CUSTOMER DRIVEN. BUSINESS MINDED.

Michigan Medical Marihuana Program

Application Form for Registry Identification Card

(517) 284-6400 | www.michigan.gov/mmp

For Official Use Only MMP 3501 (Rev. 1/15)
□ $60 Patient (with no caregiver) Fee Received
□ $85 Patient (with caregiver) Fee Received

Section A: Patient Information (REQUIRED) as it appears on your identication

1. Legal First Name	2. Middle Initial	3a. Legal Last Name	3b. Suffix (Jr., Sr., III, etc.)

4. Patient Registry ID Card Number (For Renewals Only)	5. MI Driver's License# or MI ID Card #	6. Date of Birth (MM/DD/YYYY)
P		

7a. Mailing Address	7b. Apartment/Suite/Lot #

8. City	9. State	10. Zip Code
	MI	

11. Email Address (If provided, you agree to receive email correspondence from MMMP)	12. Telephone Number

Section B: Person Allowed to Possess Patient's Marihuana Plants: (REQUIRED)

13. Plant possession: You must select one box. Failure to do so will result in the denial of your application.

SELECT ONLY ONE:
□ I will possess the plants
□ My caregiver will possess the plants

Section C: Caregiver Information (If the patient is designating a caregiver)

14. Legal First Name	15. Middle Initial	16a. Legal Last Name	16b. Suffix (Jr., Sr., III, etc.)

17. Caregiver Registry Card ID Number (For Renewals Only)	18. MI Driver's License# or MI ID Card #	19. Date of Birth (MM/DD/YYYY)
C		

20a. Mailing Address	20b. Apartment/Suite/Lot #

21. City	22. State	23. Zip Code
	MI	

24. Email Address (If provided, you agree to receive email correspondence from MMMP)	25. Telephone Number

26. Other Names Used by Caregiver (Nicknames, maiden names etc. Use a separate piece of paper if you need space for additional names)

Section D: Caregiver Patient Signature & Date (Required)

I attest the information I provided is true and accurate and that I will comply with the requirements of the Michigan Medical Marihuana Act (Initiated Law 1 of 2008, MCL 333.26421 et seq.), Administrative Rules and amendments thereafter. I understand that a false or fraudulent statement, with the intent to aid, abet, or assist in defrauding the state is guilty of perjury punishable in the manner provided by law.

Signature of Patient/Applicant: X _____ **Date:** _____

Signature of Caregiver: X _____ **Date:** _____

RENEWAL WORKSHEET

Name _____ Date _____

Phone number(s)_____Date of Birth _____

In what year did you first get your card? _____

Who was your certifying physician? _____

What was your qualifying condition? _____

_____ **Please initial to acknowledge that you have brought us all the records you can obtain from doctors who have cared for your qualifying condition.**

Please list any **procedures** or **surgeries** you have had in the last year: _____

_____

Please list any **new diagnoses** or **conditions** _____

_____

Please list any **new medications** you are taking _____

_____

Please check the areas medical marijuana has helped you with in the last year:

__ *Sleep* __ *Appetite* __ *Pain relief* __ *Anxiety* __ *Nausea relief* __ *Reducing other medications*

Are there other improvements you'd like to tell us about? _____

_____

Are you experiencing any negative side effects from marijuana? _____

_____

Have you had any legal problems since we saw you? __ Y __ N

If yes, please explain _____

What modes of administration do you use (circle all that apply) *Smoke* *Vaporiser* *Edibles* *Topicals*

What strains work best? _____

How much do you use per week (estimate)? _____

When do you usually medicate? _____

We want to keep on file for you any new medical records from your other doctor visits.
Please send medical records from any visits with other physicians over the past year, and during the next two years.

MEDICAL QUESTIONNAIRE

Date_____

Please answer these questions as completely as you can.
We realize this form is long, but the information is extremely valuable to us in providing the best possible care.

Patient name _____
Last First Middle

Phone _____ Date of birth _____

Patient's occupation _____

Emergency contact _____

Relationship to patient _____

Phone number(s) _____

If you were referred, who told you about Michigan Holistic Health? (please **circle)**

Physician Family member/Friend

Compassion Club Other_____

If you heard or saw advertising or a news story, please tell us where – check all that apply.

__ Newspaper article __Print ad __ TV ad __ Radio ad

__ Media interview __ Billboard __ Internet / website

Please check whether if you'd like a list of free/low cost health clinics **__ YES __ NO**

_____ Please initial to acknowledge that you have brought us all the records you can obtain from doctors who have cared for your qualifying condition.

Michigan **Holistic Health**

AUTHORIZATION TO NOTIFY YOUR PRIMARY CARE PHYSICIAN.

NAME OF YOUR PRIMARY CARE PHYSICIAN ____

Do you want record of today's visit sent to your primary doctor?

__ **NO**

__ **YES** *I request and authorize Michigan Holistic Health to alert my primary care doctor that I have been recommended to apply to the Michigan Medical Marijuana Program by Michigan Holistic Health.*

Whether you answered YES or NO, please fill-in the two lines below.

Signature ____ Date ____________________

Your name: ____ Date of birth ____________________

- -

****ONLY fill out the information below IF you answered YES to the question above:**

Physician's Location (City, State) ____

Phone # ____
Area code

FAX # (if available) ____
Area code

_ _

FOR OFFICIAL USE ONLY

To the primary care physician/practice: We are sending this notice as a courtesy to our mutual patient.

S/he was seen in our practice today and plans to apply to the Michigan Medical Marijuana Program for a registry card.

It is the professional opinion of our doctor that the applicant is suffering from the following debilitating medical condition:

____

The medical use of marijuana is likely to provide palliative or therapeutic benefits for the symptoms or effects of the patient's condition.

We have not <u>prescribed</u> marijuana, rather have affirmed the patient's condition on paperwork the patient plans to send to the state.

Please call with any questions: 855-420-8100.

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT'S SIGNED

Rev 6.13

Name _____

Date of Birth: _____

GENERAL MEDICAL HISTORY

List your current and past illnesses (such as diabetes, hypertension, etc.)

Condition Month/year diagnosed

_____

_____

_____

_____

_____

Please list all previous surgical procedures and their dates (if known):

Surgical Procedure Month/year

_____

_____

_____

_____

_____

MEDICATIONS:

Please list all medications that you are currently taking and their dosage (if known):

Medication Dose # of times per day For how long

_____

_____

_____

_____

_____

Are you taking aspirin or any other over-the-counter medicines? No ___ Yes ___

If yes, please list: _____

_____

Do you have any known drug allergies? No ___ Yes ___

If yes, please list: _____

_____

Name _____

Date of Birth: _____

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS?

	NO	YES
General		
Fever	___	___
Unexplained weight loss	___	___
Night sweats	___	___
Ear, nose, or throat		
Ringing in ears	___	___
Hearing Loss	___	___
Pain	___	___
Allergy/Immunology	___	___
Iodine allergy	___	___
Contrast material (dye) allergy	___	___
Nervous System		
Headache	___	___
Stroke	___	___
Seizure/epilepsy	___	___
Weakness, numbness, tingling	___	___
Heart or circulatory problems		
Heart attack or heart failure	___	___
Irregular heart rhythm	___	___
Chest pain	___	___
Pacemaker	___	___
Hypertension	___	___
Endocrine		
Thyroid disease	___	___
Diabetes	___	___
Hormonal disease	___	___
Skin/breast		
Masses/tumors	___	___
Rash	___	___
Discharge from breast	___	___
Lungs/Breathing		
Breathing difficulty	___	___
Asthma	___	___
Lung disease	___	___

	NO	YES
Digestive System		
Diarrhea	___	___
Ulcer disease	___	___
Hepatitis	___	___
IBS	___	___
Constipation	___	___
Heart burn	___	___
Genitourinary		
Kidney disease	___	___
Urinary tract infection	___	___
Urinary bleeding	___	___
Altered menses	___	___
Blood		
Anemia	___	___
Blood tumors/disease	___	___
Swollen glands	___	___
Bleeding disorder	___	___
Musculoskeletal		
Joint pain/arthritis	___	___
Back pain	___	___
Neck pain	___	___
Fractured bones	___	___
Pain with chewing	___	___
Scalp pain/tenderness	___	___
Muscle spasms	___	___
Psychiatric		
Depression	___	___
Mood swings	___	___
Anxiety	___	___
PTSD	___	___
Admission to hospital/ psychiatric illness	___	___
Other:		

_____

COMMENTS: _____

_____

_____

"No marijuana-related legal action pending" Agreement

By signing below, I, _____, assert that

as of today, the _____ day of _____ in the year _____,

I have NO marijuana-related legal issues pending in the courts of any level of government.

Examples of pending marijuana-related legal issues include, but are not limited to: unresolved misdemeanor or felony criminal charges stemming from the growing, possessing or operating a vehicle under the influence of marijuana, probation violation hearings concerning testing positive for marijuana activity (medical or otherwise) and civil actions against employers or former employers concerning termination of employment relating to your status as a medical marijuana patient.

I understand that according to the Michigan Medical Marihuana Act's affirmative defense outlined in MCL 333.76428(a)(1), a bona-fide patient-doctor relationship must be established by any defendant/patient who seeks to have his criminal charges successfully dismissed under the MMMA. I understand and agree that breaching this agreement will render null and void any bona-fide patient-doctor relationship that may have existed between myself and the physicians at Michigan Holistic Health, PLLC at the time of service.

I also further assert that any and all information I give pertaining to my "qualifying condition" as defined by the State of Michigan, is accurate and complete.

I further understand that should an applicable court refuse to dismiss a pending criminal charge as a result of the contents of this agreement, I will hold Michigan Holistic Health, PLLC harmless for the legal consequences associated with my potential sentence, incarceration, civil forfeiture, fines, restitution, court and attorney costs.

This agreement pertains to treatment and services provided by Michigan Holistic Health PLLC – a Michigan Corporation.

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____
Michigan Holistic Health, PLLC

Physician Release from all Liability Form

Signing this form releases the physicians of Michigan Holistic Health from all liability for providing a state of Michigan medical marijuana "Physician's Certification." And by signing this form, you, the patient-applicant, are stating that you understand and agree with the following statements of fact:

1. The federal Food and Drug Administration approves all drugs prescribed by physicians. Medical Marijuana is not an FDA approved medication. Crude marijuana is not standardized regarding its purity, strength or dosage size.
2. Therefore, the physicians of Michigan Holistic Health cannot write a prescription for medical marijuana and has no control over the ingredients or the effects or the adverse risks of whatever medical cannabis you decide to consume and cannot in any way help or tell you how to acquire or grow it.
3. The physicians of Michigan Holistic Health may not be able to provide you with thoroughly researched conclusions regarding all the potential benefits and adverse risks of cannabis use for your 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.
4. The physicians of Michigan Holistic Health cannot provide you with a regimen for the use of medical marijuana. You are solely responsible for administering medical marijuana as your condition warrants, as determined on the basis of your own judgment and are solely responsible for all the consequences.
5. The cultivation, possession and use of cannabis – even for medical purposes – remains a crime under federal law.
6. Medical marijuana 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 amotivation.

I, _____, agree not to make any legal claim or complaint, or commence any proceeding against Michigan Holistic Health & Assoc. in providing me with a "Physician's Certification" as required by the Michigan Medical Marijuana Act. And I further agree not to make any legal claim or complaint or commence any proceeding against the same physician for my use use of crude medical marijuana. I release the same physician from any and all actions, causes of actions, claims, complaints and demands for damages, loss of injury whatsoever arising directly or indirectly as a result of my medical marijuana application to the state of Michigan or my use of medical marijuana. This release of liability is to be binding on my heirs, executors and assigns. I have read, understand and agree with all the statements in this form.

_____ _____

Signature of applicant Date

_____ _____

Signature of witness Date

OFFICE USE ONLY:
New _____ Additional _____

Michigan Holistic Health

MEDICAL RECORDS RELEASE FORM

Patient's name _____ Date of Birth _____/_____/_____

Street Address _____ SS # _____

City_____ State _____ Zip_____ Phone (_____)_____

Patient signature: _____ Date signed: _____

Please note: we are not responsible for medical records beyond 90 days of receipt.

Purpose or need for the information requested:

☐Continuing care ☐Patient Request ☐Other: _____

I understand this consent is voluntary and that I may revoke this authorization at any time by providing written notice to the above named party. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected. THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED.

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2).

I request and authorize to release healthcare information of the patient named above to:

Dr. David A. Crocker MD
Michigan Holistic Health, PC
500 W. Crosstown Parkway, Kalamazoo, MI 49008
Phone toll free 1-855-420-8100

FAX TO: 269.382.1197

Please use this form as cover sheet

Doctor's name _____

Fax #: _____* Phone #: _____

We cannot process your request without this fax number.

Please FAX to Michigan Holistic Health at (269) 382-1197:

1. **Most recent history &physical**
   AND
2. **Last five office notes pertaining to _____**
   (qualifying condition)