



Government of the District of Columbia
Department of Health



Health Regulation and Licensing
Administration
Division of Medical Marijuana and Integrative Therapy (MMIT)

Healthcare Practitioner Affidavit Form

The undersigned healthcare provider (Physician, Advanced Practice Registered Nurse, Naturopathic Physician, Physician Assistant, Dentist) applicant for a Medical Marijuana Dispensary attests to the fact that I understand that I am prohibited under the regulations governing the District's Medical Marijuana Program from recommending the use of medical marijuana to a patient for participation in the District of Columbia Medical Marijuana Program.

Signature of Applicant: _____

Print Name: _____

Company Name: _____

Title: _____

Date: _____

Subscribed and sworn to before me this _____ day of _____, 20____.

My commission expires _____

Notary Signature and Seal: _____