Department of Health
Center for Professional Licensing
Room 105A - 3 Capitol Hill
Providence, RI 02908-5097
401-222-3752 - www.health.ri.gov/hsr/mmp

PRACTITIONER WRITTEN CERTIFICATION FORM

Instructions: *Please complete patient information and have your practitioner complete all other sections of this form in order to comply with the registration requirements of the Rhode Island Medical Marijuana Act. Please attach this form to the Patient Application Form and mail the completed forms to the address listed above.*

NOTE: This does NOT constitute a prescription for marijuana

Patient Name, Date of Birth and Phone Number:

Full Name

Birth Month | Birth Day | Birth Year | Phone

Practitioner Name, License Number and Address Information

Full Name

License Number

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City | State | Zip Code

Phone

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

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

- ☐ Cancer or the treatment of this condition. Is the patient receiving chemotherapy? ☐ Yes ☐ No
- ☐ Glaucoma or the treatment of this condition
- ☐ Positive status for Human Immunodeficiency Virus (HIV) or the treatment of this condition
- ☐ Acquired immune deficiency syndrome (AIDS) or the treatment of this condition
- ☐ Hepatitis C or the treatment of this condition

Practitoner 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))

- ☐ Cachexia or wasting syndrome
- ☐ Severe, debilitating, chronic pain-(specify)_____
- ☐ Severe nausea
- ☐ Seizures, including but not limited to those characteristic of epilepsy
- ☐ Severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis or Crohn's disease
- ☐ Agitation related to Alzheimer's Disease
- ☐ Post Tramatic Stress Disorder (PTSD) - Patient must be 18 years or older
- ☐ Autism Spectrum Disorder - Practitioner must complete Page 5 if this diagnosis is checked.

Comments: **Practitioner" means a person 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 hereby certify that I am a practitioner as defined above. I have a practitioner-patient relationship with the qualifying patient and have completed a full assessment of the patient's medical history. The above-named patient has been diagnosed with a debilitating medical condition as listed above. Marijuana used medically may mitigate the symptoms or effects of this patient's condition. Further, it is my professional opinion that the potential benefits of the medical use of marijuana would likely outweigh the health risks for this patient.

HOSPICE ONLY: If this patient is eligible for hospice care, the physician must sign here otherwise sign below.
Practitioner Signature (patient eligible for Hospice)_____

Practitioner's Printed Name:_____

Practitioner's Signature:_____ Date of Signature:_____

This form is to be completed by the Attending Practitioner.

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PRACTITIONER WRITTEN CERTIFICATION FORM FOR USE WITH AUTISM SPECTRUM DISORDER DIAGNOSIS

NOTE: A patient who has been diagnosed with Autism Spectrum Disorder based on diagnostic criteria listed in DSM-V – Diagnosis Code 299.00 may qualify for registration as a patient in the Rhode Island Medical Marijuana Program only if the patient presents with one or both the following symptoms. Please check symptom(s) that apply.

☐ Repetition of self-stimulatory behavior of such severity that the physical health of the persons with ASD or others is jeopardized, and/or

☐ Avoidance of others or inability to communicate with others to such severity that the physical health of the person with ASD is jeopardized.

For patients who meet the above diagnostic criteria, the practitioner signing this form is certifying that all of the following treatment considerations and practices have been met:

I have considered FDA-approved medications for this patient, including the off-label use of the pharmaceutic grade forms of pure CBD, prior to initiating medical marijuana therapy. If use of these medications was not implemented, I have documented the reason in the patient's medical record. _____ (Initial here)

If this patient is a minor, I have consulted with a pediatric sub-specialist in child psychiatry, pediatric neurology, or developmental pediatrics prior to signing this form, and the results of that consult is documented in the patient's medical record. _____ (Initial here)

I hereby certify that I will assess this patient (if he/she is a minor) at least three (3) months after initiation of medical marijuana therapy, in consultation with a pediatric sub-specialist in child psychiatry, pediatric neurology, or developmental pediatrics. This assessment and consultation will be documented in the patient's medical record. _____ (Initial here)

I hereby certify that I will discontinue medical marijuana therapy if there is no improvement in the patient's presenting symptom/s as listed above or is there is a worsening of those symptoms. If this is the case, I agree to contact the RIDOH Medical Marijuana Program to withdraw this Certification. (NOTE: Another trial of medical marijuana therapy will be allowed only after the passage of at least three (3) months after the previous trial of medical marijuana has been discontinued.) _____ (Initial here)

Practitioner's Printed Name: _____

Practitioner's Signature _____ DATE:_____