

Compassionate Use Registry Identification Card Application Instructions for Qualified Patients

In order to apply for a Compassionate Use Registry Identification Card each patient must: be a Florida resident, be diagnosed with a qualifying condition, and must have been added to the Compassionate Use Registry (and received a Compassionate Use Registry Patient Identification Number) by a physician licensed under Chapter 458 or Chapter 459, Florida Statutes, to receive low-THC cannabis, medical cannabis, or a cannabis delivery device from an authorized Florida dispensing organization.

NEW PATIENT APPLICATIONS MUST INCLUDE ALL OF THE FOLLOWING

- A completed application. By providing your email address, you consent to the Department contacting you through the email address, including the provision of a temporary verification email.
- A copy of your Florida driver license or Florida identification card, or other proof of residency listed below
- A \$75 check or money order (application fee) made out to Florida Department of Health.
- A full-face, passport-type 2x2 inches in size, color photograph taken within the 90 days immediately preceding application

Minor applications must also include:

- A designated legal representative and Compassionate Use Registry Identification Card Legal Representative Application
- A copy of the parent's or designated legal representative's proof of residency

PROOF OF RESIDENCY

Patients must submit a copy of a valid Florida driver license or Florida identification card. If the patient does not possess a valid Florida driver license or Florida identification card, they may submit a copy of a utility bill in the patient's name including a Florida address, or a Florida voter registration card. The name and address on the documents provided for residency must match the name and address in this application.

For minor patients, the parent or designated legal representative must submit proof of residency of the parent or designated legal representative.

RENEWAL APPLICATIONS

All Compassionate Use Registry Identification Cards expire 1 year after the date of the physician's initial order. Submit renewal applications 45 days before your card expires. Renewal applications CANNOT be used to purchase low-THC cannabis, medical cannabis, or a cannabis delivery device.

LEGAL REPRESENTATIVE

If you are signing on behalf of the qualified patient in the application, you must provide proof of legal representation. A legal representative means the qualified patient's parent, legal guardian acting pursuant to a court's authorization as required under section 744.3215(4), Florida Statutes, health care surrogate acting pursuant to the qualified patient's written consent or a court's authorization as required under section 765.113, Florida Statutes, or an individual who is authorized under a power of attorney to make health care decisions on behalf of the qualified patient.

NOTICE ON THE COLLECTION, USE, OR RELEASE OF SOCIAL SECURITY NUMBERS

Florida law requires that public agencies provide individuals with a written statement identifying the state or federal law governing the collection, use, or release of social security numbers for each purpose for which the public agency collects an individual's social security number. The collection of social security numbers by the Florida Department of Health is either specifically authorized by law or imperative for the performance of the Florida Department of Health's duties and responsibilities as prescribed by law. This notice is provided pursuant to Subsection 119.071(5)(a), Florida Statutes. For the Compassionate Use Registry Identification Card Qualified Patient Application, social security numbers are collected and used for identification purposes to ensure that the number identifier assigned to the qualified patient is unique and matches the identity of the qualified patient, as authorized by sections 119.071(5)(a)2. and 119.071(5)(a)6., Florida Statutes. Social security numbers collected for this purpose will remain confidential.

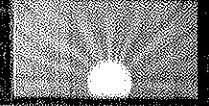
KEEP THESE INSTRUCTIONS AND A COPY OF YOUR COMPLETED APPLICATION FOR FUTURE REFERENCE.

ELECTRONIC APPLICATION:

Expedite your application by applying online at <https://curegistry.flhealth.gov/>

MAIL COMPLETED APPLICATION TO:

Florida Department of Health
ATTN: Office of Compassionate Use
4052 Bald Cypress Way
Tallahassee, FL 32399



Rick Scott, Governor of the State of Florida
 Colostephine Phillip, MD, MPH, Surgeon General and Secretary

FloridaHealth.gov

4052 Bald Cypress Way, Tallahassee, Florida 32399-3265 • 850-245-4657

Compassionate Use Registry Patient Identification Card Qualified Patient Application

- Initial Application Renewal Application Minor Application

Mail Completed Application to: Florida Department of Health ATTN: Office of Compassionate Use 4052 Bald Cypress Way Tallahassee, FL 32399	Patient Registry ID #: _____
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Patient Information					
First Name		Last Name		Middle Initial	
Date of Birth	Social Security Number		Mailing Address		
City	Apt/Ste #	State	Zip Code	County	
Telephone		Email (optional to receive communication, including a temporary verification)			

Patient Passport Photo	
<p>Attach a color photograph taken within 90 days of registration</p>	<p>Submit a full-face, passport-type, color photograph of the patient taken within the 90 days immediately preceding registration, and 2x2 inches in size.</p> <p>The image size measured from the bottom of your chin to the top of your head (including hair) should not be less than 1 inch, and not more than 1 3/8 inches. The photograph must be color, clear, with a full front view of your face, and printed on photo quality paper with a plain light (white or off-white) background. The photograph must be taken in normal street attire, without a hat, head covering, or dark glasses unless a signed statement is submitted by the applicant verifying the item is worn daily for religious purposes or a signed doctor's statement is submitted verifying the item is used daily for medical purposes. Headphones, "bluetooth", or similar devices must not be worn in the passport photograph. Any photograph retouched so that your appearance is changed is unacceptable. A snapshot, most vending machine prints, and magazine or full-length photographs are unacceptable.</p>

Designate a Legal Representative (if applicable)

Legal Representative First Name	Legal Representative Last Name	Legal Representative Date of Birth
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I hereby certify the above information to be accurate and complete and no one other than me, or my legal representative, is submitting this request on my behalf.

Patient or Legal Representative Name (*Print*)

Patient or Legal Representative Signature

Date

JAMES R. MILNE D.O., P.A.
www.peacemedicalfla.com
954-775-7655
5333 North Dixie Highway, Suite 204
Fort Lauderdale, Fl 33334

PATIENT INFORMATION

Date: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State/Zip: _____

Home Telephone: _____ Cell Phone: _____

****Email:** _____ **DOB:** _____ **Age:** _____

SS#: _____ Sex: M F Marriage Status: S M W D Sep

Race/Ethnicity: White Black Native American Native Hawaiian Hispanic Asian Middle Eastern

Employer: _____ Employer Address: _____

Work Phone: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

Is Patient Responsible Party? YES NO if no complete responsible party information.

Name of Responsible Party or Legal Representative: _____

Phone: _____ Relationship: _____

Address: _____

MEDICAL HISTORY

Current Medical Problem: _____

Date of Onset/Injury: _____ Was This an Accident? YES NO

Referral Source: _____

***** You must provide an email address to receive your State ID Card*****

FINANCIAL AGREEMENT

The patient or legal guardian is responsible financially for all services provided by Dr. James R. Milne and there in agree to all terms listed in the agreement.

TERMS OF AGREEMENT

- Dr. James R. Milne requires a 24 hour notification on all cancellations. Missed appointment and late cancellation will result in a \$25.00 charge to the patient. Payment for services rendered are non-refundable.
- I will notify a Dr. James R. Milne representative of any changes in my information, including but not limited to address, phone number.
- I understand that I am financially responsible for all charges.
- I understand that all payments are non-refundable.
- Should any professional collection efforts be necessary, I understand that I will be responsible for any and all costs of collections including, but not limited to court costs, interest and attorney fees.

Patient Signature [or legal guardian/care giver]

Date Social Security Number

CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, you consent to the use and disclosure of your protected health information by Dr. James R. Milne, our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices. The terms of this Notice may change. If the terms do change, you may obtain a revised version by contacting Dr. James R. Milne 954-776-7566 and requesting a revised Notice. You have the right to request that we restrict our uses or disclosures of your protected health information which we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. You have the right to revoke the consent in writing, except to the extent that we have taken action in reliance on it.

Signature

Date

Please give name[s] of person[s] that may obtain verbal information regarding your medical history

Name _____

Relation _____

Name _____

Relation _____

CONSENT FOR CARE AND TREATMENT

I understand my right to participate in my treatment process. I am mentally competent and do hereby consent to necessary examination, procedure and or treatment prescribed by Dr. James R. Milne, his assistants and designees as is necessary in his/her judgment.

Date _____

Medical Marijuana Consent Form

A qualified physician may not delegate the responsibility of obtaining written informed consent to another person. The qualified patient or the patient's parent or legal guardian if the patient is a minor must initial each section of this consent form to indicate that the physician explained the information and, along with the qualified physician, must sign and date the informed consent form.

- a. **The Federal Government's classification of marijuana as a Schedule I controlled substance.**

_____ The federal government has classified marijuana as a Schedule I controlled substance. Schedule I substances are defined, in part, as having (1) a high potential for abuse; (2) no currently accepted medical use in treatment in the United States; and (3) a lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution and possession of marijuana even in states, such as Florida, which have modified their state laws to treat marijuana as a medicine.

_____ When in the possession or under the influence of medical marijuana, the patient or the patient's caregiver must have his or her medical marijuana use registry identification card in his or her possession at all times.

- b. **The approval and oversight status of marijuana by the Food and Drug Administration.**

_____ Marijuana has not been approved by the Food and Drug Administration for marketing as a drug. Therefore, the "manufacture" of marijuana for medical use is not subject to any federal standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients, which may vary in potency, impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.

- c. **The potential for addiction.**

_____ Some studies suggest that the use of marijuana by individuals may lead to a tolerance to, dependence on, or addiction to marijuana. I understand that if I require increasingly higher doses to achieve the same benefit or if I think that I may be developing a dependency on marijuana, I should contact Dr. _____ (name of qualified physician).

- d. **The potential effect that marijuana may have on a patient's coordination, motor skills, and cognition, including a warning against operating heavy machinery, operating a motor vehicle, or engaging in activities that require a person to be alert or respond quickly.**

_____ The use of marijuana can affect coordination, motor skills and cognition, i.e., the ability to think, judge and reason. Driving under the influence of cannabis can double the risk of crashing, which escalates if alcohol is also influencing the driver. While using medical marijuana, I should not drive, operate heavy machinery or engage in any activities that require me to be alert and/or respond quickly and I should not participate in activities that may be dangerous to myself or others. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."

e. The potential side effects of medical marijuana use.

_____ Potential side effects from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, sedation, low blood pressure, impairment of short term memory, euphoria, difficulty in completing complex tasks, suppression of the body's immune system, may affect the production of sex hormones that lead to adverse effects, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia in persons predisposed to that disorder. In addition, the use of medical marijuana may cause me to talk or eat in excess, alter my perception of time and space and impair my judgment. Many medical authorities claim that use of medical marijuana, especially by persons younger than 25, can result in long-term problems with attention, memory, learning, drug abuse, and schizophrenia.

_____ I understand that using marijuana while consuming alcohol is not recommended. Additional side effects may become present when using both alcohol and marijuana.

_____ I agree to contact Dr. _____ if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact Dr. _____ if I experience respiratory problems, changes in my normal sleeping patterns, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.

g. The risks, benefits, and drug interactions of marijuana.

_____ Signs of withdrawal can include: feelings of depression, sadness, irritability, insomnia, restlessness, agitation, loss of appetite, trouble concentrating, sleep disturbances and unusual tiredness.

_____ Symptoms of marijuana overdose include, but are not limited to, nausea, vomiting, hacking cough, disturbances in heart rhythms, numbness in the hands, feet, arms or legs, anxiety attacks and incapacitation. If I experience these symptoms, I agree to contact Dr. _____ immediately or go to the nearest emergency room.

_____ Numerous drugs are known to interact with marijuana and not all drug interactions are known. Some mixtures of medications can lead to serious and even fatal consequences. I agree to follow the directions of Dr. _____ regarding the use of prescription

64B8ER17-1 (64B8-9.018, F.A.C.)
64B15ER17-1 (64B15-14.013, F.A.C.)
DH-MQA-5026
08/17

and non-prescription medication. I will advise any other of my treating physician(s) of my use of medical marijuana.

_____ Marijuana may increase the risk of bleeding, low blood pressure, elevated blood sugar, liver enzymes, and other bodily systems when taken with herbs and supplements. I agree to contact Dr. _____ immediately or go to the nearest emergency room if these symptoms occur.

_____ I understand that medical marijuana may have serious risks and may cause low birthweight or other abnormalities in babies. I will advise Dr. _____ if I become pregnant, try to get pregnant, or will be breastfeeding.

h. The current state of research on the efficacy of marijuana to treat the qualifying conditions set forth in this section.

_____ **Cancer**

- There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for cancers, including glioma.

There is evidence to suggest that cannabinoids (and the endocannabinoid system more generally) may play a role in the cancer regulation processes. Due to a lack of recent, high quality reviews, a research gap exists concerning the effectiveness of cannabis or cannabinoids in treating cancer in general.

- There is conclusive evidence that oral cannabinoids are effective antiemetics in the treatment of chemotherapy-induced nausea and vomiting.
There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for cancer-associated anorexia-cachexia syndrome and anorexia nervosa.

_____ **Epilepsy**

- There is insufficient evidence to support or refute the conclusion that cannabinoids are an effective treatment for epilepsy.

Recent systematic reviews were unable to identify any randomized controlled trials evaluating the efficacy of cannabinoids for the treatment of epilepsy. Currently available clinical data therefore consist solely of uncontrolled case series, which do not provide high-quality evidence of efficacy. Randomized trials of the efficacy of cannabidiol for different forms of epilepsy have been completed and await publication.

_____ **Glaucoma**

- There is limited evidence that cannabinoids are an ineffective treatment for improving intraocular pressure associated with glaucoma.

Lower intraocular pressure is a key target for glaucoma treatments. Non-randomized studies in healthy volunteers and glaucoma patients have shown short-term reductions in intraocular pressure with oral, topical eye drops, and intravenous cannabinoids, suggesting the potential for therapeutic benefit. A good-quality systemic review identified a single small trial that found no effect of two cannabinoids, given as an oromucosal spray, on intraocular pressure. The quality of evidence for the finding of no effect is limited. However, to be effective, treatments targeting lower intraocular pressure must provide continual rather than transient reductions in intraocular pressure. To date, those studies showing positive effects have shown only short-term benefit on intraocular pressure (hours), suggesting a limited potential for cannabinoids in the treatment of glaucoma.

_____ **Positive status for human immunodeficiency virus**

- There is limited evidence that cannabis and oral cannabinoids are effective in increasing appetite and decreasing weight loss associated with HIV/AIDS.

There does not appear to be good-quality primary literature that reported on cannabis or cannabinoids as effective treatments for AIDS wasting syndrome.

_____ **Acquired immune deficiency syndrome**

- There is limited evidence that cannabis and oral cannabinoids are effective in increasing appetite and decreasing weight loss associated with HIV/AIDS.

There does not appear to be good-quality primary literature that reported on cannabis or cannabinoids as effective treatments for AIDS wasting syndrome.

_____ **Post-traumatic stress disorder**

- There is limited evidence (a single, small fair-quality trial) that nabilone is effective for improving symptoms of posttraumatic stress disorder.

A single, small crossover trial suggests potential benefit from the pharmaceutical cannabinoid nabilone. This limited evidence is most applicable to male veterans and contrasts with non-randomized studies showing limited evidence of a statistical association between cannabis use (plant derived forms) and increased severity of posttraumatic stress disorder symptoms among individuals with posttraumatic stress disorder. There are other trials that are in the process of being conducted and if successfully completed, they will add substantially to the knowledge base.

_____ **Amyotrophic lateral sclerosis**

- There is insufficient evidence that cannabinoids are an effective treatment for symptoms associated with amyotrophic lateral sclerosis.

Two small studies investigated the effect of dronabinol on symptoms associated with ALS. Although there were no differences from placebo in either trial, the

64B8ER17-1 (64B8-9.018, F.A.C.)

64B15ER17-1 (64B15-14.013, F.A.C.)

DH-MQA-5026

08/17

sample sizes were small, the duration of the studies was short, and the dose of dronabinol may have been too small to ascertain any activity. The effect of cannabis was not investigated.

_____ **Crohn's disease**

- There is insufficient evidence to support or refute the conclusion that dronabinol is an effective treatment for the symptoms of irritable bowel syndrome.

Some studies suggest that marijuana in the form of cannabidiol may be beneficial in the treatment of inflammatory bowel diseases, including Crohn's disease.

_____ **Parkinson's disease**

- There is insufficient evidence that cannabinoids are an effective treatment for the motor system symptoms associated with Parkinson's disease or the levodopa-induced dyskinesia.

Evidence suggests that the endocannabinoid system plays a meaningful role in certain neurodegenerative processes; thus, it may be useful to determine the efficacy of cannabinoids in treating the symptoms of neurodegenerative diseases. Small trials of oral cannabinoid preparations have demonstrated no benefit compared to a placebo in ameliorating the side effects of Parkinson's disease. A seven-patient trial of nabilone suggested that it improved the dyskinesia associated with levodopa therapy, but the sample size limits the interpretation of the data. An observational study demonstrated improved outcomes, but the lack of a control group and the small sample size are limitations.

_____ **Multiple sclerosis**

- There is substantial evidence that oral cannabinoids are an effective treatment for improving patient-reported multiple sclerosis spasticity symptoms, but limited evidence for an effect on clinician-measured spasticity.

Based on evidence from randomized controlled trials included in systematic reviews, an oral cannabis extract, nabiximols, and orally administered THC are probably effective for reducing patient-reported spasticity scores in patients with MS. The effect appears to be modest. These agents have not consistently demonstrated a benefit on clinician-measured spasticity indices.

_____ **Medical conditions of same kind or class as or comparable to the above qualifying medical conditions**

- The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy of marijuana to treat the patient's medical condition.
- The summary is attached to this informed consent as Addendum_____.

64B8ER17-1 (64B8-9.018, F.A.C.)
64B15ER17-1 (64B15-14.013, F.A.C.)
DH-MQA-5026
08/17

_____ **Terminal conditions diagnosed by a physician other than the qualified physician issuing the physician certification**

- The qualifying physician has provided the patient or the patient's caregiver a summary of the current research on the efficacy of marijuana to treat the patient's terminal condition.
- The summary is attached to this informed consent as Addendum _____.

_____ **Chronic nonmalignant pain**

- There is substantial evidence that cannabis is an effective treatment for chronic pain in adults.

The majority of studies on pain evaluated nabiximols outside the United States. Only a handful of studies have evaluated the use of cannabis in the United States, and all of them evaluated cannabis in flower form provided by the National Institute on Drug Abuse. In contrast, many of the cannabis products that are sold in state-regulated markets bear little resemblance to the products that are available for research at the federal level in the United States. Pain patients also use topical forms.

While the use of cannabis for the treatment of pain is supported by well-controlled clinical trials, very little is known about the efficacy, dose, routes of administration, or side effects of commonly used and commercially available cannabis products in the United States.

i. That the patient's de-identified health information contained in the physician certification and medical marijuana use registry may be used for research purposes.

_____ The Department of Health submits a data set to The Medical Marijuana Research and Education Coalition for each patient registered in the medical marijuana use registry that includes the patient's qualifying medical condition and the daily dose amount and forms of marijuana certified for the patient.

_____ I have had the opportunity to discuss these matters with the physician and to ask questions regarding anything I may not understand or that I believe needed to be clarified. I acknowledge that Dr. _____ has informed me of the nature of a recommended treatment, including but not limited to, any recommendation regarding medical marijuana.

Dr. _____ also informed me of the risks, complications, and expected benefits of any recommended treatment, including its likelihood of success and failure. I acknowledge that Dr. _____ informed me of any alternatives to the recommended treatment, including the alternative of no treatment, and the risks and benefits.

64B8ER17-1 (64B8-9.018, F.A.C.)
64B15ER17-1 (64B15-14.013, F.A.C.)
DH-MQA-5026
08/17

Dr. _____ has explained the information in this consent form about the medical use of marijuana.

Patient (print name) _____

Patient signature or signature of the parent or legal guardian if the patient is a minor:

_____ Date _____

I have explained the information in this consent form about the medical use of marijuana to _____ (Print patient name).

Qualified physician signature:

_____ Date _____

Witness:

_____ Date _____

NAME _____ DATE _____

MEDICAL HISTORY

1. What is your most significant problem[s]: _____

2. Have you seen a physician _____ chiropractor _____ therapist _____ psychiatrist _____ for your condition.
Name[s] of those seen: _____
3. Please indicate treatment[s] that were attempted, approximate duration of treatment and outcome:
Medication _____ massage/physical therapy _____ injections _____ exercise _____ surgery _____ acupuncture _____
Psychological Counseling _____ other _____
Outcome of treatment/did it help: _____ Duration _____
4. Do you now or have you ever had any of the following:
Muscle spasms ALS[Lou Gehrig's] Muscular Dystrophy Anorexia Parkinson's Arthritis
Cachexia[wasting] Severe Back Pain Severe Nausea PTSD Cancer Sickle Cell
Anemia Crohn's Disease Spasity Chronic Abdominal Pain Diabetes
Epilepsy Glaucoma Hepatitis C HIV IBS Lyme Disease
Migraines Multiple Sclerosis Seizures
Any other debilitating condition: _____
5. List all allergies to food or medicine: _____
6. List all medications you are presently taking. **Indicate dosage and if they are prescribed:**

7. List all surgeries and date[s]: _____

SOCIAL HISTORY

1. Are you Employed YES NO What do you do for work _____
2. Do you smoke cigarettes: YES NO Number of cigarettes per day _____
Do you smoke THC: YES NO Frequency _____
Do you drink alcohol: YES NO Number of drinks per day _____
Do you have a history of alcohol abuse: NO YES _____
Do you have a history of drug abuse/addiction: NO YES _____
3. Give a brief family history, including illnesses, and, if applicable, cause of death:
Mother _____ Father _____
Sister[s] _____ Brother[s] _____

REVIEW OF SYMPTOMS: Circle Current:

GENERAL

Constipation
Weight changes
Weakness
Fatigue
Fever
Difficulty sleeping
Night sweats
Chills
Sore throat

NEURO

Fainting
Paralysis
Weakness
Tremor
Seizures
Tingling
Memory problems
Numbness

GASTRO

Nausea/vomiting
Bleeding
Indigestion
Pain
Diarrhea
Constipation

SKIN

Infections
Nail changes
Itching
Hair changes
Rashes

CARDIAC

Chest pain/pounding
Palpitations

ENDOCRINE

Temp. Intolerance
Frequent urination
Hunger
Thirst

PSYCH

Nervousness
Tension
Depression
Anxiety
Mood swings
Insomnia

HEAD

Headache
Vision problems
Glaucoma

SKELETAL

Stiffness
Swelling
Cramps
Spasms

OTHER:

Sex Drive
Memory
Focus
Concentration