

Notice of choice of medical treatment

Attention Doctor _____ ;

Pleased be advised that I, _____; am officially informing you of my decision to use Cannabis/Marijuana for medical reasons to treat the following ailments/symptoms:

Be advised that I use ___ grams per day as required in the following forms:

1. _____ grams per day inhaled (smoked or vaporized)
2. _____ grams per day orally (eaten)
3. _____ grams per day orally (steeped in hot water as a tea)

This notice is to give you adequate information about my choice of medication so that you may continue to treat me and my present ailments and future medical problems as safely as possible with a minimum negative interaction to present and future proposed medical treatment, and for a legal excuse to be in possession of Cannabis should the need arise until such time as I obtain federally exempted status under the MMAR .

(patient's name, address and telephone) please print

(patient's signature)

(witness signature and printed name)

Received by _____

(Physician's signature of receipt of notice and stamp) (Physician's signature is not considered as endorsement or recommendation or prescription for cannabis use but is only to affirm receipt of this notice)