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

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address</th>
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<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Apartment or Suite #</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>IL</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Female</td>
</tr>
</tbody>
</table>

# Illinois Medical Cannabis Pilot Program
**Physician Written Certification Form**

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

<table>
<thead>
<tr>
<th>Name of Hospital, University or Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
</tr>
<tr>
<td>Office Address</td>
</tr>
<tr>
<td>Suite #</td>
</tr>
<tr>
<td>Office Telephone Number (###-###-####)</td>
</tr>
<tr>
<td>Illinois Physician License Number</td>
</tr>
<tr>
<td>DEA Registration Number</td>
</tr>
<tr>
<td>Specialty or primary area of clinical practice</td>
</tr>
<tr>
<td>Length of time patient has been under your care (years/months)</td>
</tr>
</tbody>
</table>
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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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IOCI 15-164
Illinois Medical Cannabis Pilot Program
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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)
Illinois Medical Cannabis Pilot Program
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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)