

“No marijuana-related legal action pending” Agreement

By signing below I, _____, assert that as of today, the _____ day of _____ in the year _____, I have NO marijuana-related legal issue pending in the courts of any level of government.

Examples of pending marijuana-related legal issues include, but are not limited to: *unresolved* misdemeanor or felony criminal charges stemming from growing, possessing or operating a vehicle under the influence of marijuana, probation violation hearings concerning testing positive for marijuana, CPS or family court proceedings concerning marijuana activity (medical or otherwise) and civil actions against employers or former employers concerning termination of employment relating to your status as a medical marijuana patient.

I understand that according to the Michigan Medical Marihuana Act’s affirmative defense outlined in MCL 333.76428(a)(1), a bona-fide patient-doctor relationship must be established by any defendant/patient who seeks to have his criminal charges successfully dismissed under the MMMA. I understand and agree that breaching this agreement will render null and void any bona-fide patient-doctor relationship that may have existed between myself and the physicians at Michigan Holistic Health, PLLC at the time of service.

I also further assert that any and all information I give pertaining to my “qualifying condition” as defined by the State of Michigan, is accurate and complete.

I further understand that should an applicable court refuse to dismiss a pending criminal charge as a result of the contents of this agreement, I will hold Michigan Holistic Health, PLLC harmless for the legal consequences associated with my potential sentence, incarceration, civil forfeiture, fines, restitution, court and attorney costs.

This agreement pertains to treatment and services provided by Michigan Holistic Health PLLC – a Michigan Corporation.

Signature of Patient _____ Date _____

Signature of Witness _____ Date _____
Michigan Holistic Health, PLLC

Physician Release from all Liability Form

Signing this form releases your physician from all liability for providing a state of Michigan medical marijuana "Physician's Certification". And by signing this form you, the patient-applicant, are stating that you understand and agree with the following statements of fact:

1. The federal Food and Drug Administration approves all drugs prescribed by physicians. Medical Marijuana is not an FDA approved medication. Crude marijuana is not standardized regarding its purity, strength or dosage size.
2. Therefore, your physician cannot write a prescription for medical marijuana and has no control over the ingredients or the effects or the adverse risks of whatever medical cannabis you decide to consume and cannot in any way help or tell you how to acquire or grow it.
3. Your physician may not be able to provide you with thoroughly researched conclusions regarding all the potential benefits and adverse risks of cannabis use for your particular qualifying medical condition. The scientific research on cannabis is incomplete and does not meet the high requirements for all other medicines approved by the FDA.
4. Your physician cannot provide you with a regimen for its use. You are solely responsible for administering medical marijuana as your condition warrants, as determined on the basis of your own judgment and are solely responsible for all the consequences.
5. The cultivation, possession and use of cannabis – even for medical purposes – remains a crime under federal law, although the administration of President Obama has issued directives not to prosecute persons who stay within state medical marijuana laws.

I, _____, agree not to make any legal claim or complaint, or commence any proceeding against **Michigan Holistic Health & Assoc.** in providing me with a "Physician's Certification" as required by the Michigan Medical Marijuana Act. And I further agree not to make any legal claim or complaint or commence any proceeding against the same physician for my use of crude medical marijuana. I release the same physician from any and all actions, causes of actions, claims, complaints and demands for damages, loss of injury whatsoever arising directly or indirectly as a result of my medical marijuana application to the state of Michigan or my use of medical marijuana. This release of liability is to be binding on my heirs, executors and assigns. I have read, understand and agree with all the statements in this form .

Signature of applicant

Date

Signature of witness

Date

GENERAL MEDICAL HISTORY

List your current and past illnesses (such as diabetes, hypertension, etc.) in chronological order, if possible. (Do NOT include eye conditions that you have previously listed.)

Condition: _____ Month/Year of diagnosis: _____
Condition: _____ Month/Year of diagnosis: _____
Condition: _____ Month/Year of diagnosis: _____
Condition: _____ Month/Year of diagnosis: _____
Condition: _____ Month/Year of diagnosis: _____

Please list all previous surgical procedures (not involving eyes) and their dates:

Surgical Procedure	Month/Year

MEDICATIONS:

Please list all medications that you are currently taking and their dosage (if known):

Medication	Dose	No. times per day	For how long

Are you taking aspirin or any other over-the-counter medicines? No ____ Yes ____
If yes, list: _____

Do you have any known drug allergies? No _____ Yes _____ If yes, list: _____

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS?

	NO	YES		NO	YES
<u>General</u>			<u>Lungs/Breathing</u>		
Fever	___	___	Breathing difficulty	___	___
Unexplained weight loss	___	___	Asthma	___	___
Night sweats	___	___	Lung disease	___	___
<u>Ear, nose, or throat</u>			<u>Digestive System</u>		
Ringling in ears	___	___	Diarrhea	___	___
Hearing loss	___	___	Ulcer disease	___	___
Pain	___	___	Hepatitis	___	___
<u>Nervous System</u>			<u>Genitouinary</u>		
Headache	___	___	Kidney disease	___	___
Stroke	___	___	Urinary tract		
			Infection	___	___
Seizure/epilepsy	___	___	Urinary bleeding	___	___
Weakness, numbness, tingling	___	___	Altered menses	___	___
<u>Heart or circulatory problems</u>			<u>Blood</u>		
Heart attack or heart failure	___	___	Anemia:		
			(low blood count)	___	___
Irregular heart rhythm	___	___	Blood tumors/		
			disease	___	___
Chest pain	___	___	Swollen glands	___	___
Pacemaker	___	___	Bleeding disorder	___	___
Hypertension	___	___			
<u>Endocrine</u>			<u>Musculoskeletal</u>		
Thyroid disease	___	___	Joint pain/arthritits	___	___
Diabetes	___	___	Fractured bones	___	___
Hormonal disease	___	___	Pain with chewing	___	___
			Scalp pain/		
			or tenderness	___	___
<u>Allergy/Immunology</u>			<u>Psychiatric</u>		
Environmental allergies	___	___	Depression	___	___
Iodine allergy	___	___	Mood Swings	___	___
Contrast material (dye allergy)	___	___	Anxiety	___	___
Cat scratch or cat bite	___	___	Admission to		
			hospital/		
			psychiatric illness	___	___
<u>Skin/breast</u>			<u>Other:</u> _____		
Masses/tumors	___	___	_____		
Rash	___	___	_____		
Discharge from breast	___	___	_____		

COMMENTS: _____
