State of Vermont
Medical Cannabis Program
89 Main Street
Montpelier, Vermont 05620-7001
www.ccb.vermont.gov

[phone] 802-241-5115
[fax] 802-241-5230
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Cannabis Control Board

MENTAL HEALTH CARE PROVIDER FORM

*(REQUIRED FOR PATIENTS WITH **PTSD** INDICATED ON THE HEALTH CARE PROFESSIONAL VERIFICATION FORM.)*

Instructions: This form *must* be completed and submitted for all applicants with Post-Traumatic Stress Disorder (PTSD) identified as the only debilitating medical condition on the Health Care Professional Verification Form. Vermont law requires the Medical Cannabis Program (MCP) to confirm applicants with PTSD are undergoing psychotherapy, or counseling with a Vermont licensed mental health care provider. The MCP 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 licensed in Vermont to practice medicine who specializes in the practice of psychiatry; a psychologist, a psychologist-doctorate, or a psychologist-master; a clinical social worker; or a clinical mental health counselor.

1. Patient Information

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

Date of Birth: _____ Telephone Number: _____

2. Mental Health Care Provider Information

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

Office Mailing Address: _____

City, State, Zip Code: _____ Telephone Number: _____

3. Vermont 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. Vermont License Number: _____

4. Verification

I certify I am licensed in Vermont as a mental health care provider in good standing and provide psychotherapy and/or counseling to the patient identified on this form. I declare under pains and penalty of perjury that the information provided on this form in its entirety is true and accurate and that the facts stated above are accurate to the best of my knowledge and belief.

SIGNATURE: _____ **DATE:** _____

MAIL COMPLETED APPLICATIONS TO:
Cannabis Control Board
Medical Cannabis Program
89 Main Street
Montpelier, VT 05620-7001

OFFICE USE ONLY: Notes: _____