Medicinal Cannabis Control Commission

CHAIR Lisa Brunner VICE CHAIR Regina Murray COMMISSIONER Marcy Hart

Patient Self-Certification Form

Patient Name: _____
First Middle Last

Address: _____City _____State ___ Zip Code_____

DOB: _____ Last Four Digits of Social Security No. _____

Driver's License Number/ID Number Verification: _____

Qualified Medical Conditions
(*Please check all that apply)

- ○ Alzheimer's Disease
- ○ Amyotrophic Lateral Sclerosis (ALS)
- ○ Autism Spectrum Disorder
- ○ Cancer*
- ○ Chronic Motor or Vocal Tic Disorder
- ○ Chronic Pain
- ○ Glaucoma
- ○ HIV/AIDS
- ○ Inflammatory Bowel Disease, including Crohn's disease.
- ○ Intractable Pain
- ○ Irritable Bowel Syndrome
- ○ Obsessive-Compulsive Disorder
- ○ Obstructive Sleep Apnea
- ○ Post-Traumatic Stress Disorder (PTSD)
- ○ Seizures, including those characteristics of epilepsy
- ○ Severe and Persistent Muscle Spasms, including those characteristics of multiple sclerosis (MS)
- ○ Sickle Cell Disease
- ○ Terminal Illness, with a probable life expectancy of less than one year*
- ○ Tourette Syndrome

*If your illness or its treatment produces one or more of the following:

- ○ Cachexia or Severe Wasting
- ○ Severe or Chronic Pain
- ○ Nausea or Severe Vomiting

Acknowledgment and release:

I represent and warrant that the Qualified Medical Conditions listed within this Patient Self-Certification Form are true and accurate in all respect. The undersigned releases the Medicinal Cannabis Control Commission, and any member thereof, Waabigwan Mashkiki LLC and any of its members, officers, directors, and employees, the White Earth Band of Minnesota Chippewa Tribe, and any tribal agency or entity from any loss, damages, liability, or claims related in any way to the purchase, possession or use of Medicinal Cannabis Products by the undersigned and based upon this Patient Self-Certification Form and any representations made herein by the undersigned. The undersigned acknowledges that the Medical Cannabis Control Commission recommends consultation with a healthcare practitioner before using Medicinal Cannabis Products. And the undersigned chooses to purchase, possess, and use Medicinal Cannabis Products at the undersigned's risk.

Print Patient Name:

_____

Patient Signature:

_____

Date:

_____

Medicinal Cannabis Control Commission

By: _____

It's: Member of the Commission

Date:

_____