

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**

**Department of Health**

**Health Regulation and Licensing Administration**



**Medical Marijuana Program  
Dispensary  
Physician Affidavit Form**

The undersigned physician 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: \_\_\_\_\_