

# Washington Medical Marijuana Program

Authorized Distributor  
for Wilmer, a Washington  
Approved Security Printer

Healthcare  
**SELECT**

Meeting and exceeding  
regulations

Wilmer is an approved Security printer for prescription pads, books and laser sheets, meeting or exceeding all State and Federal regulations for both Medicaid and controlled substance prescriptions.

## Security Features

- ✓ Chemical protection paper, scallop void pantograph, blue background
- ✓ Washington State Medical Marijuana image in blue ink
- ✓ Microprinting in security feature border line
- ✓ Security feature listing
- ✓ True watermark
- ✓ Invisible fluorescent fibers
- ✓ Washington Department of Health approved

**NEW!**

- Minimum order of 500 sheets
- Stocked in Ontario, CA for quick delivery
- Full Laser sheet 8 1/2" x 11"

**Medical Marijuana Authorization Form**

This authorization does not provide protection from arrest unless the qualifying patient or designated provider is also entered in the medical marijuana authorization database and holds a recognition card.

**Signature and Attestation**

Date of Birth: \_\_\_\_\_  
 City: \_\_\_\_\_ State: WA Zip: \_\_\_\_\_

I have discussed the risks and benefits of the medical use of marijuana with my healthcare practitioner. I understand that possible long-term effects to the brain in the areas of memory, coordination, and ability to drive or operate heavy machinery, physical or psychological dependence, and if I proceed, I understand that I may revoke my designated provider (if applicable) at any time in writing. I understand and understand the legal requirements of being a patient.

Date: \_\_\_\_\_

**Designated Provider Information and Attestation (If any - Mark N/A in each box if not applicable)**

Date of Birth: \_\_\_\_\_  
 City: \_\_\_\_\_ State: WA Zip: \_\_\_\_\_

I am over the age of 21 and agree to serve as the designated provider for the patient. I am licensed in the state of Washington and agree to serve as the designated provider for the patient. I understand that possible long-term effects to the brain in the areas of memory, coordination, and ability to drive or operate heavy machinery, physical or psychological dependence, and if I proceed, I understand that I may revoke my designated provider (if applicable) at any time in writing. I understand and understand the legal requirements of being a patient.

Signature: \_\_\_\_\_ License Number: (Ex: MC00001111) State: WA Zip: \_\_\_\_\_

**Additional Plant Authorization (Optional)**

I am licensed in the state of Washington and agree to serve as the designated provider for the patient. I understand that possible long-term effects to the brain in the areas of memory, coordination, and ability to drive or operate heavy machinery, physical or psychological dependence, and if I proceed, I understand that I may revoke my designated provider (if applicable) at any time in writing. I understand and understand the legal requirements of being a patient.

Cancer  Chronic Renal Failure Requiring Hemodialysis  Crohn's Disease  
 Epilepsy or Other Seizure Disorder  Glaucoma  Hepatitis C  
 HIV  Intractable Pain  Multiple Sclerosis  
 Posttraumatic Stress Disorder  Spasticity Disorder  Traumatic Brain Injury  
 A disease that results in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms or spasticity

I further attest that I have performed an in-person examination of the above named patient and assessed his or her medical history and medical condition. I have advised this patient about the potential risks and benefits of the medical use of marijuana. It is my professional opinion that this patient may benefit from the medical use of marijuana.

Healthcare Practitioner Signature: \_\_\_\_\_ Issue Date: \_\_\_\_\_  
 Authorization Expiration Date: (Maximum from issue date of six months for minors and one year for adults)

This provision is valid only if the person is entered into the authorization database and possesses a recognition card. A second signature is required if authorizing additional plants. Authorization must not exceed 15 plants.

Healthcare Practitioner Attestation: In my professional opinion, the medical needs of this patient exceed the presumptive number of plants allowed by law of 4 plants with just an authorization form or 6 plants if entered in the database. I recommend this patient or their designated provider be allowed to grow in his or her domicile \_\_\_\_\_ plants for the patient's personal use.

Healthcare Practitioner Signature: (second signature only required if recommending additional plants)

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