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

Cannabis Control Board

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HEALTH CARE PROFESSIONAL VERIFICATION FORM

The purpose of this verification form is to confirm that the patient applicant has a debilitating medical condition as defined. It should not be considered a prescription or recommendation.

"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, and Post-traumatic stress disorder or the treatment of these conditions, if the disease or the treatment results in severe, persistent, intractable symptoms.

B) 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.

PATIENT INFORMATION (Please print legibly)

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

Date of Birth: _____ Telephone Number: _____

HEALTH CARE PROFESSIONAL INFORMATION (Please print legibly)

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

Office Mailing Address: _____

City, State, Zip: _____ Telephone Number: _____

HEALTH CARE PROFESSIONAL LICENSE INFORMATION:

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

LICENSURE CATEGORY

☐ Doctor of Medicine ☐ Osteopathic Physician ☐ Naturopathic Physician

☐ Physician Assistant ☐ Advanced Practice Registered Nurse

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 disease or medical condition or its treatment that is chronic, debilitating, and produces one or more of the following intractable symptoms listed below. *(Please fill out BOTH diagnosis and symptom subsections)*

Indicate specific diagnosis: _____

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

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.

Health Care Professional's Signature: _____ Date: _____

MAIL, FAX, OR EMAIL COMPLETED FORMS TO:

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