NEW YORK STATE | Department of Health

Medical Marijuana Program
Patient Certification #: PC1-1143505642

This signed certification must be provided to the patient, or his or her caregiver. The certified patient, or his or her designated caregiver, will need this certification in conjunction with their active patient or designated caregiver registry identification card when purchasing medical marijuana products from a registered organization's dispensing facility. Instructions on how to register may be found at the bottom of this certification.

Practitioner Information			
First Name: BRIAN		Last Name: BABIAK	
Business Address: 167 RIDGECREST RD.			
City: ITHACA		State: NY	ZIP Code: 14850
Phone: 6073791335		Email: bdbabiak@gmail.com	
NYS Practitioner License Number: 248298		DEA Registration Number: BB7413418	
Patient Information			
First Name: BONZEANNE		Last Name: BLAYK	
Address: 1668 TRUMANSBURG RD			DOB: 05/01/1956
City: ITHACA		State: NY	ZIP Code: 14850
Phone: (607) 351-4879		Email: bonzesaunders@gmail.com	
Severe Debilitating Condition(s): Post-Traumatic Stress Disorder (PTSD)		Associated Condition(s) or Symptom(s): PTSD	
Temporary Resident? No	Incapable of Consent? No	Contact ID: 1-1143505632	
Dosing Recommendations			
1-1143505659	Product: No Preference	Form/Administration Method: /Per Pharmacist Consultation	
	THC/CBD Ratio: High:Low	Concentration: High THC Low CBD	
	Recommendations/Limitations: HIGH/LOW THC/CBD EVENING INHALATION INHALATION DAYTIME AND MAY USE INHALATION, SUBLINGUAL, ORAL, FLOWER, POWDER, TINCTURE OR ANY OTHER PREPARATION PER PHARMACIST'S RECOMMENDATION		
	Start Date: 03/18/2021	End Date: 03/17/2022	
1-1143505651	Product: No Preference	Form/Administration Method: /Per Pharmacist Consultation	
	THC/CBD Ratio: 1:1	Concentration: Equal THC:CBD	
	Recommendations/Limitations: 1:1 THC/CBD INHALATION DAYTIME AND MAY USE INHALATION, SUBLINGUAL, ORAL, FLOWER, POWDER, TINCTURE OR ANY OTHER PREPARATION PER PHARMACIST'S RECOMMENDATION		
	Start Date: 03/18/2021	End Date: 03/17/2022	
Patient Certification Issue Date: 03/18/2021		**Patient Certification Expiration Date: 03/18/2022**	

As the practitioner named above, I attest to the following:

- I have reviewed the Prescription Monitoring Program registry for this patient, prior to issuing the certification;
- I am caring for this patient in relation to the serious and associated conditions listed above;
- By training and/or experience, I am qualified to treat the serious condition(s) listed above;
- In my professional opinion and based on my review of past treatments, the patient named above is likely to receive therapeutic or palliative benefit from the primary or adjunctive treatment with medical marijuana for the serious condition(s) listed above;
- I have explained the potential risks and benefits of the use of medical marijuana to the above-named qualifying patient and/or the qualifying patient's parent or legal guardian, if applicable, and have documented in the patient's medical record that such explanation has been provided; and
- The above-named qualifying patient and/or the qualifying patient's parent or legal guardian, if applicable, have provided informed consent.
- This certification, containing my handwritten signature, will be provided to the patient and a copy of this signed certification will be included in the patient's medical record.

Practitioner Signature: Brian Babiak MD **Date:** 03/18/2021

BRIAN BABIAK

FALSE STATEMENTS MADE HEREIN ARE PUNISHABLE AS A CLASS A MISDEMEANOR PURSUANT TO PENAL LAW § 210.45. ISSUANCE OF A CERTIFICATION WHEN (i) THE RECIPIENT HAS NO MEDICAL NEED FOR IT, OR (ii) IT IS FOR A PURPOSE OTHER THAN THOSE DEFINED IN PHL § 3360 (7) IS PUNISHABLE AS A CLASS E FELONY PURSUANT TO PENAL LAW § 179.10.

Questions? Contact the Medical Marijuana Program by emailing MMP@health.ny.gov or calling 1-844-863-9312.

Step by step instructions for patient registration should be included with this certification and are also available on the Medical Marijuana Program website at: https://www.health.ny.gov/regulations/medical_marijuana/patients/ .

Patient Registration Instructions

Step-by-step instructions for the registration process may also be found on the Medical Marijuana Program website at: **https://www.health.ny.gov/regulations/medical_marijuana/patients/** under "How to Register".

1. Go to https://my.ny.gov/.
    a. If you do not have a personal My.Ny.Gov account, visit https://my.ny.gov/ and click the "Don't have an Account?" button to create a personal My.NY.Gov ID. Please make note of the User Name and Password you create and keep it in a safe place as this will be the only username able to access your account.

2. Select "Health Applications" from the available services menu.

3. Click the "Medical Marijuana Data Management System" link.

4. Select the role of "Patient."

5. Enter the required information exactly as it appears on the certification and select "Next".
    a. The Certification No. can be found on the upper right-hand corner of the certification form issued by your registered practitioner. Please enter the number exactly as it appears on the form starting with "PC1-" then follow with the number and no spaces.
    b. The date of birth must be entered in MM/DD/YYYY format.

    If you receive an error message, please check that the name, date of birth and zip code on your certification are correct. If you find information that is incorrect on your certification, please contact your practitioner. The practitioner may need to issue you a new certification. **DO NOT** register using the incorrect information as this may delay your registration.

6. On the Patient Home Page select "REGISTER/VIEW MY REGISTRATIONS".

7. Click the green "Start New Registration" button.
    If you already started the registration and need to return to the registration to complete it, click on the blue registration number listed that begins with "PR1-".

8. Complete the registration form and select "Submit" at the bottom of the page.
    The Department will contact you at the telephone number provided if additional information is required in order to approve your registration. Once approved, you may access a temporary ID card within the system that may be used immediately to purchase medical marijuana products from a registered organization's dispensing facility. Your temporary card is only valid for 30 days. If you do not receive an ID card in the mail within two weeks, contact the Department at the telephone number provided below.

Registration Tips:

- When entering a NYS ID (New York State Driver's License or Non-Driver ID card), enter the 9-digit number without any spaces or dashes.
- When uploading a document in the "Upload Supporting Documents for Patient" section, you must use the "Attachment Type" menu to label each attachment before proceeding to the next.
- If you designate a caregiver during the registration process, your caregiver will also need to register after your registration is approved.

No Computer Access?

Registering online using the instructions provided with your certification is the quickest way to submit your registration and to access your temporary ID card when your registration is approved. If you do not have computer access and need assistance registering, please contact the Medical Marijuana Program at 1-844-863-9312. If you are unable to submit your registration online, you will be asked to complete the attestation below and return it to the Department.

Optional Telephone Registration - Patient Attestation:

I acknowledge that all the information provided to the Department is true and that a false statement in the application is punishable under section 210.45 of the Penal law. I acknowledge that the Department of Health may request additional information from me, or my certifying practitioner, to verify information in my application. I authorize the New York State Department of Motor Vehicles to release to the Department of Health personal identity information, including: my name, client identification number, date of birth, address and digital image, for verification and use on my Medical Marijuana Registry Identification Card.

Patient Name (PRINT): _____

Patient Signature: _____ **Date:** _____