State of Illinois
Illinois Department of Public Health

Illinois Medical Cannabis Patient Program

Reviewing Health Care Professional Written Certification Form for Qualifying Patients Under 18 Years of Age

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 minor patient application.

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

The reviewing health care professional written certification form is required for all qualifying patients under 18 years of age, EXCEPT for a qualifying patient who has been diagnosed with a terminal illness with a life expectancy of six months or less.

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 OR THE STATE WHERE LICENSED

Name of Hospital, University or Practice			
First Name	Middle Name	Last Name	
Office Address (Location where the Qualifying Patient's Medical Examination was conducted)			
Suite #	City	State	ZIP Code
Office Telephone Number (###-###-####)	E-mail Address		
Health Care Professional License Number (Indicate state where licensed)			

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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 reviewing health care professional), have made or confirmed a diagnosis of a debilitating medical condition, as defined in the Compassionate Use of Medical Cannabis Patient Program Act, for the qualifying patient, and have completed a comprehensive review of the qualifying patient's medical history, including the review of medical records from the other treating health care professionals. By my signature below, I certify that I am duly licensed to practice medicine in the state of ____.

_____ _____

Health Care Professional 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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