Medical Cannabis Voluntary Identification Card Program

PHYSICIAN'S STATEMENT

This certifies that _____/____/_____, is a patient under
Print patient's name Date of Birth
my medical care and supervision. I certify that this patient has a medical disorder which may benefit from the use of cannabis treatment.

I have discussed the medical benefits and risks of cannabis use with the patient as a treatment for these medical conditions.

If my patient chooses to use cannabis therapeutically, I intend to continue to monitor his/her medical condition and to provide advice on his/her progress and treatment.

I understand that Santa Cruz County will not retain any copies of this form.

Recommended Period for Medical Use (up to three years):

From _____ to _____

Patient: _____
Signature

Physician: _____ _____
Signature Name (Print)

_____ _____
CA License No. Telephone Number

_____ _____
Street Address City/Zip Code

_____
Date

This form is for implementation of Proposition 215, the Compassionate Use Act of 1996, and Measure B.

The purpose of this voluntary identification card program is to help law enforcement officers identify individuals whose possession of medical cannabis is permissible under Health and Safety Code Section 11362.5. This form shall not be used to assist anyone in obtaining or gaining access to cannabis.