State of Vermont
Medical Cannabis Program
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Cannabis Control Board

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, Post-Traumatic Stress Disorder, Ulcerative Colitis 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 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.

Applicants under 21 years of age REQUIRED -under 7 V.S.A 952
"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:

(A) an applicant has been diagnosed with a terminal illness, cancer, or acquired immune deficiency syndrome.

(B) an applicant is currently under hospice care.

(C) an applicant 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.

(D) 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.

(E) an applicant 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 applicant's medical history and current medical condition, including a personal physical examination; or

(F) a patient's debilitating medical condition is of recent or sudden onset.

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: ____________________________________

Practice 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 ☐ Ulcerative Colitis ☐ 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*

For patients under 21 years of age BONA FIDE HEALTH CARE PROFESSIONAL-PATIENT RELATIONSHIP

(1) Have you completed a full assessment of the patient applicant's medical history and current medical condition?
□ Yes □ No
(2) Have you completed a personal physical examination of the patient?
□ Yes □ No
(3) Do you have a treating or consulting relationship with the patient applicant of at least three (3) months?
□ Yes □ No (If no, which of the following apply? As defined on the cover sheet)

(A) Has the patient applicant been diagnosed with a terminal illness, cancer, or acquired immune deficiency syndrome?
□ Yes □ No
(B) Is the patient currently under hospice care?
□ Yes □ No
(C) Was the patient applicant diagnosed in another state or jurisdiction where they formally resided and moved to Vermont within the last 3 months?
□ Yes □ No
(D) Was the applicant previously enrolled as a patient with the Medical Cannabis Program and changed providers three month or less prior to the renewal? Full assessment of medical history and personal physical examination required.
□ Yes □ No
(E) Was the patient applicant referred to you by another health care professional because of your advanced knowledge and training specific to the applicant's debilitating medical condition?
□ Yes □ No
(F) Was the patient applicant recently diagnosed with a debilitating medical condition or is it of sudden onset?
□ Yes □ No

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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