DOCUMENTATION REQUIRED UNDER SECTION 381.986 (4)(b), FLORIDA STATUTES

Section 381.986(4)(b), Florida Statutes, requires a qualified physician who issues a physician certification for a qualified patient diagnosed with a medical condition of the same kind or class as or comparable to those conditions listed in Section 381.986(2)(a)-{j), Florida Statutes, to submit the documentation below to the Boards of Medicine or Osteopathic Medicine within 14 days after issuing the physician certification. In addition, information on subsequent certifications for these diagnoses must also be submitted. Do not provide any patient identifying information other than what is requested in this form. **Do not attach patient records as part of the documentation.**

Send the completed form to:	BOARD OF OSTEOPATHIC MEDICINE **or** BOARD OF MEDICINE P.O. Box 6340 Tallahassee, FL 32314

The Department of Health is required by law to provide documentation to the Coalition for Medical Marijuana Research and Education. Patient identifying information will not be provided to the Coalition.

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1. Qualified Patient ID:
2. Qualified MD/DO License Number:
3. Date physician certification issued:
4. Qualifying patient's year of birth:
5. Florida resident: Yes ☐ No ☐ If No, what is qualifying patient's state of permanent residence:
6. Qualifying patient's county of residence:
7. Gender: Male ☐ Female ☐
8. Specify qualifying patient's medical condition of the same kind or class as or comparable to those enumerated in Section 381.986(2), (a)-(j), Florida Statutes :

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9. Documentation supporting qualified physician's opinion that the medical condition is of the same kind or class as the conditions in paragraphs (2)(a)-(j):

10. Documentation (clinical, medical, or scientific data) that establishes the efficacy of marijuana as treatment for the condition:

11. Documentation supporting the qualified physician's opinion that the benefits of medical use of marijuana would likely outweigh the potential health risks for the patient.

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Print qualified physician's name

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Signature of qualified physician **Date**