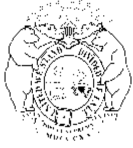

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF COMMUNITY AND PUBLIC HEALTH

MISSOURI HEMP EXTRACT REGISTRATION CARD CERTIFICATION FOR WAIVER

Date Received

PATIENT INFORMATION (please print or type)

Patient Full Legal Name (last name, first name, and middle name) (include suffixes, i.e., Junior, Senior, II, III, etc.)		Date of Birth	Gender ☐ Male ☐ Female
Address	City	State	Zip Code

Race
☐ Asian/Native Hawaiian/Pacific Islander
☐ African American/Black
☐ American Indian/Alaskan Native
☐ White
☐ Mixed Race
☐ Other

Ethnicity
☐ Hispanic
☐ Non-Hispanic

PHYSICIAN STATEMENT

I am a physician licensed under Chapter 334, RSMo. I assert that, based on the above patient's medical history, in my professional judgment, twenty (20) ounces of hemp extract is an insufficient amount to properly alleviate the patient's medical condition or symptoms associated with such medical condition.

PHYSICIAN INFORMATION (please print or type)

Name		Degree	
Address	City	State	Zip Code
Missouri License Number		Telephone Number	

PHYSICIAN SIGNATURE (original signature required)

	Date

If the patient already has a current hemp extract registration card from the department, attach a copy of the card to this form and submit both to:

Department of Health and Senior Services
Division of Community and Public Health
P.O. Box 570
Jefferson City, MO 65102-0570