

# Basic Facts

July 2002

- You must be an Oregon resident to be a registered patient in the Oregon Medical Marijuana Program (OMMP).
- You must have a qualifying debilitating medical condition as listed on the Attending Physician's Statement.
- Your physician must be a Medical Doctor (MD) or Doctor of Osteopathy (DO) licensed to practice medicine in Oregon. You must have an established patient/physician relationship with your "attending physician." Naturopaths, chiropractors, and nurse practitioners cannot sign the documentation.
- The OMMP cannot refer you to a physician. The OMMP does not have a physician referral list.
- You must list a grow site address on your application. You, or your designated primary caregiver, may grow your own medication. There is no place in the State of Oregon to legally purchase medical marijuana.
- The OMMP cannot find a designated primary caregiver for you. The OMMP does not keep a referral list of persons who want to be caregivers for patients. (You are not required to list a caregiver, unless you are less than 18 years old.) Your caregiver cannot be your physician.
- The OMMP cannot supply you with seeds or starter plants, or give you advice on how to grow medical marijuana.
- The application fee cannot be waived. Partial payments cannot be accepted.

# Application Form and Instructions

**KEEP A COPY OF YOUR APPLICATION FOR YOUR RECORDS**

## Page 1: Application Form

### Part A - Applicant Information

- Complete all of Part A.
- You must provide a clear, legible copy of your current Oregon photo ID card to show that you are an Oregon resident.
- If the information or expiration date on the front of your ID is not current, please copy the back of the card.

### Part B - Primary Caregiver

A primary caregiver is a person age 18 or older who has significant responsibility for your care (in this instance, a primary caregiver cannot be your physician).

- Part B of the application allows you to designate a primary caregiver. You do not have to designate a primary caregiver unless you are under age 18.
- If you choose to list a primary caregiver, that person must provide a copy of his or her current photo ID as well as his or her date of birth, address, and phone number.
- There is no additional fee for a primary caregiver registry identification card.

### Part C - Marijuana Grow Site

- Part C allows you to identify the grow site address for your medical marijuana. This information is required under Oregon Administrative Rule (OAR) 333-008-0020(1)(b).
- You may provide the physical address where your medical marijuana will be grown or you may provide the physical address of where you would most likely grow your medical marijuana.
- A PO Box is not acceptable for a grow site address.

### Part D - Annual Registration Fee

- A registration fee of \$150 is required for all new and renewal applications.
- Please make your check or money order out to "State of Oregon". Do not send cash.

#### **Part E - Signature & Date**

- Part E requires you to sign your name and date the application form.
- If a proxy is signing the application for you, please note this on your application.

## **Page 2: Attending Physician's Statement**

#### **Part A - Patient Information**

- Clearly print the patient's full name and date of birth.

#### **Part B - Physician Name and Address**

- Clearly print the physician's name, mailing address and telephone number.

#### **Part C - Physician's Statement**

The physician signing your OMMP documentation must be a Medical Doctor (MD) or Doctor of Osteopathy (DO) currently licensed to practice medicine in Oregon under Oregon Revised Statute Chapter 677. He or she must meet the definition of an "attending physician" (OAR 333-008-0010(1)).

- The physician must complete this section by checking the boxes to indicate your qualifying debilitating medical condition.
- The physician must sign and date the form. The date must be current within 3 months of the date of your application or card expiration.

As an alternative to the Attending Physician's Statement, you may submit signed, dated, valid, written documentation from your physician.

This documentation can be in the form of a signed and dated copy of your medical records or a signed and dated letter and must state:

- You are his or her patient;

- You have been diagnosed with a debilitating medical condition covered by the Oregon Medical Marijuana Act; and
- (For a new application) the medical use of marijuana may mitigate the symptoms or effects of your condition.
- This documentation must also be current within 3 months of the date of your application or card expiration.

If you are a minor...

If the applicant is under age 18, the parent or guardian must complete the Declaration of Person Responsible for a Minor form and complete Part B of the Application Form as a primary caregiver. The Declaration of Person Responsible for a Minor form is available from the OMMP office. This form must be notarized.

All information on your application will be verified by the OMMP.

## APPLICATION FORM

### Registration for the Oregon Medical Marijuana Program

**Instructions:** Please complete all required information to comply with the registration requirements of the Oregon Medical Marijuana Act. Attach legible copies of ID and enclose your payment. If applicant is a minor (under 18), the custodial parent or legal guardian with responsibility for health care decisions must be listed as the Primary Caregiver. Please type or print legibly.

If you want this document in a larger print, please contact this office: 503-731-4002 x 233

Please contact the Oregon Department of Human Services if you need this material in an alternative format.

<b>A APPLICANT INFORMATION (REQUIRED)</b>	
NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:
MAILING ADDRESS:	TELEPHONE NUMBER:
CITY, STATE AND ZIP CODE:	COUNTY:
Photo Identification: A photocopy of one of the following must be attached. Please check appropriate box below. <input type="checkbox"/> Oregon Drivers License <input type="checkbox"/> Oregon Identification Card <input type="checkbox"/> Voter Registration Card, plus current photo.	

<b>B PRIMARY CAREGIVER (IF APPLICABLE)</b>	
NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:
MAILING ADDRESS:	TELEPHONE NUMBER:
CITY, STATE AND ZIP CODE:	COUNTY:
Photo Identification: If applicable, a photocopy of one of the following must be attached. Please check appropriate box. <input type="checkbox"/> Oregon Drivers License <input type="checkbox"/> Oregon Identification Card <input type="checkbox"/> Voter Registration Card, plus current photo.	

<b>C MARIJUANA GROW SITE (REQUIRED)</b>	
To be protected under the OMMA, you must list a physical grow site address (a PO Box is not acceptable). <b>CHOOSE EITHER OPTION 1 OR OPTION 2.</b> Failure to complete this section will result in a denial of your application.	
OPTION 1:	OR
<b>My physical grow site address:</b>  STREET: _____ CITY: _____ STATE: _____ ZIP CODE: _____	<b>If you are uncertain where your medical marijuana will be grown, please list the address where it would most likely be grown:</b>  STREET: _____ CITY: _____ STATE: _____ ZIP CODE: _____
For their protection, please list the names of other adults living at this address:	

<b>D ANNUAL REGISTRATION FEE (REQUIRED)</b>
The annual registration fee is <b>\$150</b> . Enclose your <b>check</b> or <b>money order</b> made payable to "State of Oregon".

<b>E SIGNATURE &amp; DATE (REQUIRED)</b>	
<b>I TESTIFY THAT THE ABOVE INFORMATION IS TRUE.</b>	
APPLICANT OR PROXY SIGNATURE:	DATE:

MAIL APPLICATION FORM TO:

DHS/OMMP  
 PO BOX 14450  
 Portland, OR 97293-0450



**ATTENDING PHYSICIAN'S STATEMENT**  
**Oregon Medical Marijuana Act Program**

**Instructions:** Please complete all required information in order to comply with the registration requirements of the Oregon Medical Marijuana Act **OR** provide relevant portions of the patient's medical record containing all information required on this form. **This does not constitute a prescription for marijuana.**

If you want this document in a larger print, please contact this office: 503-731-4002 X 233

Please contact the DHS/Health Services if you need this material in an alternative format.	
<b>A PATIENT INFORMATION</b>	
PATIENT NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:
<b>B PHYSICIAN NAME AND ADDRESS</b>	
PHYSICIAN NAME: (Please Print <u>Legibly</u> )	
MAILING ADDRESS:	TELEPHONE NUMBER:
CITY, STATE AND ZIP CODE:	
<b>C PHYSICIAN'S STATEMENT</b>	
<b>Debilitating Medical Condition: Check appropriate boxes</b>	
<input type="checkbox"/> 1. Malignant neoplasm (Cancer)	
<input type="checkbox"/> 2. Glaucoma	
<input type="checkbox"/> 3. Positive status for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)	
<input type="checkbox"/> 4. Agitation due to Alzheimer's Disease	
5. A medical condition or treatment for a medical condition that produces for a specific patient	
one or more of the following: (check all that apply)	
<input type="checkbox"/> a. Cachexia	
<input type="checkbox"/> b. Severe pain	
<input type="checkbox"/> c. Severe nausea	
<input type="checkbox"/> d. Seizures, including but not limited to seizures caused by epilepsy	
<input type="checkbox"/> e. Persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis	
Comments:	
I hereby certify that I am a physician duly licensed to practice medicine in Oregon under ORS Chapter 677. I have primary responsibility for the care and treatment of the above-named patient. The above-named patient has been diagnosed with a debilitating medical condition, as listed above. Marijuana used medically may mitigate the symptoms or effects of this patient's condition. <u>This is not a prescription for the use of medical marijuana.</u>	
<b>PHYSICIAN'S SIGNATURE:</b>	<b>DATE:</b>

MAIL ATTENDING PHYSICIAN'S STATEMENT TO:

DHS/OMMP  
 PO Box 14450  
 Portland, OR 97293-0450



**DECLARATION OF PERSON RESPONSIBLE FOR A MINOR  
TO PARTICIPATE IN  
Oregon Medical Marijuana Program**

**Instructions:** Complete all required information in order to comply with the registration requirements of the Oregon Medical Marijuana Act. This form is required in addition to the patient application form if the patient is under 18 years of age.

If you want this document in a larger print, please contact this office: 503-731-4002 x 233

Please contact the DHS/OMMP if you need this material in an alternative format.

**DECLARATION (REQUIRED)**

I \_\_\_\_\_, do hereby declare:

1. That I am the Custodial Parent or Legal Guardian with responsibility for health care decisions for:

\_\_\_\_\_  
Applicant's Name

2. The applicant's attending physician has explained to the applicant and to me the possible risks and benefits of the medical use of marijuana;

3. I consent to the use of marijuana by the applicant for medical purposes;

4. I agree to serve as the applicant's designated primary caregiver; AND

5. I agree to control the acquisition of marijuana and the dosage and frequency of use by the applicant.

**SIGNATURE OF PERSON WITH PRIMARY CUSTODY (REQUIRED):**

ADDRESS:

TELEPHONE NUMBER:

CITY, STATE, AND ZIP CODE:

Subscribed to before me on this

\_\_\_\_\_ day of \_\_\_\_\_

Notary Signature \_\_\_\_\_

Seal/Stamp

Notary Instructions: If notary is using a raised seal, indicate in which state you are registered as a notary and the date your commission expires. Notary signature and seal must appear on this form. Do not attach a separate notary statement.

MAIL DECLARATION FORM TO:

DHS/OMMP  
PO BOX 14450  
Portland, OR 97293-0450



## CHANGE REQUEST FORM Oregon Medical Marijuana Program

**Instructions:** The Oregon Medical Marijuana Act requires any changes made to an application be submitted to the Oregon Medical Marijuana Program within 30 days. For your protection, please use this form to submit changes. Attach legible copies of ID, if applicable. If applicant is a minor (under 18), the custodial parent or legal guardian with responsibility for health care decisions must be listed as the Primary Caregiver. Please type or print legibly.

If you want this document in a larger print, please contact this office: 503-731-4002 x 233

Please contact the Oregon Department of Human Services if you need this material in an alternative format.

A APPLICANT INFORMATION	
NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:
MAILING ADDRESS:	TELEPHONE NUMBER:
CITY, STATE AND ZIP CODE:	COUNTY:
Photo Identification: A photocopy of one of the following must be attached. Please check appropriate box below. <input type="checkbox"/> Oregon Drivers License <input type="checkbox"/> Oregon Identification Card <input type="checkbox"/> Voter Registration Card, plus current photo.	

B PRIMARY CAREGIVER	
NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:
MAILING ADDRESS:	TELEPHONE NUMBER:
CITY, STATE AND ZIP CODE:	COUNTY:
Photo Identification: If applicable, a photocopy of one of the following must be attached. Please check appropriate box. <input type="checkbox"/> Oregon Drivers License <input type="checkbox"/> Oregon Identification Card <input type="checkbox"/> Voter Registration Card, plus current photo.	

C MARIJUANA GROW SITE	
To be protected under the OMMA, you must list a physical grow site address ( <i>a PO Box is not acceptable</i> ). <b>CHOOSE EITHER OPTION 1 OR OPTION 2.</b> Failure to complete this section will result in a denial of your application.	
<b>OPTION 1:</b>	<b>OR</b>
<b>OPTION 2:</b>	
<b>My physical grow site address:</b>  STREET: _____ CITY: _____ STATE: _____ ZIP CODE: _____	<b>If you are uncertain where your medical marijuana will be grown, please list the address where it would most likely be grown:</b>  STREET: _____ CITY: _____ STATE: _____ ZIP CODE: _____
For their protection, please list the names of other adults living at this address:	

D SIGNATURE & DATE (REQUIRED)	
<b>I TESTIFY THAT THE ABOVE INFORMATION IS TRUE.</b>	
APPLICANT OR PROXY SIGNATURE:	DATE:

MAIL CHANGE REQUEST FORM TO:

DHS/OMMP  
PO BOX 14450  
Portland, OR 97293-0450



## APPLICATION FORM – Renewal Registration Re-registration for the Oregon Medical Marijuana Program

**Instructions:** Please complete all required information to comply with the registration requirements of the Oregon Medical Marijuana Act. Attach legible copies of ID and enclose your payment. If applicant is a minor (under 18), the custodial parent or legal guardian with responsibility for health care decisions must be listed as the Primary Caregiver. Please type or print legibly.

If you want this document in a larger print, please contact this office: 503-731-4002 x 233

Please contact the Oregon Department of Human Services if you need this material in an alternative format.

A <b>APPLICANT INFORMATION (REQUIRED)</b>	
NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:
MAILING ADDRESS:	TELEPHONE NUMBER:
CITY, STATE AND ZIP CODE:	COUNTY:
Photo Identification: A photocopy of one of the following must be attached. Please check appropriate box below. <input type="checkbox"/> Oregon Drivers License <input type="checkbox"/> Oregon Identification Card <input type="checkbox"/> Voter Registration Card, plus current photo.	

B <b>PRIMARY CAREGIVER (IF APPLICABLE)</b>	
NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:
MAILING ADDRESS:	TELEPHONE NUMBER:
CITY, STATE AND ZIP CODE:	COUNTY:
Photo Identification: If applicable, a photocopy of one of the following must be attached. Please check appropriate box. <input type="checkbox"/> Oregon Drivers License <input type="checkbox"/> Oregon Identification Card <input type="checkbox"/> Voter Registration Card, plus current photo.	

C <b>MARIJUANA GROW SITE (REQUIRED)</b>	
To be protected under the OMMA, you must list a physical grow site address ( <i>a PO Box is not acceptable</i> ). <b>CHOOSE EITHER OPTION 1 OR OPTION 2.</b> Failure to complete this section will result in a denial of your application.	
<b>OPTION 1:</b>	<b>OR</b>
<b>OPTION 2:</b>	
<b>My physical grow site address:</b>  STREET: _____ CITY: _____ STATE: _____ ZIP CODE: _____	<b>If you are uncertain where your medical marijuana will be grown,</b> please list the address where it would most likely be grown:  STREET: _____ CITY: _____ STATE: _____ ZIP CODE: _____
For their protection, please list the names of other adults living at this address:	

D <b>ANNUAL REGISTRATION FEE (REQUIRED)</b>
The annual registration fee is <b>\$150</b> . Enclose your <u>check</u> or <u>money order</u> made payable to "State of Oregon".

E <b>SIGNATURE &amp; DATE (REQUIRED)</b>	
<b>I TESTIFY THAT THE ABOVE INFORMATION IS TRUE.</b>	
APPLICANT OR PROXY SIGNATURE:	DATE:

MAIL APPLICATION FORM TO:

DHS/OMMP  
 PO BOX 14450  
 Portland, OR 97293-0450



**ATTENDING PHYSICIAN'S STATEMENT – Renewal Registration  
Oregon Medical Marijuana Act Program**

**Instructions:** Please complete all required information in order to comply with the registration requirements of the Oregon Medical Marijuana Act **OR** provide relevant portions of the patient's medical record containing all information required on this form. **This does not constitute a prescription for marijuana.**

If you want this document in a larger print, please contact this office: 503-731-4002 X 233

Please contact the DHS/Health Services if you need this material in an alternative format.	
<b>A PATIENT INFORMATION</b>	
PATIENT NAME (LAST, FIRST, M.I.):	DATE OF BIRTH:
<b>B PHYSICIAN NAME AND ADDRESS</b>	
PHYSICIAN NAME: (Please Print <u>Legibly</u> )	
MAILING ADDRESS:	TELEPHONE NUMBER:
CITY, STATE AND ZIP CODE:	
<b>C PHYSICIAN'S STATEMENT</b>	
<b>Debilitating Medical Condition: Check appropriate boxes</b>	
<input type="checkbox"/> 1. Malignant neoplasm (Cancer)	
<input type="checkbox"/> 2. Glaucoma	
<input type="checkbox"/> 3. Positive status for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)	
<input type="checkbox"/> 4. Agitation due to Alzheimer's Disease	
5. A medical condition or treatment for a medical condition that produces for a specific patient one or more of the following: (check all that apply)	
<input type="checkbox"/> a. Cachexia	
<input type="checkbox"/> b. Severe pain	
<input type="checkbox"/> c. Severe nausea	
<input type="checkbox"/> d. Seizures, including but not limited to seizures caused by epilepsy	
<input type="checkbox"/> e. Persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis	
Comments:	
I hereby certify that I am a physician duly licensed to practice medicine in Oregon under ORS Chapter 677. I have primary responsibility for the care and treatment of the above-named patient. The above-named patient has been diagnosed with a debilitating medical condition, as listed above.	
<b>PHYSICIAN'S SIGNATURE:</b>	<b>DATE:</b>

MAIL ATTENDING PHYSICIAN'S STATEMENT TO:

DHS/OMMP  
PO Box 14450  
Portland, OR 97293-0450



# Frequently Asked Questions About the Oregon Medical Marijuana Act

The Oregon Medical Marijuana Program (OMMP) receives many questions that are not answered in the Oregon Medical Marijuana Act (OMMA, 1998), Oregon Revised Statutes (ORS), Oregon Administrative Rules (OAR), or the application. The information provided here is an effort to help you understand the role of the OMMP, its benefits and limitations.

The role of the Oregon Department of Human Services, Health Services is simply to administer the Oregon Medical Marijuana Act as approved by the voters of this State. The Department did not write the law and does not have any authority to change it or to disregard its provisions. The principal goal of the OMMP is to make the registration process work smoothly and efficiently for qualified patients.

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## 1. **Can the OMMP refer me to a physician?**

No. The names of physicians who have submitted forms, letters, or chart notes for their patients are confidential, and the OMMP does not have a physician referral list.

## 2. **Where do I get the seeds or plants to start growing medical marijuana?**

The OMMP is not a resource for the growing process and does not have information to give to patients.

## 3. **I do not have the money for the application fee. Is it a one-time payment? Can it be waived? Can I make installment payments? Will my insurance pay?**

The answer to all these questions is "no". The fee must be paid in full with each new or renewal application.

## 4. **Why do I need to have a physician sign and date the form or send a chart note to the OMMP? Why can't I just provide my medical records?**

According to the Oregon Medical Marijuana Act (Section 4 (2)(a)), and OAR 333-008-0020(1)(a) that govern the OMMP, a physician must state in writing that the patient has a qualifying debilitating medical condition and that medical marijuana might mitigate the symptoms or effects of that condition. A signed and dated "Attending Physician's Statement," copies of chart notes or medical records must be current within 3 months of the date of a person's new or renewal application.

Sending medical records to the OMMP is fine as long as they clearly state the physician is aware that medical marijuana is being used as a treatment, and he or she clearly states that medical marijuana might benefit the patient. The physician must sign and date the relevant portions of any medical record you want to send to the OMMP. Otherwise, your physician must provide a signed and dated written statement, form, or authorized chart note to the OMMP. The OMMP contacts each physician during the application process to verify that the patient is under the physician's care. The OMMP urges patients to work closely with their attending physicians throughout the application process.

**5. Why are only MDs (Medical Doctors) and DOs (Doctors of Osteopathy) qualified to sign the "Attending Physician's Statement" of the application? Why not naturopaths, chiropractors, or nurse practitioners? Does the physician have to be licensed in Oregon?**

The Oregon Medical Marijuana Act states that an "attending physician" means a physician licensed under ORS chapter 677. The definition of an "attending physician" can be found in OAR 333-008-0010(1). MDs and DOs are the physicians licensed under this chapter. The law also specifies that a physician must be licensed in Oregon. The OMMP verifies with the Board of Medical Examiners that each patient's attending physician has a valid license to practice medicine in Oregon and has no disqualifying restrictions.

**6. Do I have to list a "grow site" address on my application (that is, the address where I plan to grow my medical marijuana)?**

Yes. OAR 333-008-0020(1)(b) requires the patient to provide the OMMP with the address where his or her marijuana will be manufactured or produced--that is, a grow site address. The OMMP is aware that some patients do not plan to grow their medical marijuana and at the time of making a new or renewal application, may not yet have a designated primary caregiver and/or may not be certain where their grow site will be.

For this requirement, the OMMP offers patients two options. First, the patient knows the physical address where his or her medical marijuana will be grown and provides this address to the OMMP on the application form. Second, the patient is not certain where his or her medical marijuana will be grown and provides the physical address where the medical marijuana will most

likely be grown. A PO Box is not permitted as a grow site address. Providing incorrect grow site information or failing to notify the OMMP of any change of grow site address within 30 days of such a change will result in the patient not being protected from criminal laws if local or state law enforcement agencies determine the patient or his or her designated primary caregiver is growing marijuana at a grow site not registered with the OMMP (ORS 475.316).

**7. Do I have to tell my landlord that I am a patient in the OMMP? Can my landlord evict me if I am a patient in the OMMP and have my grow site in my rental housing? Can I live in subsidized housing and be a patient in the OMMP?**

It is up to you to decide whether or not to tell your landlord that you are a patient in the OMMP. Nothing in OMMP laws specifically addresses whether or not you can be evicted because you are a patient in the OMMP, even if you have only the amount of medical marijuana allowed by law. Nothing in OMMP laws specifically addresses whether or not a person can be an OMMP patient and live in subsidized housing. If you have questions about these important issues, the OMMP recommends you talk to your personal attorney to learn about your rights and protections.

**8. Do I have to tell the OMMP if I change my mailing address, add or remove a designated primary caregiver, or change my grow site address?**

The answer to all these questions is "yes". You are required to tell the OMMP in writing of any such changes within 30 days of the change. The OMMP does not accept changes of information over the telephone. The OMMP will not accept changes about the patient's address, designated primary caregiver, or grow site from any other person affiliated with the patient without the express permission of the patient. You may send your changes to the OMMP by mail, by using the facsimile number listed on the cover page of these "Frequently Asked Questions," or by coming to the State Office Building in Portland, if this is convenient. At this time, if you make a change after your registry identification card has been issued, the OMMP will not issue a new card to you. You will get written confirmation from the OMMP that the change was received. Your changes will be made in our computer database and will be put in your file. You will be protected from civil and criminal penalties for these changes.

**9. What happens to my application once I mail it? What if I don't send in all the required parts of my application?**

When the OMMP receives your application, it will be reviewed to make sure all parts of it have been received and are current. If your application is complete, you will get a "complete letter" from the OMMP letting you know your registry identification card will be issued within 30 days after the OMMP receives verification from your attending physician. On the same day that the OMMP sends you a "complete letter," we mail a "verification letter" to your attending physician. The purpose of this letter is to verify that you are a patient of this physician, and for a new application, that you are affected by a debilitating medical condition covered by the Oregon Medical Marijuana Act, and that medical marijuana may reduce the symptoms of your condition. If you are renewing your application, the verification letter to your attending physician is to verify that you are his or her patient.

If you don't send in all the required parts of your application, the OMMP will send you an "incomplete letter" telling you what parts of your application are missing. The incomplete letter tells you that you have 14 days from the date of the letter to get the missing parts to the OMMP and tells you the terms under which your application may be denied. When you get all missing parts of your application to the OMMP, you will be sent a "complete letter" and the OMMP will verify your status with your attending physician.

10. **Do I need to keep a copy of my application and any other information I send to the OMMP?**  
Yes! You are strongly urged to keep copies of everything you send to the OMMP. For example, the copy of your application is your proof of protection until you are issued a registry identification card.
11. **Why can't I go to a pharmacy to fill a prescription for medical marijuana?**  
Pharmacies can only dispense medications that are prescribed by licensed medical practitioners. The federal government classifies marijuana as a Schedule I drug, which means licensed medical practitioners cannot prescribe it. The Oregon Medical Marijuana Act allows patients to grow their own medical marijuana for private use.
12. **Is the Oregon Medical Marijuana Act recognized by other states? Can I travel to another state with an ounce of medical marijuana and my OMMP registry identification card and not be arrested or charged with civil or criminal**

**penalties?**

At this time, the OMMP is not aware of any "reciprocity" agreements with any other states to honor the Oregon law. This includes even those states that have medical marijuana laws of their own, such as Washington and California. At this time, the Oregon Medical Marijuana Act is only recognized within our State.

**13. Is my confidentiality protected?**

Yes. The OMMP does not give out lists of patients or physicians. Law enforcement personnel may call the OMMP only to verify a specific name or address of a patient or caregiver. The OMMP will tell law enforcement staff if that patient, caregiver, or address is registered, or if an application is in process. The OMMP will disclose patient information to others only at the specific written request of the patient. OMMP computer files are secure and paper files are kept locked when not in use.

**14. Why is getting a registry identification card important for me?**

A patient is protected from civil and criminal penalties for the possession of limited amounts of marijuana specified by the law if he or she has a registry identification card and is complying with all aspects of the Oregon Medical Marijuana Act.

**15. What should I tell my employer when I am subjected to a drug test?**

The Oregon Medical Marijuana Act states that employers are not required to accommodate employees who use medical marijuana. However, the OMMP has heard that several employers treat medical marijuana like any prescription drug that might impair ability. A patient may contact the OMMP in writing to ask the Program to release information about the patient's registration to an employer.

**16. It is time to renew my card and my physician's clinic has adopted a policy of not signing "Attending Physician's Statements."**

A renewal application does not require a statement from a physician regarding the use of medical marijuana; however, a renewal does require the patient to demonstrate his or her debilitating medical condition continues. This could be demonstrated by a copy of relevant portions of your medical record made within 3 months of your application signed and dated by a physician stating that the patient is being treated for a debilitating medical condition. The OMMP urges patients to work closely with their attending physicians throughout the application process.