

Illinois Medical Cannabis Pilot Program Physician Written Certification Form ***Do not use this form for Terminal Illness***

INSTRUCTIONS

First Name

Home Address

Type or print clearly and answer all of the questions. This certification does not constitute a prescription for medical cannabis.

PHYSICIAN - GIVE THE COMPLETED and SIGNED FORM TO THE PATIENT

Middle Name

This FORM must be included with the qualifying patient application.

The qualifying patient shall scan form in .PDF format and upload with application documents on-line https://medicalcannabispatients.illinois.gov/ or mail WITH application to: Illinois Department of Public Health, Division of Medical Cannabis

The physician written certification form is required for all qualifying patients, including those under 18 years of age, EXCEPT for terminally ill patients and qualifying patients who are veterans receiving treatment for a debilitating condition at a medical facility operated by the U.S. Veteran's Administration (VA).

Last Name

QUALIFYING PATIENT INFORMATION

Apartment or Suite #	City			State IL	ZIP Code			
Date of Birth (mm/dd/yyyy)		Gender Male Female						
PHYSICIAN INFORMATION ON FILE WITH THE ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION								
First Name		Middle Name		Last Name				
Office Address (Location whe	re the Qualifyir	ng Patient's Medical Ex	camination was conduc	ted)				
Suite #	City			State IL	ZIP Code			
Office Telephone Number (##	!#-###-###)	E-mail Address						
Illinois Physician License Nur 036.		Illinois Controlled Substances License Number (last two digits) 336.						
Length of time patient has been under your care (years/months)			Date of in-person medical examination relating to this certification (mm/dd/yyyy)					



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DEBILITATING MEDICAL CONDITION

The qualifying patient is diagnosed with and is currently undergoing treatment for the following debilitating medical condition(s) (check all that apply).

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	agitation of Alzheimer's disease		fibrous dysplasia glaucoma		 □ Post-Traumatic Stress Disorder (PTSD) □ reflex sympathetic dystrophy (RSD) complex regional pain syndromes Type I 		spinal cord injury - damage to the nervous
	acquired immune deficiency syndrome (AIDS)	_ _	hepatitis C hydrocephalus				tissue of the spinal cord with objective neurological indication
	amyotrophic lateral sclerosis (ALS)		hydromyelia				of intractable spasticity.
	Arnold-Chiari malformation		interstitial cystitis lupus		residual limb pain rheumatoid		ataxia (SCA) Syringomyelia
	cancer		multiple sclerosis		arthritis (RA)		Tarlov cysts
	Causalgia		muscular dystrophy myasthenia gravis		seizures (including those characteristic		Tourette's syndrome traumatic brain injury
	chronic inflammatory demyelinating polyneuropathy		myoclonus		of Epilepsy)		(TBI) and post-
			nail-patella syndrome		severe fibromyalgia Sjogren's syndrome		concussion syndrome cachexia/wasting
	Crohn's disease		neurofibromatosis		spinal cord disease: including but not	_	syndrome Indicate the underlying chronic or debilitation
_	CRPS (complex regional pain		Parkinson's disease				
	syndromes Type II)		positive status for human		limited to arachnoiditis		condition
	dystonia		immunodeficiency				

virus (HIV)



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ATTESTATIONS

I	(the physician), h	nave made or confirmed a diagnosis
	ebilitating medical condition, as defined in the Compassionate Use of r the qualifying patient and by my signature below certify the following	Medical Cannabis Pilot Program
1.	I have established a bona-fide physician-patient relationship with the qualifying patient is under my care, either for his/her primary care or condition, as specified on this form. This bona-fide physician-patient preparation of a written certification for the patient to use medical cathat purpose.	for his/her debilitating medical relationship is not limited to the
2.	I have conducted an in-person physical examination of the qualifying days. I completed an assessment of the qualifying patient's current me signs and diagnostic testing, related to the debilitating medical condunderstand the Illinois Department of Public Health may request add assessment(s) performed for this qualifying patient's debilitating medical conductions.	edical condition, including symptoms, ition I diagnosed or confirmed. I ditional confirmation of the
3.	I have completed an assessment of the qualifying patient's medical his records from other treating physicians from the previous 12 months. for the qualifying patient related to the patient's debilitating condition condition(s) under my care.	I have established a medical record
conditi	the physician), he censed to practice medicine in the state of Illinois. The qualifying paties on(s) specified, and the patient is under my treatment or management their primary care. I attest the information provided in this written cere	nt for the debilitating condition(s)
This r	ecommendation does not constitute a prescription for medical c	annabis.
Physicia	an signature (no stamps accepted)	Date of signature (mm/dd/yyyy)