



**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.debiltingconditions@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 IL	ZIP Code
Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			

PHYSICIAN INFORMATION ON FILE WITH THE ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

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 IL	ZIP Code
Office Telephone Number (###-###-####)			E-mail Address		
Illinois Physician License Number					



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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).

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> agitation of Alzheimer's disease | <input type="checkbox"/> fibrous dysplasia | <input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD) | <input type="checkbox"/> spinal cord injury - damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity. |
| <input type="checkbox"/> acquired immune deficiency syndrome (AIDS) | <input type="checkbox"/> glaucoma | <input type="checkbox"/> reflex sympathetic dystrophy (RSD) complex regional pain syndromes Type I | <input type="checkbox"/> spinocerebellar ataxia (SCA) |
| <input type="checkbox"/> amyotrophic lateral sclerosis (ALS) | <input type="checkbox"/> hepatitis C | <input type="checkbox"/> residual limb pain | <input type="checkbox"/> Syringomyelia |
| <input type="checkbox"/> Arnold-Chiari malformation | <input type="checkbox"/> hydrocephalus | <input type="checkbox"/> rheumatoid arthritis (RA) | <input type="checkbox"/> Tarlov cysts |
| <input type="checkbox"/> cancer | <input type="checkbox"/> interstitial cystitis | <input type="checkbox"/> seizures (including those characteristic of Epilepsy) | <input type="checkbox"/> Tourette's syndrome |
| <input type="checkbox"/> Causalgia | <input type="checkbox"/> lupus | <input type="checkbox"/> severe fibromyalgia | <input type="checkbox"/> traumatic brain injury (TBI) and post-concussion syndrome |
| <input type="checkbox"/> chronic inflammatory demyelinating polyneuropathy | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> Sjogren's syndrome | <input type="checkbox"/> cachexia/wasting syndrome |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> muscular dystrophy | <input type="checkbox"/> spinal cord disease: including but not limited to arachnoiditis | <i>Indicate the underlying chronic or debilitation condition</i> |
| <input type="checkbox"/> CRPS (complex regional pain syndromes Type II) | <input type="checkbox"/> myasthenia gravis | | |
| <input type="checkbox"/> dystonia | <input type="checkbox"/> myoclonus | | |
| | <input type="checkbox"/> nail-patella syndrome | | |
| | <input type="checkbox"/> neurofibromatosis | | |
| | <input type="checkbox"/> Parkinson's disease | | |
| | <input type="checkbox"/> positive status for human immunodeficiency virus (HIV) | | |

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 Illinois.

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.