

Medical Marijuana Acknowledgement Form

(Patient Name) _____

- I acknowledge that I am a qualified patient who has been added to the medical marijuana registry by a qualified physician in the state of FL.
- I desire to continue taking medical marijuana while I'm in the hospital
- I understand and acknowledge that my hospital physicians are not qualified under FL law to act as a qualified physician who can participate in my use of medical marijuana. I further understand that the physicians are not qualified to give an opinion about the risks, benefits, and drug interactions related to taking medical marijuana in conjunction with the medications that are being prescribed for me while I'm in the hospital
- I understand that the hospital does not dispense medical marijuana and medical marijuana treatment centers are the sole source where a patient may obtain medical marijuana.
- I understand the only person permitted by law to assist me with my medical marijuana use is my caregiver who is registered with the state and carries a care-giver identification card. Hospital staff is not permitted to administer marijuana.
- I acknowledge that my hospital physician has advised me to seek advice from my qualified physician as to the risks and benefits of continuing the use of medical marijuana while I am in the hospital.
- I understand it will be my sole responsibility to possess and secure my medical marijuana while I am in the hospital. If I am not able to possess or secure my medical marijuana while I am hospitalized, I will request that my caregiver take responsibility for the medical marijuana.
- I have been advised _____ (Health System Name) will not replace or compensate for lost or stolen medical marijuana at any time.
- I understand that smoking and vaping is not permitted in the hospital or on any hospital premises, including within vehicles located on hospital property

Patient Name _____ Patient ID Number _____

Patient Signature _____ Date _____

Caregiver Name _____ Caregiver ID # _____

Witness Name _____

Witness Signature _____ Date _____

Witness Name _____

Witness Signature _____ Date _____

