State of Illinois
Illinois Department of Public Health

Illinois Medical Cannabis Patient Program

Health Care Professional 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.**

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

This FORM must be included with the qualifying patient application.

The qualifying patient shall scan form in .PDF format and upload with application documents on-line https://medicalcannabispatients.illinois.gov or mail WITH application to: Illinois Department of Public Health, Division of Medical Cannabis

The health care professional 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		

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 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)
- ❑ anorexia nervosa
- ❑ Arnold-Chiari malformation
- ❑ autism
- ❑ cancer
- ❑ Causalgia
- ❑ chronic inflammatory demyelinating polyneuropathy
- ❑ chronic pain
- ❑ Crohn's disease
- ❑ CRPS (complex regional pain syndromes Type II)
- ❑ dystonia
- ❑ Ehlers-Danlos syndrome (EDS)
- ❑ fibrous dysplasia
- ❑ glaucoma
- ❑ hepatitis C
- ❑ hydrocephalus
- ❑ hydromyelia
- ❑ interstitial cystitis
- ❑ irritable bowel syndrome
- ❑ lupus
- ❑ migraines
- ❑ multiple sclerosis
- ❑ muscular dystrophy
- ❑ myasthenia gravis
- ❑ myoclonus
- ❑ nail-patella syndrome
- ❑ Neuro-Behcet's autoimmune disease
- ❑ neuropathy
- ❑ neurofibromatosis
- ❑ osteoarthritis
- ❑ Parkinson's disease
- ❑ polycystic kidney disease (PKD)
- ❑ 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)
- ❑ superior canal dehiscence syndrome
- ❑ Syringomyelia
- ❑ Tarlov cysts
- ❑ Tourette's syndrome
- ❑ traumatic brain injury (TBI) and post-concussion syndrome
- ❑ ulcerative colitis
- ❑ cachexia/wasting syndrome

Indicate the underlying chronic or debilitation condition

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ATTESTATIONS

I _____ (the health care professional), have made or confirmed a diagnosis of a debilitating medical condition, as defined in the Compassionate Use of Medical Cannabis Program Act, 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 debilitating medical condition, as specified on this form. This bona-fide 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 health care professionals 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 health care professional), hereby certify I am 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.

_____ _____

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

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