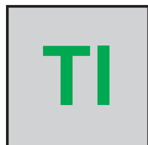
State of Illinois
Illinois Department of Public Health



Illinois Medical Cannabis Pilot Program

Physician Confirmation of Diagnosis of Terminal Illness

*** This section to be completed by the Qualifying Patient's physician ***

Do Not Complete for Veterans Receiving Medical Care at a VA Facility

PHYSICIAN INFORMATION ON FILE WITH THE ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

Physician First Name		Physician Middle Name		Physician Last Name	
Office Address (Location where the Qualifying Patient's Medical Examination was conducted)					
Suite #	City			State IL	ZIP Code
Office Telephone Number (###-###-####)		E-mail Address			
Illinois Physician License Number **036.**			Illinois Controlled Substances License Number (last two digits) **336.**		
Length of time patient has been under your care (years/months)			Date of in-person medical examination relating to this certification (mm/dd/yyyy)		

ATTESTATIONS

I ____ (the physician), have made a diagnosis of terminal illness of ____ (insert name of disease or illness) with a life expectancy of six (6) months or fewer for the qualifying patient (insert full name of patient) ____________________________________ (date of birth) ___/___/_____ and by my signature below certify the following:

1. I have established a bona-fide physician-patient relationship with the qualifying patient applicant. The qualifying patient is under my care, either for his/her primary care or for his/her terminal illness, as specified on this form. This bona-fide physician-patient relationship is not limited to the diagnosis of terminal illness for the patient to use medical cannabis or a consultation simply for that purpose.
2. I have conducted an in-person physical examination of the qualifying patient within the last 90 calendar days. I understand the Illinois Department of Public Health may request additional confirmation of the assessment(s) performed for this qualifying patient's terminal illness.
3. I have completed an assessment of the qualifying patient's medical history, including the review of medical records from other treating physicians from the previous 12 months. I have established a medical record for the qualifying patient related to the patient's terminal illness and continued treatment under my care.

I ____ (the physician), hereby certify I am a physician duly licensed to practice medicine in the state of Illinois. The qualifying patient has the terminal illness specified, and the patient is under my management for the terminal illness and/or their primary care. I attest the information provided in this written certification is true and correct.

____ ______________________

Physician signature (no stamps accepted) – Sign in blue ink only Date of signature (mm/dd/yyyy)

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