**State of Illinois**
Illinois Department of Public Health

Illinois Medical Cannabis Pilot Program

# Reviewing Physician 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.

**THIS MUST BE MAILED or EMAILED BY THE PHYSICIAN – DO NOT GIVE TO THE PATIENT**

Email a scanned COLOR copy of this form to dph.debilitatingconditions@illinois.gov or mail this form to:

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

The reviewing physician 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<br>IL | ZIP Code |
| Date of Birth (mm/dd/yyyy) | Gender<br>❑ Male ❑ Female | | |

### PHYSICIAN INFORMATION ON FILE WITH THE ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION OR THE STATE WHERE THE PHYSICIAN IS 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 | | |
| Physician 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)
- ❑ Arnold-Chiari malformation
- ❑ cancer
- ❑ Causalgia
- ❑ chronic inflammatory demyelinating polyneuropathy
- ❑ Crohn's disease
- ❑ CRPS (complex regional pain syndromes Type II)
- ❑ dystonia
- ❑ fibrous dysplasia
- ❑ glaucoma
- ❑ hepatitis C
- ❑ hydrocephalus
- ❑ hydromyelia
- ❑ interstitial cystitis
- ❑ lupus
- ❑ multiple sclerosis
- ❑ muscular dystrophy
- ❑ myasthenia gravis
- ❑ myoclonus
- ❑ nail-patella syndrome
- ❑ neurofibromatosis
- ❑ Parkinson's disease
- ❑ 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)
- ❑ Syringomyelia
- ❑ Tarlov cysts
- ❑ Tourette's syndrome
- ❑ traumatic brain injury (TBI) and post-concussion syndrome
- ❑ cachexia/wasting syndrome

*Indicate the underlying chronic or debilitation condition*

## ATTESTATIONS

I _____ (the reviewing physician), have made or confirmed a diagnosis of a debilitating medical condition, as defined in the Compassionate Use of Medical Cannabis Pilot 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 physicians. By my signature below, I certify that I am a physician duly licensed to practice medicine in the state of _____.

_____ _____

Physician 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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