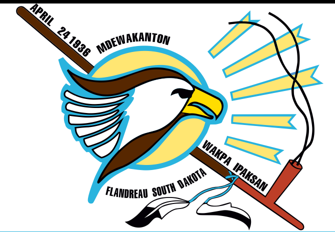
FLANDREAU SANTEE SIOUX TRIBE
MEDICAL MARIJUANA PROGRAM

Verification Of Patient Eligibility Form



PATIENT INFORMATION

First Name	Middle Name	Last Name	Suffix

Street Address	Phone Number	Date of Birth

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) Migraines
(7) Post-Traumatic Stress Disorder
(8) Anxiety Disorder
(9) Diabetes
(10) Depression

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.

______________________________ Medical Practitioner Signature

______________________________ Date