Maine Medical Cannabis Certification

Patient Registration Form

We text. We return voicemails!
Trouble Texting? Call 207.313.9335

Patient Information

Phone: (__ __ __) __ __ __-- __ __ __ __

Date of Birth: __ __ / __ __ / __ __ __ __ Zip Code: __ __ __ __ __

First Name: __

Last Name: __

Street Address: __

City: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

State: Maine Residents Only Email: _____

Patient Agreement/Consent: I will disclose all information regarding my medical and behavioral health condition(s). I agree to provide supporting documents pertaining to my medical condition(s) if requested. I consent to a VIDEO telemedicine evaluation via Doxy.ME by the Nurse Practitioner to be certified for the medical use of cannabis. Cost includes telemedicine evaluation by Certified Nurse Practitioner, Medical Cannabis Certification Card expiring in one year, any required diagnosis letter, free card replacement if lost or damaged and optional six-month telemedicine follow up. I acknowledge that it is my sole responsibility to schedule and participate in any follow up during my 6th month of treatment if desired.

Signature: _____