

Name: _____ DOB: _____ Date: _____

ICC Patient Exception Request Liability/Responsibility Statement

I, am requesting a medical exception, via Iona Cannabis Clinic (ICC) to the state of Florida. This medical exception references the daily dosing limits set forth through: The State of Florida Emergency Rule 64ER22-8, which has a lower dosing guideline than had been previously accepted by the state. As prescribed, my present dosing regimen will exceed the state of Florida's daily limits set forth through emergency rule 64ER22-8. Based on my prescribed dosage levels and current usage, the states dosing recommendations will not provide sufficient relief for my disease symptoms. I acknowledge that an ICC physician or Patient Educator had previously discussed micro-dosing therapy. We reviewed micro-dosing in hopes of finding the lowest dosing levels while achieving significant relief of symptoms. Unfortunately, micro-dosing has proven to be insufficient for my needs.

I acknowledge there are risks in using Medical Cannabis, including but not limited to: allergic reactions, impairment, euphoria, cannabis use disorder, Cannabis Hyperemesis Syndrome, and others. I was given multiple opportunities to discuss these and other potential risks with my physician and together we have decided the potential benefit outweighs these risks. I have accepted any potential harm which may result from these increased dosing limits as my own.

I, understand the information I have provided directly to ICC and therefore indirectly to the state of FL is to the best of my knowledge true and correct. I attest I have not manipulated or given incorrect information for any reason or purpose. I understand that any medicine received by me from a dispensary is intended solely for my personal use. This medicine will not be shared, sold or in any way misused. This is my medicine and mine alone, and I accept any responsibility implied herein. Any intentional misrepresentation or misinformation I have provided will be subject to my possible dismissal as a patient of ICC.

<p>Patient Signature: _____ Date: _____</p>

Witness Signature: _____

Witness Name (Printed): _____

Date: _____