APPLICATION TO REQUEST THAT AN ADDITIONAL FORM OF MEDICAL CANNABIS BE LAWFUL IN WEST VIRGINIA

Pursuant to W. Va. Code R. §64-110-10, the following forms of medical cannabis are currently lawful in West Virginia: pill; oil; topical forms including gels, creams or ointments; a form medically appropriate for administration by vaporization or nebulization; tincture; liquid; dermal patch; and dry leaf or plant form.

To request that an additional form of medical cannabis be lawful in West Virginia, please complete this application in its entirety and submit to:

West Virginia Office of Medical Cannabis 350 Capitol Street, Room 523 Charleston, West Virginia 25301 <u>medcanwv@wv.gov</u>

The Board may request additional information after initial evaluation of this submission.

Contact Information							
Full Name:	First	Middle	Last	Suffix			
Mailing Addre				Sunk			
-							
	City	State		Zip			
Phone:		Email:					
		Additional Form of Medical	Cannabis				
Provide the name and a brief description of the additional form(s) of medical cannabis that you request be lawful in West Virginia.							
Has this form	of medical canr	nabis been approved in any other st	ate? 🗌 Yes	No Unsure			

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If this form of medical o	annabis has been approved any other state(s), please list the state(s) where it
has been approved:	
	Physician Information

Are you a licensed physician?	Yes	No No						
If you are a licensed physician,	please provide	your West	Virginia	medical	license	number	and	your
primary specialty.								

License Number:	Creatialty u
License Number:	Specialty:
	operative

If you are not a licensed, you must provide the contact information of a licensed physician who supports your request that an additional form of medical cannabis be lawful in West Virginia. The Office of Medical Cannabis will contact the licensed physician identified below to confirm that they support your request. If the physician does not support your request for an additional form of medical cannabis to be lawful in West Virginia, your request will be denied.

Name of Suppo	rting Physician:								
		First	Middle	Last	Suffix				
Mailing Address	Mailing Address:								
	City		State		Zip				
Phone: Email (if known):									
Supporting Medical Evidence									

If applicable, provide medical evidence (clinical, medical, or scientific data) which demonstrates that the additional form of medical cannabis that you are requesting be lawful in West Virginia is effective for therapeutic or palliative care. Additional information may be submitted on a separate sheet of paper and should follow the format identified below.

Citation: _____

University/Publisher:_____

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Summary:					
Citation:					
University/Publisher:					
Summary:					
Certification					

By signing this application, I hereby certify that the information provided is true and correct to the best of my knowledge.

Signature:			
Date:	 		