State of Vermont *Cannabis Control Board*
Medical Cannabis Program [phone] 802-241-5115
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HEALTH CARE PROFESSIONAL VERIFICATION FORM

This verification form is NOT considered a prescription and the only purpose of this verification form is to confirm that the patient applicant has a debilitating medical condition as defined.

Notwithstanding any law to the contrary, a person who knowingly gives to any law enforcement officer false information to avoid arrest or prosecution, or to assist another in avoiding arrest or prosecution, shall be imprisoned for not more than one year or fined not more than $1,000.00 or both.

DEFINITIONS:

"Bona fide health care professional-patient relationship" means:

A treating or consulting relationship of not less than three months' duration, in the course of which a health care professional has completed a full assessment of the registered patient's medical history and current medical condition, including a personal physical examination. The three-month requirement shall not apply if:

(i) a patient has been diagnosed with a terminal illness, cancer, or acquired immune deficiency syndrome.
(ii) a patient is currently under hospice care.
(iii) a patient had been diagnosed with a debilitating medical condition in another state and has moved to Vermont within the past 3 months. The new health care professional must have completed a full assessment of the patient's medical history and current medical condition, including a personal physical examination.
(iv) a renewal patient changes health care professionals three months or less prior to renewing their registration, provided the new health care professional has completed a full assessment of the patient's medical history and current medical condition, including a personal physical examination.
(v) a patient is referred by his or her health care professional to another health care professional who has completed advanced education and clinical training in specific debilitating medical conditions, and that health care professional conducts a full assessment of the patient's medical history and current medical condition, including a personal physical examination; or
(vi) a patient's debilitating medical condition is of recent or sudden onset.

"Debilitating medical condition" means:

A) Cancer, multiple sclerosis, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, glaucoma, Crohn's disease, Parkinson's disease or the treatment of these conditions, if the disease or the treatment results in severe, persistent, and intractable symptoms;

B) Post-traumatic stress disorder, provided the Department confirms the applicant is undergoing psychotherapy or counseling with a licensed mental health care provider; or

C) A disease or medical condition or its treatment that is chronic, debilitating and produces and one or more of the following intractable symptoms: cachexia or wasting syndrome, chronic pain, severe nausea, or seizures.

"Health care professional" means an individual who is:

A) Licensed to practice medicine under 26 V.S.A Chapter 23 or Chapter 33;
B) Licensed as a naturopathic physician under 26 V.S.A. Chapter 81;
C) Certified as a physician assistant under 26 V.S.A. Chapter 31; or
D) Licensed as an advanced practice registered nurse under 26 V.S.A. Chapter 28.

This definition includes individuals who are professionally licensed under substantially equivalent provisions in New Hampshire, Massachusetts, or New York.

An applicant without a "debilitating medical condition" is not eligible for a registry identification card.

HEALTH CARE PROFESSIONAL VERIFICATION FORM

INSTRUCTIONS: This form must be completed by the patient applicant's health care professional and signed within the past 6 months. *The Medical Cannabis Program (MCP) will contact the health care professional completing this form to confirming the accuracy of the information.*

This verification form is NOT considered a prescription and the only purpose of this verification form is to confirm that the patient applicant has a debilitating medical condition as defined.

1) PATIENT INFORMATION (Please print legibly)

First Name: _____ M.I. _____ Last Name: _____

Date of Birth: _____ Telephone Number: _____

2) HEALTH CARE PROFESSIONAL INFORMATION (Please print legibly)

First Name: _____ M.I. _____ Last Name: _____

Office Mailing Address: _____

City, State, Zip: _____ Telephone Number: _____

3) HEALTH CARE PROFESSIONAL LICENSE INFORMATION:

License Number: _____ Issuing State (circle one): VT NH MA NY

4) LICENSURE CATEGORY

☐ Doctor of Medicine ☐ Osteopathic Physician ☐ Naturopathic Physician

☐ Physician Assistant ☐ Advanced Practice Registered Nurse

5) VERIFICATION OF A DEBILITATING MEDICAL CONDITION

(A) Does the patient applicant have a debilitating medical condition as defined on the Cover Sheet?

☐ No ☐ Yes *(if "Yes", Section B **MUST** be completed)*

(B) The patient applicant I am treating or consulting has been diagnosed with *(check all that apply)*:

☐ Acquired Immune Deficiency Syndrome ☐ Glaucoma

☐ Cancer ☐ Human Immunodeficiency Virus

☐ Crohn's Disease ☐ Multiple Sclerosis

☐ Parkinson's Disease

☐ *Post-Traumatic Stress Disorder *(*A Mental Health Care Provider Form is required to be completed and submitted to the* MCP*)*

☐ A disease or medical condition or its treatment that is chronic, debilitating, and produces one or more of the following intractable symptoms listed in subdivision B. ***(**Subsections I and II MUST be completed**)***

I.) **Indicate specific diagnosis**: _____

II.) **Indicate specific symptom** (*circle all that apply*)**:** *cachexia chronic pain severe nausea seizures*

OFFICE USE ONLY – HCPF VERIFIED: Yes ☐ No ☐ Date: _____ NOTES: _____

6) BONA FIDE HEALTH CARE PROFESSIONAL-PATIENT RELATIONSHIP INFORMATION

(A) Have you completed a full assessment of the patient applicant's medical history and current medical condition, including a personal physical examination?

☐ Yes ☐ No

(B) Do you have a treating or consulting relationship with the patient application of at least three (3) months?

☐ Yes ☐ No

(C) Has the patient applicant been diagnosed with a terminal illness and/or currently under hospice care?

☐ Yes ☐ No

(D) Was the patient applicant diagnosed in another state or jurisdiction where they formally resided and moved to Vermont within the last three (3) months?

☐ Yes ☐ No

(E) Was the patient applicant diagnosed with the debilitating medical condition specified on the previous page within the last three (3) months?

☐ Yes (Date of diagnosis: _____/_____/_____) ☐ No

(F) Was the patient applicant referred to you by another health care professional because of your advanced education and clinical training specific to the debilitating medical condition specified on the previous page?

☐ Yes ☐ No

7) HEALTH CARE PROFESSIONAL SIGNATURE

I certify that:

(A) I am a health care professional:

A) Licensed to practice medicine under 26 V.S.A Chapter 23 or Chapter 33;
B) Licensed as a naturopathic physician under 26 V.S.A. Chapter 81;
C) Certified as a physician assistant under 26 V.S.A. Chapter 31; or
D) Licensed as an advanced practice registered nurse under 26 V.S.A. Chapter 28; or,
E) Professional licensed under substantially equivalent provisions in NH, MA, or NY.

(B) I am in good standing with the state (VT, NH, MA, or NY) regulating my professional license, and that the facts stated on this Health Care Professional Verification Form are true and accurate to the best of my knowledge and belief.

(C) I understand, notwithstanding any law to the contrary, a person who knowingly provides false information on this application may be guilty of perjury and imprisoned for not more than one year or fined not more than $1,000.00 or both. This penalty shall be in addition to any other penalties that may apply.

This verification form is not considered a prescription and that the only purpose of this verification form is to confirm that the applicant patient has a debilitating medical condition.

Health Care Professional's Signature: _____ Date: _____

<u>This form must be completed and submitted with a Registered Patient Application.</u>

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

THIS SECTION MUST BE COMPLETED BY THE PATIENT APPLICANT

I hereby authorize the health care professional named on this form to release my protected medical information to the Medical Cannabis Program (MCP) to verify and confirm the accuracy of the information contained within this form. I authorize the named health care professional to:

- Disclose the nature, symptoms, and duration of the medical condition identified on this form for the purpose of determining that it meets the legal definition of a debilitating medical condition on page 1 of this form;
- Disclose whether the named health care professional and I have a bona fide health care professional-patient relationship, as defined by law and on page 1 of this form;
- Confirm the accuracy of the information contained in this form.

I understand that any information released to the MCP will be used solely to confirm the accuracy of the information contained in this form. While the information will no longer be covered by the HIPAA Privacy Rule, Vermont law requires the MCP to keep all information confidential, except for the prosecution of false swearing. I understand this authorization is valid for one year from the date the MCP receives this form, unless a written communication revoking this authorization, or a new authorization is received by the MCP. I understand that I have the right to revoke this authorization at any time by notifying both the health care professional named on this form and to the MCP in writing.

Patient Applicant Signature REQUIRED: _____ Date: _____

*If the patient applicant is **under the age of 18** or has a **court appointed guardian** the section below must be completed:*

Parent or Guardian Signature: _____ Date: _____