Illinois Medical Cannabis Patient Program

Health Care Professional Confirmation of Diagnosis of Terminal Illness

*** This section to be completed by the Qualifying Patient's health care professional ***

Do Not Complete for Veterans Receiving Medical Care at a VA Facility

HEALTH CARE PROFESSIONAL INFORMATION ON FILE WITH THE ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

Health Care Professional First Name	Health Care Professional Middle Name	Health Care Professional 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 License Number		Illinois Controlled Substances License Number (last two digits)	
Length of time patient has been under your care (years/months)		Date of in-person medical examination relating to this certification (mm/dd/yyyy)	

ATTESTATIONS

I ____ (the health care professional), have made a diagnosis of terminal illness of ____ (insert name of disease or illness) with a life expectancy of six (6) months or fewer for the qualifying patient ____, and by my signature below certify the following:

1. I have established a bona-fide relationship with the qualifying patient applicant. The qualifying patient is under my care, either for his/her primary care or for his/her terminal illness, as specified on this form. This bona-fide relationship is not limited to the diagnosis of terminal illness 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 understand the Illinois Department of Public Health may request additional confirmation of the assessment(s) performed for this qualifying patient's terminal illness.
3. I have completed an assessment of the qualifying patient's medical history, including the review of medical records from other treating health care professionals from the previous 12 months. I have established a medical record for the qualifying patient related to the patient's terminal illness and continued treatment under my care.

I ____ (the health care professional), hereby certify I am duly licensed to practice medicine in the state of Illinois. The qualifying patient has the terminal illness specified, and the patient is under my management for the terminal illness and/or their primary care. I attest the information provided in this written certification is true and correct.

____ _______________________

Health Care Professional signature (no stamps accepted) – Sign in blue ink only | Date of signature (mm/dd/yyyy)

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