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: (971) 673-1234

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

DHS