LOW THC OIL
Physician Certification Form

PATIENT INFORMATION (TYPE OR PRINT LEGIBLY)

Last Name (must match ID)	First Name (must match ID)	Date of Birth
Patient Address		
Patient Telephone:	Email Address:	

1. **CAREGIVER INFORMATION (TYPE OR PRINT LEGIBLY)** Caregiver means the parent, guardian, or legal custodian of an individual who is less than 18 years of age or the legal guardian of an adult.

Caregiver's Last Name	Caregiver's First Name	MInitial
Caregiver's Mailing Address		
Caregiver's Telephone:	Caregiver's Email Address:	

2. CAREGIVER INFORMATION (TYPE OR PRINT LEGIBLY)

Caregiver's Last Name	Caregiver's First Name	MInitial
Caregiver's Mailing Address		
Caregiver's Telephone:	Caregiver's Email Address:	

PHYSICIAN INFORMATION (TYPE OR PRINT LEGIBLY)

License Number	Last Name	First Name	MInitial
Mailing Address			
City	State	Zip Code	
Telephone Number	Fax Number	Email Address	

1. The above-named patient has been diagnosed with and is currently undergoing treatment for:
   - ☐ Cancer, when such diagnosis is end stage or the treatment produces related wasting illness or recalcitrant nausea and vomiting
   - ☐ Amyotrophic lateral sclerosis, when such diagnosis is severe or end stage
   - ☐ Seizure disorders related to diagnosis of epilepsy or trauma related head injuries
   - ☐ Multiple sclerosis, when such diagnosis is severe or end stage
   - ☐ Crohn's disease
   - ☐ Mitochondrial disease
   - ☐ Parkinson's disease, when such diagnosis is sever or end stage
   - ☐ Sickle cell disease, when such diagnosis is severe or end stage
   - ☐ Tourette's syndrome, when such syndrome is diagnosed as severe
   - ☐ Autism spectrum disorder, when (a) patient is 18 years of age or more, or (b) patient is less than 18 years of age and diagnosed with severe autism
   - ☐ Epidermolysis bullosa
   - ☐ Alzheimer's disease, when such disease is severe or end stage
   - ☐ AIDS when such syndrome is severe or end stage
   - ☐ Peripheral neuropathy, when symptoms are severe or end stage
   - ☐ Patient is in hospice program, either as inpatient or outpatient
   - ☐ Intractable pain
   - ☐ Post-traumatic stress disorder (PTSD) resulting from direct exposure to or the witnessing of a trauma for a patient who is at least 18 years of age

2. Are you going to continue treating the patient following the use of THC Oil? ◉ Yes ○ No
3. Does this patient currently reside in the State of Georgia? ◉ Yes ○ No
   (If no, is the patient considered a legal resident of Georgia? ◉ Yes ○ No
4. How long have you been treating the patient? _____
5. How long has the patient been diagnosed with the condition(s) listed in #1? _____
6. What other treatments has/does this patient receive(d):

   _____

   _____

7. Comments: (If no comments, cross through this area to prevent comments after your signature.)

   _____

   _____

Physician Attestation

I hereby certify that I am a physician duly licensed in good standing to practice medicine in Georgia. I have a bona fide physician-patient relationship with the above-named patient in compliance with state statutes. I have assessed this patient's medical history and current medical condition and have performed or reviewed appropriate diagnostic tests in making the above-indicated diagnosis. I conclude that this patient is eligible for the use of low THC oil as provided in Georgia law. This authorization is not a prescription.