Registered Patient Acknowledgements
(REQUIRED)

Name: _____ Date: _____

Instructions: Take your time to read each item carefully to ensure your understanding of each statement. ALL statements MUST be INITIALED signifying that you have read and understand the information.

____I understand if my application is approved, my medication may only be used for symptom relief.

____I understand that it is my responsibility to follow-up with the office to maintain my registration and that all fees are non-refundable and subject to change.

____If a patient loses their registration status and has possession of Florida cannabis from an approved dispensary, then it is a violation of Florida Statutes. Registration is based on a face to face encounter.

____ Additionally, I understand that I must report lost or stolen medical marijuana / cannabis medication.

____ I understand the use of marijuana is prohibited; on the property of a registered dispensary; in any public place, including at a school or on bus, public transportation, while operating a motor vehicle, boat, or any other vehicle propelled or drawn by power; in a workplace; operating heavy machinery or handling a dangerous instrumentality; or in a manner that endangers the health or well-being of another person.

____I understand if my application is denied the decision may be appealed. The Notice of Appeal must be submitted within 7 days and the review is limited to the information submitted with this application and consultation with my Heath Care Professional.

____I understand if my application is approved, I may not grow the medicine but may acquire it through an approved Florida dispensary. The fees from the office do not include the medication costs.

____My medication will be held in a secure indoor facility. This means a building or room equipped with locks or other security devices that only permit access to me (and my registered caregiver(s), if applicable).
____I understand that the Office of Medical Marijuana Use (OMMU) and Florida Department of Health are resources for updates.
____I understand if my application is approved, I can designate a dispensary.
____I understand if my application is approved, marijuana may not be transported in public, including in a motor vehicle except in a locked container; this includes transporting marijuana from a dispensary.
____I understand a Law Enforcement Officer is not required to return marijuana or paraphernalia after seizure. Additionally, Law Enforcement that discovers marijuana cultivation is subject to consequences.
____I have instructed my registered caregiver(s) or next of kin, in the event of my death, the office must be notified within 72 hours and can help arrange for disposal of any and all marijuana products.
____I understand that providing false information on this application or to Law Enforcement, may result in imprisonment, a fine, or both. This penalty may be in addition to other penalties that may apply.
____I understand the possession of marijuana remains a violation of Federal Law and state law does not provide protections against Federal Law violations. Medical Marijuana/Cannabis is also not FDA approved.
____I understand that my health insurer is not required to cover the cost of marijuana for symptom relief. The financial policies and prices are subject to change; the office will make an effort to notify me of any changes. Business associates and/or dispensaries may need additional limited information to facilitate treatment plans.
_____ I am advised to maintain a primary care provider, for annual drug abuse screening, monitoring vital signs and general health. If I develop any side effects from the medical marijuana, I will stop medical marijuana immediately and consult with my providers. Additionally, where applicable, I will maintain regular follow-up appointments with my specialists - Neurologists, Pain Physician, Physical Medicine and Rehabilitation Doctor, Psychiatrist, Oncologists and other specialists, based on my debilitating condition(s).
_____ I am advised to discuss and notify my other physicians of my medical marijuana / cannabis registration.
_____ I hereby declare that I have truthfully and completely disclosed all information regarding my condition.
_____ I understand that the office does not perform formal disability assessments, nor does the office staff, independent contractors, affiliates, employees and associates function as my primary care provider.
_____ I should maintain my current primary care provider and medical specialists or establish them for my general health needs or disability paperwork.
_____ The use of cannabis may affect my coordination, memory, and cognition in ways that could impair my ability to drive and function. I agree not to operate heavy machinery, drive or engage in potentially hazardous activities while under the influence of cannabis. Patients should wait a minimum of 6 hours after cannabis use before engaging in potentially dangerous activities. Cannabis may cause permanent damage to the brain and other organs.

___ I understand that patients can become addicted or dependent on cannabis. This means they may experience mild withdrawal symptoms when they stop using cannabis. Signs of withdrawal symptoms, while generally mild can include feelings of depression, sadness, irritability, insomnia, loss of appetite, restlessness or mild agitation, trouble concentrating, sleep disturbances and/or unusual tiredness.

___ Cannabis varies in potency. The effects of cannabis can also vary with the delivery system. Estimating the proper cannabis dosage is extremely important. Nausea, hacking cough, disturbances to heart rhythms and numbness in the limbs are some of the many symptoms of cannabis overdose. Fungal and other infections of the lungs, blood stream, and any bodily organ can occur. There may also be known and unknown side effects.

____Chronic cannabis use can lead to bronchitis and infection, laryngitis, and general apathy, reduced brain development, brain damage, unknown side effects, rapid and/or gradual multiple organ failure and death.

____Although cannabis may produce a psychosis, the possibility exists that it may exacerbate schizophrenia in patients predisposed to that condition. I will maintain a psychiatrist for any psychiatric issues and concerns

____The cultivation, possession, and use of cannabis, even for medical purposes is still currently illegal under Federal Law. There are 100s to 1000s of unknown, unstudied substances in the Cannabis plant and medication.

____ Physicians licensed in Florida may discuss and approve the medical use of cannabis to patients suffering from a qualifying medical condition. Visit the internet, DOH websites and our office for additional information.

____ Release of liability: The physician and staff are addressing specific aspects of my medical care and are in no way establishing themselves as my primary care provider. I agree to follow up with my doctor(s) with supporting updated medical records pertaining to my condition. These documents can be brought in person, mailed, faxed or emailed. Also, cannabis may worsen my condition or cause new life threatening conditions.

____ I attest that I do not intend to use my medical recommendation for illegal purposes.

____I attest that I am not a member, employee or agent of any media or law enforcement agency. It is illegal to film or record in this office with a video camera, cell phone or any other recording device. This is a direct violation of HIPAA regulations and doctor/patient confidentiality.

___I hereby acknowledge that I have read and understand the HIPAA - Notice of Privacy Practices and may obtain a copy at my request.

____ All fees are subject to change without notice.

____ Information may be used to further education, research, improve access to treatment for current and future generations

____ Nothing will used to identify me or connect my identity with this data.

____I have received and have access to Medical Records Release, Florida Patient's Bill of Rights and Responsibilities, & HIPAA.

____Plans of care will be updated with the DOH registry

____ I am aware that my recommendation can be revoked at any time if I have misrepresented myself or my condition, my intentions, or falsified any medical records to the physician and I am in no way guaranteed to have a recommendation for medical cannabis. The doctor may discuss my medical condition for verification purposes only. Any surveys, market research, research studies, clinical trials, etc. is optional.

____ For women, I am not pregnant, planning pregnancy, or breastfeeding and if that status changes, I will stop the medical cannabis immediately.
____For men, I am not attempting to get my significant other pregnant and if that status changes, I will stop the medical cannabis immediately.
____ Both sexes may experience weight gain.

Patient Name:_____

Patient Signature: _____ Date: _____

Physician: VANIA E. FERNANDEZ, M.D

Signature: _____ Date:_____

Witness:_____ Date:_____