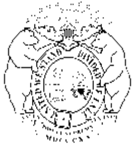

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF COMMUNITY AND PUBLIC HEALTH

MISSOURI HEMP EXTRACT REGISTRATION CARD
NEUROLOGIST CERTIFICATION

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

NEUROLOGIST STATEMENT

I am a physician licensed under Chapter 334, RSMo, and am board certified in neurology.

I have overseen three (3) or more treatment options for the patient listed above and have determined the patient does not respond to those options.

The patient listed above suffers from intractable epilepsy and may benefit from treatment with hemp extract as evidenced by the attached copy of a record of my evaluation and observation of the patient relating to the patient's treatment for intractable epilepsy.

I understand that I am required to keep a record of my evaluation and observation of the patient, including the patient's response to hemp extract, and to transmit the record of my evaluation and observation of the patient to the Department of Health and Senior Services.

NEUROLOGIST INFORMATION (please print or type)

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

NEUROLOGIST SIGNATURE (original signature required)

	Date

This form must be submitted to the Department of Health and Senior Services by the patient (or if the patient is a minor, the patient's parent or legal guardian) with the Missouri Hemp Extract Registration Card Application.