RENEWAL WORKSHEET

Today's Date ________________

Name ____ Date of Birth ___________________

Phone number ____

In what year did you first get your card? _____________________

Who was your certifying physician? ____

What was your qualifying condition? ____

_____ Please initial to acknowledge that you have brought us all the records you can obtain from doctors who have cared for your qualifying condition.

Please list any **procedures** or **surgeries** you have had in the last year:

____

Please list any **<u>new</u> diagnoses** or **conditions** ____

Please list any **<u>new</u> <u>medications</u>** you are taking ____

____

Please check the areas medical marijuana has helped you with in the last year:

__ *Sleep* __ *Appetite* __ *Pain relief* __ *Anxiety* __ *Nausea relief* __ *Reducing other medications*

Are there other improvements you'd like to tell us about? ____

Are you experiencing any negative side effects from marijuana? ____

Have you had any legal problems since we saw you? __ Y __ N

If yes, please explain ____

What modes of administration do you use (circle all that apply) *Smoke* *Vaporiser* *Edibles* *Topicals*

What strains work best? ____

How much do you use per week (estimate)? ____

When do you usually medicate? ____

Primary Care Provider Information

Name: ___________________________________ Phone: _____________________ Specialty: ____________________

Address: ____ ___________________________ ________ ______________

City State Zip Code

Do you want record of today's visit sent to your Primary Care Provider? Yes No

We want to keep on file for you any new medical records from your other doctor visits.
Please send medical records from any visits with other physicians over the past year, <u>and during the next two years</u>.

YOUR FOLLOW-UP CARE

Please call us within 30 days to inform us how the program is working for you. As always, our business staff is available 5 days a week to answer any questions you may have. You can also email us at ask@michiganholistichealth.com. We expect to provide follow-up care to you to monitor the efficacy of your medical use of marijuana.

As of April 1, 2013, the state is issuing two-year cards. However court cases in Michigan have held that a registry card—even one verified by the state-does not prove "ongoing" contact between the physician and patient.

For your protection, Michigan Holistic Health will need an annual appointment with you to maintain your doctor-patient relationship as required by the state. The charge for this annual appointment next year will be $75. We will review and assess your medical history and current medical conditions to determine that you are still likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat your condition. We will also discuss how well the program is working for you and offer recommendations for any additional care, such as alternative therapy.

____ Patient Name (please print)

_________________ Date of birth

____ Patient signature

_________________ Today's Date

THE PHYSICIAN MUST INITIAL EACH LINE BELOW:

I do hereby declare that the written certificate was prepared in the course of a bona fide physician-patient relationship in which each of the following were present as part of the treatment or counseling relationship:

____ I have reviewed this patient's relevant medical records and completed a full assessment of this patient's medical history and current medical condition, including a relevant, in-person, medical evaluation of this patient. (MCL333.26423(a)(1))

____ I have created and will maintain records of this patient's condition in accord with medically accepted standards.(MCL333.26423(a)(2))

____ I have a reasonable expectation that I will provide follow-up care to this patient to monitor the efficacy of the use of medical marihuana as a treatment of this patient's debilitating medical condition. (MCL333.26423(a)(3))

____ If the patient (or for minor: parent/legal guardian) has given permission, I have notified this patient's Primary care physician of this patient's debilitating medical condition and certification for the use of medical marihuana to treat that condition(MCL333.26423(a)(4))

“No marijuana-related legal action pending” Agreement

By signing below, I, ____, assert that

as of today, the _____ day of ________________________ in the year ______________,

I have NO marijuana-related legal issues pending in the courts of any level of government.

Examples of pending marijuana-related legal issues include, but are not limited to: unresolved misdemeanor or felony criminal charges stemming from the growing, possessing or operating a vehicle under the influence of marijuana, probation violation hearings concerning testing positive for marijuana activity (medical or otherwise) and civil actions against employers or former employers concerning termination of employment relating to your status as a medical marijuana patient.

I understand that according to the Michigan Medical Marihuana Act’s affirmative defense outlined in MCL 333.76428(a)(1), a bona-fide patient-doctor relationship must be established by any defendant/patient who seeks to have his criminal charges successfully dismissed under the MMMA. I understand and agree that breaching this agreement will render null and void any bona-fide patient-doctor relationship that may have existed between myself and the physicians at Michigan Holistic Health, PLLC at the time of service.

I also further assert that any and all information I give pertaining to my “qualifying condition” as defined by the State of Michigan, is accurate and complete.

I further understand that should an applicable court refuse to dismiss a pending criminal charge as a result of the contents of this agreement, I will hold Michigan Holistic Health, PLLC harmless for the legal consequences associated with my potential sentence, incarceration, civil forfeiture, fines, restitution, court and attorney costs.

This agreement pertains to treatment and services provided by Michigan Holistic Health PLLC – a Michigan Corporation.

Signature of Patient ____ Date ______________

Signature of Witness ____ Date ______________
Michigan Holistic Health, PLLC

2015

Physician Release from all Liability Form

Signing this form releases the physicians of Michigan Holistic Health from all liability for providing a state of Michigan medical marijuana "Physician's Certification." And by signing this form, you, the patient-applicant, are stating that you understand and agree with the following statements of fact:

1. The federal Food and Drug Administration approves all drugs prescribed by physicians. Medical Marijuana is not an FDA approved medication. Crude marijuana is not standardized regarding its purity, strength or dosage size.
2. Therefore, the physicians of Michigan Holistic Health cannot write a prescription for medical marijuana and has no control over the ingredients or the effects or the adverse risks of whatever medical cannabis you decide to consume nor can they, in any way, help or tell you how to acquire or grow it. Please consult the internet or your local compassion club.
3. The physicians of Michigan Holistic Health may not be able to provide you with thoroughly researched conclusions regarding all the potential benefits and adverse risks of cannabis use for your particular qualifying medical condition. The scientific research on cannabis is incomplete and does not meet the high requirements for all other medicines approved by the FDA.
4. The physicians of Michigan Holistic Health cannot provide you with a regimen for the use of medical marijuana. You are solely responsible for administering medical marijuana as your condition warrants, as determined on the basis of your own judgment and are solely responsible for all the consequences.
5. Please take care if you have not used marijuana before. You are advised to keep a log of how much medicine you use and its effects on your symptoms. This will help you make adjustments to your dose and frequency.
6. You are in charge of the most comfortable and effective method of delivery – vaporizer, topicals, smoking or edibles. (It is not advisable for patients with lung issues or smoke allergies to smoke marijuana.) These are general guidelines and should be used in conjunction with your own common sense and wisdom about your health.
7. The cultivation, possession and use of cannabis – even for medical purposes – remains a crime under federal law.
8. Medical marijuana is generally tolerated well by patients. Any side effects tend to be mild and temporary, usually lasting one week or less as patients adjust. Common side effects include irritated throat, dry mouth, elevated heart rate, mild time and space disorientation, mild euphoria, a general sense of well-being, and in some instances drowsiness and amotivation.

I, ____, agree not to make any legal claim or complaint, or commence any proceeding against Michigan Holistic Health & Assoc. in providing me with a "Physician's Certification" as required by the Michigan Medical Marijuana Act. And I further agree not to make any legal claim or complaint or commence any proceeding against the same physician for my use of crude medical marijuana. I release the same physician from any and all actions, causes of actions, claims, complaints and demands for damages, loss of injury whatsoever arising directly or indirectly as a result of my medical marijuana application to the state of Michigan or my use of medical marijuana. This release of liability is to be binding on my heirs, executors and assigns. I have read, understand and agree with all the statements in this form.

____ ________________________
Signature of applicant Date

____ ________________________
Signature of witness Date

OFFICE USE ONLY:
New _____ MHH Exp. _____ Additional _____

Michigan **Holistic Health**

Dr. David A. Crocker MD
500 W. Crosstown Parkway
Kalamazoo, MI 49008
Phone toll free 1-855-420-8100
FAX TO: 269.382.1197

MEDICAL RECORDS RELEASE FORM

Patient's name ____________________________________ Date of Birth ______/______/______

Street Address ____________________________________ SS # ____________________

City____________________ State ______ Zip______________ Phone (_______)______________

I voluntarily consent and allow the organization named below to release healthcare information to Dr. David Crocker of Michigan Holistic Health to get information from:

Primary Doctor's name: ____

Doctor's Office/Practice Location: ____

Doctor's Phone #: ________________________ Fax #: ________________________
(required) (if available)

INFORMATION TO BE RELEASED

1. Most recent history & physical

AND

2. Office notes from the 5 most recent visits pertaining to ________________________
(qualifying condition)

PURPOSE OR NEED FOR THE INFORMATION REQUESTED IS CONTINUING MEDICAL CARE

I understand this consent is voluntary and that I may revoke this authorization at any time by providing written notice to the above named party. This consent will remain in effect no more than ninety (90) days from the date I signed this consent. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected. THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED.

I understand that this information may include, when applicable, information relating to sexually transmitted disease, Human Immunodeficiency Virus (HIV Infection, Acquired Immune Deficiency Syndrome or AIDS Related Complex) and any other communicable disease. It may also include information about behavioral or mental health services, and referral and/or treatment for alcohol and drug abuse (as permitted by MCL 330.1748, P.A. 258 of 1974 and 42 CFR Part 2).

Patient signature: ______________________________ **Date signed:** ________________

Michigan Medical Marihuana Program
Application Form for Registry Identification Card

(517) 284-6400 | www.michigan.gov/mmp

For Official Use Only MMP 3501 (Rev. 1/15)
□ $60 Patient (with no caregiver) Fee Received
□ $85 Patient (with caregiver) Fee Received

Section A: Patient Information (REQUIRED) as it appears on your identication

1. Legal First Name	2. Middle Initial	3a. Legal Last Name	3b. Suffix (Jr., Sr., III, etc.)

4. Patient Registry ID Card Number (For Renewals Only)	5. MI Driver's License# or MI ID Card #	6. Date of Birth (MM/DD/YYYY)
P		

7a. Mailing Address	7b. Apartment/Suite/Lot #

8. City	9. State	10. Zip Code
	MI	

11. Email Address (If provided, you agree to receive email correspondence from MMMP)	12. Telephone Number

Section B: Person Allowed to Possess Patient's Marihuana Plants: (REQUIRED)

13. Plant possession: You must select one box. Failure to do so will result in the denial of your application.

SELECT ONLY ONE: I will possess the plants
My caregiver will possess the plants

Section C: Caregiver Information (If the patient is designating a caregiver)

14. Legal First Name	15. Middle Initial	16a. Legal Last Name	16b. Suffix (Jr., Sr., III, etc.)

17. Caregiver Registry Card ID Number (For Renewals Only)	18. MI Driver's License# or MI ID Card #	19. Date of Birth (MM/DD/YYYY)
C		

20a. Mailing Address	20b. Apartment/Suite/Lot #

21. City	22. State	23. Zip Code
	MI	

24. Email Address (If provided, you agree to receive email correspondence from MMMP)	25. Telephone Number

26. Other Names Used by Caregiver (Nicknames, maiden names etc. Use a separate piece of paper if you need space for additional names)

Section D: Caregiver Patient Signature & Date (Required)

I attest the information I provided is true and accurate and that I will comply with the requirements of the Michigan Medical Marihuana Act (Initiated Law 1 of 2008, MCL 333.26421 et seq.), Administrative Rules and amendments thereafter. I understand that a false or fraudulent statement, with the intent to aid, abet, or assist in defrauding the state is guilty of perjury punishable in the manner provided by law.

Signature of Patient/Applicant: X ______________________ **Date:** __________

Signature of Caregiver: X ______________________ **Date:** __________