State of Illinois
Illinois Department of Public Health

Illinois Medical Cannabis Patient Program

Waiver for Increasing the Allotment of Medical Cannabis For a Registered Qualifying Patient

INSTRUCTIONS

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

HEALTH CARE PROFESSIONAL – GIVE THE COMPLETED and SIGNED FORM TO THE PATIENT

Mail this form, along with a check from the patient for $25.00 (payable to Illinois Department of Public Health), to:

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

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		
Qualifying Patient Registry Identification Number QP.	Qualifying Debilitating Condition		

HEALTH CARE PROFESSIONAL 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 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 waiver (mm/dd/yyyy)		

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NOTE: The waiver for increasing the adequate supply for medical cannabis for a registered medical cannabis patient requires an in-person medical examination within 30 days of the date of this recommendation. The in-person medical examination and the recommendation document must be completed by the health care professional who certified the qualifying patient for his/her registration application and list the reason, other than the debilitating condition, for the increase in allotment of medical cannabis.

If the qualifying patient is not currently registered with the Illinois Medical Cannabis Registry Patient Program, please complete a Health Care Professional Written Certification Form.

I _____ (the health care professional), hereby certify that, based on the patient's medical history, in my professional judgement, _____ (the registered 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 Patient Program Act. It is my professional judgement a quantity of _____ ounces per 14-day period should be approved to properly alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition. I am recommending an exception to the 2.5 ounces of useable medical cannabis **for the following reasons**:

This recommendation does not constitute a prescription for medical cannabis.

_____ _____

Health Care Professional signature (no stamps accepted) Date of signature (mm/dd/yyyy)

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