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

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 BY THE REVIEWING PHYSICIAN – DO NOT GIVE TO THE PATIENT

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 qualifying patients under 18 years of age.

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		

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IOCI 15-164

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PHYSICIAN INFORMATION

Name of Hospital, University or Practice			
First Name	Middle Name	Last Name	
Office Address			
Suite #	City	State	ZIP Code
Office Telephone Number (###-###-####)	E-mail Address		
Physician License Number		Issuing State	Expiration Date
Specialty or primary area of clinical practice			

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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).

- ❑ cancer
- ❑ glaucoma
- ❑ amyotrophic lateral sclerosis
- ❑ hepatitis C
- ❑ Crohn's disease
- ❑ agitation of Alzheimer's disease
- ❑ myasthenia gravis
- ❑ hydrocephalus
- ❑ residual limb pain
- ❑ nail-patella syndrome
- ❑ muscular dystrophy
- ❑ severe fibromyalgia
- ❑ cachexia/wasting syndrome
  Indicate underlying chronic or debilitating disease or medical condition:
  _____
- ❑ spinal cord disease: damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity. (including but not limited to arachnoiditis)
- ❑ Tarlov cysts
- ❑ hydromyelia
- ❑ rheumatoid arthritis (RA)
- ❑ fibrous dysplasia
- ❑ spinal cord injury
- ❑ syringomyelia
- ❑ traumatic brain injury (TBI) and post-concussion syndrome
- ❑ multiple sclerosis
- ❑ Arnold-Chiari malformation and Syringomelia
- ❑ spinocerebellar ataxia (SCA)
- ❑ Parkinson's disease
- ❑ Tourette's syndrome
- ❑ myoclonus
- ❑ dystonia
- ❑ reflex sympathetic dystrophy, RSD (complex regional pain syndromes Type I)
- ❑ CRPS (complex regional pain syndromes Type II)
- ❑ seizures (including those characteristic of epilepsy)
- ❑ positive status for human immunodeficiency virus (HIV)
- ❑ acquired immune deficiency syndrome (AIDS)
- ❑ chronic inflammatory demyelinating polyneuropathy
- ❑ neurofibromatosis
- ❑ causalgia
- ❑ Sjogren's syndrome
- ❑ lupus
- ❑ interstitial cystitis

Comments - Provide any additional information that would be useful in assessing this patient's application to the Medical Cannabis Patient Registry. **Strike through this section if you do not have any comments.**

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ATTESTATIONS

I _____ (the reviewing physician), have 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 other treating physicians.

Initial: _____

I _____ (the reviewing physician), hereby certify I am a physician duly licensed to practice medicine in the state of _____. It is my professional opinion that the qualifying patient is likely to receive therapeutic or palliative benefit from the use of medical cannabis to treat or alleviate the patient's debilitating medical condition or symptoms of the debilitating medical condition. The qualifying patient has the debilitating medical condition(s) specified and it is my professional opinion the potential benefits of the medical use of cannabis would likely outweigh the health risks for this patient.

_____ _____

Physician signature (no stamps accepted) Date of signature (mm/dd/yyyy)

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