DOCUMENTATION REQUIRED UNDER SECTION 381.986, (4)(c) FLORIDA STATUTES, SUPPORTING THE DETERMINATION THAT THE SMOKING OF MEDICAL MARIJUANA IS AN APPROPRIATE ROUTE OF ADMINISTRATION

A qualified physician must submit the following documentation to the applicable board if the qualified physician determines that smoking is an appropriate route of administration for a qualified patient, other than a patient diagnosed with a terminal condition. Do not provide any patient identifying information other than what is requested in this form.

Send the completed form to: MQA.HCPR-DataTeam@flhealth.gov.
or
Mail to:

BOARD OF OSTEOPATHIC MEDICINE
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-1708

or

BOARD OF MEDICINE
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-1708

Qualified MD/DO License Number: _____

Date physician certification issued: _____

Qualifying patient's year of birth: _____

Qualifying patient's ID Number: _____

1. The patient has tried other routes of administration: ___Yes ___No

   If you answered yes, provide information that shows a list of other routes of administration certified by a qualified physician that the patient has tried, the length of time the patient used such routes of administration, and an assessment of the effectiveness of those routes of administration in treating the qualified patient's qualifying condition. Attach additional sheets as necessary.

Route	**Active Period** (Start Date – End Date)	**Assessment of Effectiveness**
1. _____ Inhalation, Oral, Sublingual, Suppository, or Topical	__/__/____ - __/__/____ MM/DD/YYYY MM/DD/YYYY	_____ _____ _____ _____ _____
2. _____ Inhalation, Oral, Sublingual, Suppository, or Topical	__/__/____ - __/__/____ MM/DD/YYYY MM/DD/YYYY	_____ _____ _____ _____ _____
3. _____ Inhalation, Oral, Sublingual, Suppository, or Topical	__/__/____ - __/__/____ MM/DD/YYYY MM/DD/YYYY	_____ _____ _____ _____ _____

64B8-9.018, F.A.C.
64B15-14.013, F.A.C.
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4. _____ Inhalation, Oral, Sublingual, Suppository, or Topical	__/__/____ - __/__/____ MM/DD/YYYY MM/DD/YYYY	_____ _____ _____ _____ _____
5. _____ Inhalation, Oral, Sublingual, Suppository, or Topical	__/__/____ - __/__/____ MM/DD/YYYY MM/DD/YYYY	_____ _____ _____ _____ _____

2. Provide research documenting the effectiveness of smoking as a route of administration to treat similarly situated patients with the same qualifying condition as the qualified patient. Attach additional documentation if necessary.

3. As the qualified physician, it is my opinion that the benefits of smoking marijuana for medical use outweigh the risks for the qualified patient.

_____

Signature of qualified physician **Date**

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