State of Illinois
Illinois Department of Public Health

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 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 ❑ Male ❑ Female		

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IOCI 15-164

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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).

- ❑ cancer
- ❑ glaucoma
- ❑ amyotrophic lateral sclerosis
- ❑ hepatitis C
- ❑ Crohn's disease
- ❑ agitation of Alzheimer's disease
- ❑ myasthenia gravis
- ❑ hydrocephalus
- ❑ residual limb pain
- ❑ nail-patella syndrome
- ❑ muscular dystrophy
- ❑ severe fibromyalgia
- ❑ spinal cord disease (including but not limited to arachnoiditis)
- ❑ Tarlov cysts
- ❑ hydromyelia
- ❑ rheumatoid arthritis (RA)
- ❑ fibrous dysplasia
- ❑ spinal cord injury
- ❑ syringomyelia
- ❑ traumatic brain injury (TBI) and post-concussion syndrome
- ❑ multiple sclerosis
- ❑ Arnold-Chiari malformation and Syringomelia
- ❑ cachexia/wasting syndrome
- ❑ spinocerebellar ataxia (SCA)
- ❑ Parkinson's disease
- ❑ Tourette's syndrome
- ❑ myoclonus
- ❑ dystonia
- ❑ reflex sympathetic dystrophy, RSD (complex regional pain syndromes Type I)
- ❑ CRPS (complex regional pain syndromes Type II)
- ❑ positive status for human immunodeficiency virus (HIV)
- ❑ acquired immune deficiency syndrome (AIDS)
- ❑ chronic inflammatory demyelinating polyneuropathy
- ❑ neurofibromatosis
- ❑ causalgia
- ❑ Sjogren's syndrome
- ❑ lupus
- ❑ interstitial cystitis

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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_____

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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

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)

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