

**THE OFFICES OF**

**David Dodge, MD ▼ Thomas Orvald, MD ▼ Sandra Camacho, MD ▼ Rabia Ahmed, MD**

**Eric Eisenbud, MD ▼ Paul Ironside, MD ▼ Leo Capobianco, MD**

**1813 130th Ave NE #210 Bellevue, Washington 98005**

**425.869.6186 Phone 425.869.6378 Fax**

---

**DECLARATION OF PERSON RESPONSIBLE FOR A MINOR  
TO PARTICIPATE IN WASHINGTON MEDICAL MARIJUANA PROGRAM**

**Instructions:** Complete all required information in order to comply with the registration requirements of the WA Medical Marijuana Act. This form is required in addition to the patient application form **if the patient is under 21 years of age.**

I \_\_\_\_\_, do hereby declare:

1. That I am the Custodial Parent or Legal Guardian with responsibility for health decisions for: \_\_\_\_\_

(Applicant's Name)

2. The applicant's attending physician has explained to the applicant and to me the possible risks and benefits of the medical use of marijuana;

3. I consent to the use of marijuana by the applicant for medical purposes;

4. I agree to serve as the applicant's designated primary caregiver; AND

5. I agree to control the acquisition of marijuana and the dosage and frequency of use by the applicant.

Signed: \_\_\_\_\_

**(Signature of Person With Primary Custody; REQUIRED)**

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, and Zip Code)

\_\_\_\_\_  
(Telephone Number)

\_\_\_\_\_  
(Today's Date)

Please mail or fax this completed form to the address above.