**State of Illinois**
Illinois Department of Public Health

Illinois Medical Cannabis Pilot Program

# Physician Written Certification Form

## ***Do not use this form for Terminal Illness***

### 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 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).

### 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 | | |

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

| First Name | Middle Name | Last Name | |
|---|---|---|---|
| Office Address (Location where the Qualifying Patient's Medical Examination was conducted) | | | |
| Suite # | City | State IL | ZIP Code |
| Office Telephone Number (###-###-####) | E-mail Address | | |
| Illinois Physician License Number | | Illinois Controlled Substances License Number | |
| 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).

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



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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 by my signature below certify the following:

1. I 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 the preparation of a written certification for the patient to use medical cannabis or a consultation simply for that purpose.
2. I 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.
3. I 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 related to the patient's debilitating condition and continued treatment for the condition(s) under my care.

I _____ (the physician), hereby certify I am a physician duly licensed to practice medicine in the state of Illinois. The qualifying patient has the debilitating medical condition(s) specified, and the patient is under my treatment or management for the debilitating condition(s) and/or their primary care. I attest the information provided in this written certification is true and correct.

**This recommendation does not constitute a prescription for medical cannabis.**

_____ _____
Physician signature (no stamps accepted) Date of signature (mm/dd/yyyy)

*** If emailing a scanned copy of this form, signature must be in blue ink.


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IOCI 17-8