State of Illinois
Illinois Department of Public Health

Illinois Medical Cannabis Pilot Program

Reviewing Physician Written Certification Form for Qualifying Patients Under 18 Years of Age

Do not use this form for Terminal Illness

INSTRUCTIONS

Type or print clearly and answer all of the questions. This certification does not constitute a prescription for medical cannabis.

THIS MUST BE MAILED or EMAILED BY THE PHYSICIAN – DO NOT GIVE TO THE PATIENT

Email a scanned COLOR copy of this form to dph.debilitingconditions@illinois.gov or mail this form to:

Illinois Department of Public Health
Division of Medical Cannabis
535 West Jefferson Street
Springfield, Illinois 62761-0001

The reviewing physician written certification form is required for all qualifying patients under 18 years of age, EXCEPT for a qualifying patient who has been diagnosed with a terminal illness with a life expectancy of six months or less.

QUALIFYING PATIENT INFORMATION

First Name	Middle Name	Last Name	
Home Address			
Apartment or Suite #	City	State IL	ZIP Code
Date of Birth (mm/dd/yyyy)	Gender ❑ Male ❑ Female		

PHYSICIAN INFORMATION ON FILE WITH THE ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION OR THE STATE WHERE THE PHYSICIAN IS LICENSED

Name of Hospital, University or Practice			
First Name	Middle Name	Last Name	
Office Address (Location where the Qualifying Patient's Medical Examination was conducted)			
Suite #	City	State	ZIP Code
Office Telephone Number (###-###-####)	E-mail Address		
Physician License Number (Indicate state where licensed)			

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DEBILITATING MEDICAL CONDITION

The qualifying patient is diagnosed with and is currently undergoing treatment for the following debilitating medical condition(s) (check all that apply).

- ❑ agitation of Alzheimer's disease
- ❑ acquired immune deficiency syndrome (AIDS)
- ❑ amyotrophic lateral sclerosis (ALS)
- ❑ Arnold-Chiari malformation
- ❑ cancer
- ❑ Causalgia
- ❑ chronic inflammatory demyelinating polyneuropathy
- ❑ Crohn's disease
- ❑ CRPS (complex regional pain syndromes Type II)
- ❑ dystonia
- ❑ fibrous dysplasia
- ❑ glaucoma
- ❑ hepatitis C
- ❑ hydrocephalus
- ❑ hydromyelia
- ❑ interstitial cystitis
- ❑ lupus
- ❑ multiple sclerosis
- ❑ muscular dystrophy
- ❑ myasthenia gravis
- ❑ myoclonus
- ❑ nail-patella syndrome
- ❑ neurofibromatosis
- ❑ Parkinson's disease
- ❑ positive status for human immunodeficiency virus (HIV)
- ❑ Post-Traumatic Stress Disorder (PTSD)
- ❑ reflex sympathetic dystrophy (RSD) complex regional pain syndromes Type I
- ❑ residual limb pain
- ❑ rheumatoid arthritis (RA)
- ❑ seizures (including those characteristic of Epilepsy)
- ❑ severe fibromyalgia
- ❑ Sjogren's syndrome
- ❑ spinal cord disease: including but not limited to arachnoiditis
- ❑ spinal cord injury - damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity.
- ❑ spinocerebellar ataxia (SCA)
- ❑ Syringomyelia
- ❑ Tarlov cysts
- ❑ Tourette's syndrome
- ❑ traumatic brain injury (TBI) and post-concussion syndrome
- ❑ cachexia/wasting syndrome

Indicate the underlying chronic or debilitation condition

_____

_____

_____

ATTESTATIONS

I _____ (the reviewing physician), have made or confirmed a diagnosis of a debilitating medical condition, as defined in the Compassionate Use of Medical Cannabis Pilot Program Act, for the qualifying patient, and have completed a comprehensive review of the qualifying patient's medical history, including the review of medical records from the other treating physicians. By my signature below, I certify that I am a physician duly licensed to practice medicine in the state of _____.

_____ _____

Physician signature (no stamps accepted) Date of signature (mm/dd/yyyy)

*** If emailing a scanned copy of this form, signature must be in blue ink.

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