

APPLICATION TO REQUEST THAT AN ADDITIONAL FORM OF MEDICAL CANNABIS BE LAWFUL IN WEST VIRGINIA

If this form of medical cannabis has been approved any other state(s), please list the state(s) where it has been approved: _____

Physician Information

Are you a licensed physician? Yes No

If you are a licensed physician, please provide your West Virginia medical license number and your primary specialty.

License Number: _____ Specialty: _____

If you are not a licensed, you must provide the contact information of a licensed physician who supports your request that an additional form of medical cannabis be lawful in West Virginia. The Office of Medical Cannabis will contact the licensed physician identified below to confirm that they support your request. If the physician does not support your request for an additional form of medical cannabis to be lawful in West Virginia, your request will be denied.

Name of Supporting Physician: _____
First Middle Last Suffix

Mailing Address: _____

City State Zip

Phone: _____ Email (if known): _____

Supporting Medical Evidence

If applicable, provide medical evidence (clinical, medical, or scientific data) which demonstrates that the additional form of medical cannabis that you are requesting be lawful in West Virginia is effective for therapeutic or palliative care. Additional information may be submitted on a separate sheet of paper and should follow the format identified below.

Citation: _____

University/Publisher: _____

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Summary: _____

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Certification

By signing this application, I hereby certify that the information provided is true and correct to the best of my knowledge.

Signature: _____

Date: _____