Alternative Solutions Plus, Inc.
P. O. Box 528
Petoskey, MI 49770
Office: (231)-753-2300
EFax: (231)-344-5915 **medical records can be faxed to this number**
Email: michigancertification@gmail.com **medical records can be emailed here**
Website: www.alternativesolutionsplus.com

Qualifying Conditions and the medical records they require.

To determine if you qualify, you will need to show us that you have one of the following conditions:

- Cancer (A medical record confirming cancer listing type and current therapy)
- Glaucoma (A medical record showing glaucoma and treatment)
- Crohn's Disease (Recent medical records confirming the diagnosis)
- HIV (Confirmatory blood testing and medication)
- Hepatitis C (Blood work and proof of treatment)
- Nail Patella Syndrome (Confirmation of diagnosis from your doctor)
- ALS (Confirmation of diagnosis from doctor)
- Alzheimer's disease (Confirmation of diagnosis)
- Wasting Syndrome (Diagnosis of wasting syndrome from primary care physician)
- Chronic Pain (Confirmation of 3 months of symptoms requiring treatment from a physician/ chiropractor)
- Severe Nausea (Confirmation of 3 months of symptoms and treatment for nausea)
- Seizures (Diagnosis of seizures and current anti-seizure medications)
- Muscle Spasms (Confirmation of 3 months of symptoms and current treatment)
- Post-Traumatic Stress Disorder (Confirmation of Diagnosis by Mental Health Professional)

www.alternativesolutionsplus.com

Find us on Facebook

www.facebook.com/groups/379533677121/

SAVE TIME AT YOUR APPOINTMENT!

And take advantage of our
PREPARE & PREPAY OPTION
Fill out the form below and send us your medical records;
Your file will be prepped and waiting for you

Today's Date: ________ / _________ / _________

MMJ Registry Card Expiration Date: ________ / 01 / _________

Please circle one of the following: PREVIOUS PATIENT OF Alternative Solutions Plus | NEW PATIENT TO Alternative Solutions Plus

Legal First Name: ______________________________________ MI: ___________

Legal Last Name: ____

MMJ Registry Number: P ______________________ - ______________________

MI Driver's License # or MI ID Card: ____ - _________ - _________ - _________ - _________

Date of Birth: ________ / ________ / ________

Mailing Address: ____

Apartment/Suite/Lot # ____________________

City, State, Zip Code: ____

Primary Phone Number: (   ) - _______________________________________

Email address: ____

Do you have a caregiver now? YES NO

If YES: will you be nominating the same caregiver again? YES NO

If NO; tell us what your plans are? ____

If applicable: Caregiver Contact Phone Number: (   ) - _____________________________

CIRCLE ONE ONLY: I will possess the plants | my caregiver will possess the plants

Method of Payment: CASH CHECK MONEY ORDER CALL FOR CREDIT CARD

NOTES/COMMENTS