



**State of Vermont  
 Marijuana Registry**  
 45 State Drive  
 Waterbury, Vermont 05671-1300  
[www.medicalmarijuana.vermont.gov](http://www.medicalmarijuana.vermont.gov)

[phone] 802-241-5115  
 [fax] 802-241-5230  
 [email] DPS.MJRegistry@vermont.gov

Department of Public Safety

**MENTAL HEALTH CARE PROVIDER FORM**

**Instructions:** This form *must* be completed and submitted for all applicants with Post-Traumatic Stress Disorder (PTSD) identified as a debilitating medical condition on the Health Care Professional Verification Form. Vermont law requires the Vermont Marijuana Registry to confirm applicants with PTSD are undergoing psychotherapy, or counseling with a licensed mental health care provider. The Vermont Marijuana Registry may contact the mental health care provider completing this form to confirm the accuracy of the information contained on this form.

“**Mental Health Care Provider**” means:

“A person license to practice medicine who specializes in the practice of psychiatry; a psychologist, a psychologist-doctorate, or a psychologist-master as defined in 26 V.S.A. § 3001; a clinical social worker as defined in 26 V.S.A. § 3201; or a clinical mental health counselor as defined in 26 V.S.A. § 3261.”

**1. Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**2. Mental Health Care Professional Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

Business Mailing Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**3. Licensure Information (\*\*Subsections A and B MUST be completed\*\*)**

- A.  Psychologist                       Psychologist-doctorate     Psychologist-master  
 Psychiatrist                               Clinical social worker     Clinical mental health counselor  
 Advanced Practice Registered Nurse (with Adult Psych and Mental Health Specialty)

B. License Number: \_\_\_\_\_

**4. Verification**

*I certify I am providing psychotherapy and/or counseling to the aforementioned patient. I declare under pains and penalty of perjury that the information provided on this form in its entirety is true and accurate.*

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**OFFICE USE ONLY** Confirmed:  Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Notes: \_\_\_\_\_