



Center for Professional Licensing. Medical Marijuana Program

3 Capitol Hill, Room 105A
Providence, RI 02908-5097
401-222-3752 - www.health.ri.gov/hsr/mmp

Practitioner Written Certification Form

Please enter your name, date of birth, and phone number. Ask your practitioner to complete all other sections of this form in order to comply with the requirements of the Rhode Island Medical Marijuana Act. Please upload this form to your account in the online portal. If you are not using the online portal, attach this form to the Patient Application Form and mail the completed forms to the address above.

NOTE: This does not constitute a prescription for marijuana.

Form with fields for Patient name, date of birth and phone number; Practitioner name, license number and address. Includes instructions like 'The remainder of this form must be completed by the attending practitioner.'

These are the ONLY approved qualifying debilitating medical conditions - Check the appropriate box(es):

- Checkboxes for Cancer, Glaucoma, HIV/AIDS, Hepatitis C, and chemotherapy status.

If yes, practitioner's signature:

A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following: Check all appropriate box(es).

- Checkboxes for Cachexia, Severe pain, Nausea, Seizures, Muscle spasms, Alzheimer's, PTSD, and Autism Spectrum Disorder.

I hereby certify that I am a Rhode Island practitioner who is licensed with authority to prescribe drugs pursuant to chapter 37, chapters 34, 37, and 54 of title 5 or a physician licensed with authority to prescribe drugs in Massachusetts or Connecticut. I have a practitioner-patient relationship with the qualifying patient and have completed a full assessment of the patient's medical history.

If this patient is eligible for hospice care, the physician must sign here.

Practitioner Signature (patient eligible for Hospice)

Practitioner's printed name:

Practitioner's signature: Date of signature: