STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH
BUREAU FOR PUBLIC HEALTH
Office of Medical Cannabis

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Cabinet Secretary

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PHYSICIAN'S REGISTER PREFERENCES

To better serve our registered physicians and potential patients, please provide the following information for our records.

☐ I do not wish to participate as a provider. I understand my registration will be deactivated.

☐ I wish to participate as a provider but not be listed as a Registered Physician on the Office of Medical Cannabis (OMC) website: www.omc.wv.gov

☐ I wish to be a provider for my established patients only. I will not be taking new patients. I do not want to be listed on the website.

☐ I wish to fully participate, will accept new patients, and want to be listed on the website.

My preferred method for patient contact is as follows:

Phone: _____

Address: _____

Email: _____

Website: _____

If you certify patients via employment with a telemedicine company, provide the name of the telemedicine company(ies):

Telemedicine Company Name:_____
Telemedicine Company Name:_____
Telemedicine Company Name:_____

Physician Name (please print) _____ Registration No:.PHY_____

Physician Signature: _____ Date: _____

This form must be returned to our office before your registration will be activated.

Your registration must be active before you may issue any patient certifications.