

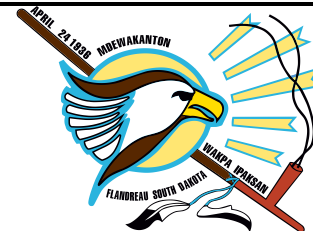
**FLANDREAU SANTEE SIOUX TRIBE
MEDICAL MARIJUANA PROGRAM
DOCUMENTATION OF PATIENT'S MEDICAL RECORDS
INSTRUCTIONS**

Please complete the attached form to participate in the Flandreau Santee Sioux Tribe's Medical Marijuana Program. This form will need to be filled out in its entirety, and sent to the Flandreau Santee Sioux Tribe Marijuana Control Commission for its review.

NO SALE OF MEDICAL MARIJUANA PRODUCTS WILL OCCUR TO ANYONE, UNTIL THEY HAVE COMPLETED THE FORM, SUBMITTED IT FOR REVIEW, AND PAID THE \$50 APPLICATION FEE.

1. Fill out the application, and have it signed by a medical professional. The medical professional needs to have the ability to prescribe medicine in the jurisdiction in which they are licensed. The medical professional does NOT need to be licensed in the State of South Dakota.
2. Please include a copy of a valid photo ID with the application.
3. If you have an out-of-state medical cannabis license, you can attach a copy of that license to your application. If you attach the out-of-state license to the application, you DO NOT need to have a medical professional sign that portion of the application.
4. You can fax, mail, or physically submit the application to the following:
 - Fax: (833) 551-0486. Please send to the attention of the FSST Cannabis Control Commission.
 - Mail: You may mail your application to 603 W. Broad Ave., Flandreau, SD 57028.
 - In Person Submission:
 - o Before July 1, 2021: You may drop your application off at the FSST Tribal Office at 603 W. Broad Ave., Flandreau, SD 57028 during normal business hours.
 - o After July 1, 2021: You may bring the application to the Native Nations Dispensary at 1314 South Veteran's Street, Flandreau, SD 57028 during its normal business hours.
5. You may submit the \$50 application fee at the time of application if you submit by mail or in person with a money order to the "Flandreau Santee Sioux Tribe". If you submit the application at the licensing location, you may pay by Cash or by money order. If you submit by fax, you can bring the \$50 application fee to the licensing location.
6. Upon submission and review of the application, the FSST Marijuana Control Commission will contact you and issue you a license to purchase cannabis products on the Flandreau Santee Sioux Reservation.

FLANDREAU SANTEE SIOUX TRIBE MEDICAL MARIJUANA PROGRAM DOCUMENTATION OF PATIENT'S MEDICAL RECORDS



PATIENT INFORMATION

| | | | |
|---------------|-------------|----------------------------------|----------|
| First Name | Middle Name | Last Name | Suffix |
| Date of Birth | | Mailing Address (number, street) | |
| City | | State | Zip Code |

PHYSICIAN INFORMATION

| | | | | |
|--|-------|----------|--------------------------------|--|
| Attending Physician Name | | | Medical License Number & State | |
| Service Mailing Address (number, street) | | | Office Telephone Number | |
| | | | () | |
| City | State | Zip Code | Office Fax Number | |
| | | | () | |

Licensing Authority: _____

MEDICAL PRACTITIONER ATTESTATION

The patient listed above is a patient under the medical care and supervision of the above named medical provider who has diagnosed the patient with one or more of the following conditions:

- (a) A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following: cachexia or wasting syndrome; severe, debilitating pain; severe nausea; seizures; or severe and persistent muscle spasms, including, those characteristic of multiple sclerosis; or
- (b) Any condition that, in the opinion of a practitioner, a patient would likely benefit from the use of marijuana, including, but not limited to:
 - (1) Acquired Immune Deficiency Syndrome (AIDS)
 - (2) Anorexia
 - (3) Arthritis
 - (4) Cancer
 - (5) Glaucoma
 - (6) Migraine

MEDICAL PRACTITIONER SIGNATURE

By my signature below, I attest to the following:

- I hold a valid, unrestricted and existing license to practice in the jurisdiction listed above with authority to prescribe drugs to human;
- I have established a medical record for the patient/applicant and a bona fide physician-patient relationship with the patient/applicant;
- I am recommending a medical marijuana license for the patient/applicant according to the accepted standards a reasonable and prudent physician would follow for recommending or approving any medication.
- I have verified the patient/applicant's identity as indicated; and
- The information in this recommendation form is true and correct.

Signature

Date