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
[email] CCB.Med@vermont.gov

Cannabis Control Board

HEALTH CARE PROFESSIONAL VERIFICATION FORM

INSTRUCTIONS: This form must be completed by the patient applicant's health care professional and signed within 6 months prior to submission. Renewal applicants must submit the patient application prior to the expiration of their registration and only require a Health Care Professional Verification Form every second renewal application. All other applicants a must submit a Health Care Professional Verification Form along with a patient application.

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 QUALIFYING MEDICAL CONDITION

(A) Does the patient applicant have qualifying medical condition as defined in 7 V.S.A. § 951?

☐ 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 disease or medical condition or its treatment that is chronic, debilitating, and produces one or more of the following intractable symptoms circled 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 – NOTES: _____

VERMONT

6) HEALTH CARE PROFESSIONAL SIGNATURE

I.) I certify 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.

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

Health Care Professional's Signature: _____ ***Date***: _____

This Section is for the PATIENT to Complete

7) PATIENT STATEMENT (ONLY required if PTSD is identified as the ONLY qualifying medical condition.)

Provide the name of the licensed mental health care provider you are undergoing psychotherapy or counseling with below.

Mental Health Care Provider Information:

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

8) RELEASE OF INFORMATION

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 disease or medical condition and symptoms identified on this form for the purpose of determining that it meets the legal definition of a qualifying medical condition.
- 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, names and identifying information about patients and caregivers on the Registry are exempt from public inspection and copying under the Public Records Act and shall be kept confidential. 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: _____ ***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: _____