pennsylvania
DEPARTMENT OF HEALTH

Qualifying Medical Conditions for Medical Marijuana Usage Application

Individual Requestor Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Medical License Number (if applicable): _____ Registry I.D. Number (if applicable): _____

Qualifying Condition Request

Name of Medical Condition _____

Has this condition been approved in any other state? YES ☐ NO ☐ If yes, where? _____

References Supporting Qualified Practitioner's Opinion

Full Name: _____ Relationship: _____

Hospital/Agency: _____ Phone: _____

Address: _____

Full Name: _____ Relationship: _____

Hospital/Agency:: _____ Phone: _____

Address: _____

_____ Relationship: _____

Full Name: _____

Hospital/Agency: _____ Phone: _____

Address:

_____

Documentation (clinical, medical, or scientific data) Supporting Efficacy of Medical Marijuana as Treatment for Condition

Citation: _____

University/ Publisher: _____

Summary:

_____

_____

_____

_____

_____

_____

*Attach additional citation separately in mirrored form.

Documentation Supporting Qualified Physicians Opinion: Benefits of Medical Marijuana Use Outweigh Health Risks for Condition

Summary:

_____

_____

_____

_____

_____

_____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

Individual Requestor Signature: _____ Date: _____