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THC CERTIFICATION & UNDERSTANDING

Patient Name: _____

DOB: _____ **Date:** _____

I understand that the information I provide is used for evaluation of my medical condition and to determine if I may qualify for the **South Dakota Medical Cannabis Program**. I further acknowledge that inaccurate or incomplete disclosure may affect the provider's ability to evaluate my condition and determine eligibility under state law.

Patient Certification

(Initial each item)

_____ I certify that the information I am providing is accurate, complete, and truthful.

_____ I certify that my condition is chronic, debilitating, and negatively impacts my quality of life.

_____ I certify that I am not seeking marijuana for recreational or illegal purposes.

Patient Understanding

(Initial each item)

_____ I understand that the medical provider, staff, and representatives of **Rapid City Health Professionals, LLC** are not recommending, prescribing, or dispensing medical cannabis. They are evaluating my eligibility only.

_____ I understand that unless otherwise stated, this evaluation does not establish an ongoing provider-patient relationship. I should continue to follow up with my primary care provider and/or mental health provider as appropriate.

_____ I understand that approval, if granted, will have a renewal date specified by the state, and it is my responsibility to arrange follow-up for continued certification.

_____ I understand that medical cannabis certification does not guarantee approval of a card, and if denied, I am not entitled to a refund.

_____ I acknowledge that I am a South Dakota resident, at least 18 years of age (or the legal guardian of a qualifying minor), and that I have not misrepresented any information.

_____ I acknowledge that marijuana is a **Schedule I controlled substance** under federal law. Federal law prohibits the manufacture, distribution, and possession of marijuana even if permitted under South Dakota law.

Printed Name: _____

Patient Signature: _____ **Date:** _____