

Practice Name: _____
Practice Street Address: _____
Practice City, Zip: _____
Practice Phone Number: _____

Date: _____

Alicia Baldwin, DO
Living Rationally, Inc.
1200 Van Arsdale Street
Oviedo, FL 32765
P: (407) 754-4690
F: (407) 365-5104

RE: Patient's Name: _____
Patient's DOB: _____
Patient's Phone Number: _____

Dear Dr. Baldwin:

My patient, _____, is currently under my care the following
diagnosis(es) for the last _____:
(amount of time treated this patient)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

I feel that _____ would benefit from an evaluation for
medical marijuana.

Sincerely,

Signature of Provider

Printed Name of Provider