



## Illinois Medical Cannabis Pilot Program Physician Written Certification Form

### INSTRUCTIONS

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

***THIS MUST BE MAILED BY THE PHYSICIAN – DO NOT GIVE TO THE PATIENT***

### Mail this form to:

Illinois Department of Public Health  
Division of Medical Cannabis  
535 West Jefferson Street  
Springfield, Illinois 62761-0001

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

### QUALIFYING PATIENT INFORMATION

First Name		Middle Name		Last Name	
Home Address					
Apartment or Suite #	City	State IL	ZIP Code		
Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			



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**PHYSICIAN INFORMATION ON FILE WITH THE ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION**

Name of Hospital, University or Practice			
First Name	Middle Name	Last Name	
Office Address			
Suite #	City	State IL	ZIP Code
Office Telephone Number (###-###-####)		E-mail Address	
Illinois Physician License Number			
DEA Registration Number			
Specialty or primary area of clinical practice			
Length of time patient has been under your care (years/months)		Date patient received an 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).

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

Comments - Provide any additional information that would be useful in assessing this patient's application to the Medical Cannabis Patient Registry. **Strike through this section if you do not have any comments.**



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### ATTESTATIONS

I \_\_\_\_\_ (the physician), have made or confirmed a diagnosis of a debilitating medical condition, as defined in the Compassionate Use of Medical Cannabis Pilot Program Act, for the qualifying patient and **(ITEMS 1 THROUGH 4 BELOW MUST BE INITIALED)**:

1. Have established a bona-fide physician-patient relationship with the qualifying patient applicant. The qualifying patient is under my care, either for his/her primary care or for his/her debilitating medical condition, as specified on this form. This bona fide physician-patient relationship is not limited to a recommendation for the patient to use medical cannabis or a consultation simply for that purpose.

Initial: \_\_\_\_\_

2. Have conducted an in-person physical examination of the qualifying patient within the last 90 calendar days. I completed an assessment of the qualifying patient's current medical condition, including symptoms, signs and diagnostic testing, related to the debilitating medical condition I diagnosed or confirmed. I understand the Illinois Department of Public Health may request additional confirmation of the assessment(s) performed for this qualifying patient's debilitating medical conditions.

Initial: \_\_\_\_\_

3. Have completed an assessment of the qualifying patient's medical history, including the review of medical records from other treating physicians from the previous 12 months. I have established a medical record for the qualifying patient with regard to his/her medical condition and his/her continued treatment for the condition(s) under my care.

Initial: \_\_\_\_\_

4. Have explained the potential risks and benefits of the medical use of cannabis to the qualifying patient.

Initial: \_\_\_\_\_

I \_\_\_\_\_ (the physician), hereby certify I am a physician duly licensed to practice medicine in the state of Illinois. It is my professional opinion that the qualifying patient is likely to receive therapeutic or palliative benefit from the use of medical cannabis to treat or alleviate the patient's debilitating medical condition or symptoms of the debilitating medical condition. The qualifying patient has the debilitating medical condition(s) specified, and the patient is under my treatment for the debilitating condition(s) and/or their primary care. It is my professional opinion the potential benefits of the medical use of cannabis would likely outweigh the health risks for this patient. I attest the information provided in this written certification is true and correct.

\_\_\_\_\_  
Physician signature (no stamps accepted)

\_\_\_\_\_  
Date of signature (mm/dd/yyyy)



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### PHYSICIAN WAIVER RECOMMENDATION FORM

Strike through this section if a waiver is not recommended.

I \_\_\_\_\_ (the physician), hereby certify that, in my professional opinion, \_\_\_\_\_ (the qualifying patient), should be approved for an exception to the 2.5 ounces of useable medical cannabis every 14 days provided in the Compassionate Use of Medical Cannabis Pilot Program Act. It is my professional opinion a quantity of \_\_\_\_\_ ounces per 14-day period should be approved to treat or alleviate the patient's debilitating medical condition or symptoms of the debilitating medical condition. It is my professional opinion the potential benefits of this amount of medical use of cannabis will likely outweigh any health risks for this patient.

\_\_\_\_\_  
Physician signature (no stamps accepted)

\_\_\_\_\_  
Date of signature (mm/dd/yyyy)