STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

THERAPEUTIC CANNABIS PROGRAM

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Written Certification for the Therapeutic Use of Cannabis

INSTRUCTIONS FOR MEDICAL PROVIDERS

Information about the Therapeutic Cannabis Program, including the enabling law (RSA 126-X), the administrative rules (He-C 400), all required forms, and the "Medical Provider Information Sheet," is available on Program's website at: http://www.dhhs.nh.gov/oos/tcp/index.htm

1. Type or print in ink your responses on the Written Certification. All certifications on this form that require signature or initialing must be completed in ink. Photocopies or facsimiles of this form will not be accepted.

2. Failure to complete this Written Certification in its entirety will cause your patient's application to be incomplete and the Written Certification to be returned to you.

3. Give the completed Written Certification to your patient to submit to the Program. DO NOT send the form directly to the Program; it must accompany the patient's application.

4. Your patient will need to submit the following items to the Program:
   (1) A completed Written Certification;
   (2) A completed Patient Application;
   (3) A $50 application fee; and
   (4) Proof of NH residency.

5. The Program will notify you in writing once a determination has been made regarding your patient's application.

6. You must be a "provider" as defined in state law, including:
   (1) A NH physician licensed to prescribe drugs to humans under RSA 329;
   (2) A NH advanced practice registered nurse (APRN) licensed to prescribe drugs to humans under RSA 326-B:18;
   (3) A NH physician assistant licensed pursuant to RSA 328-D, who has the express consent of the supervising physician; and
   (4) A physician or APRN licensed to prescribe drugs to humans under state licensing laws in Maine, Massachusetts, or Vermont, and who is primarily responsible for the patient's care related to his or her qualifying medical condition.

   In all cases, a provider must possess an active registration from the US Drug Enforcement Administration to prescribe controlled substances.

7. Your patient must have a "qualifying medical condition" as defined in state law. See page 2 for a complete list of qualifying medical conditions.

8. You must have a "provider-patient relationship" with the patient. See page 3 for a description of the required provider-patient relationship.

THIS FORM AS COMPLETED IS NOT INTENDED TO BE A PRESCRIPTION OR MEDICAL RECOMMENDATION FOR THE THERAPEUTIC USE OF CANNABIS

WRITTEN CERTIFICATION FOR THE THERAPEUTIC USE OF CANNABIS

☐ Initial Certification ☐ Renewal Certification	If a Renewal Certification, have you previously certified this patient? ☐ Yes ☐ No

PATIENT INFORMATION

Name	Last	First	Middle
Mailing Address	Street/P.O. Box		
	City	State	Zip Code
Phone Number			
Date of Birth	MM/DD/YYYY		

PROVIDER INFORMATION

Name of Provider	Last		First	Middle
Name of Medical Practice				
Office Mailing Address	Street/P.O. Box		County	
	City		State	Zip Code
Office Phone/Fax Number	Phone	Extension	Fax	
State License Number			☐ Physician ☐ Physician Assistant	
			☐ Advanced Practice Registered Nurse	
DEA Number				
Medical Specialty				

Please provide the following information for the person in the office to be contacted by the Program in order to facilitate the processing of this Certification, if different than the provider listed above.

Name and Title	
Phone Number	
Email Address	

PROVIDER'S CERTIFICATION OF A PATIENT'S QUALIFYING MEDICAL CONDITION

IMPORTANT INSTRUCTIONS – PLEASE READ:

1. Complete EITHER Box A – Condition / Symptom (both sections), OR Box B – Condition Only
2. Sign and date at the bottom of the page

A. Condition / Symptom (Check all that apply)

I certify that I am treating _____ who has the following condition(s):
(Patient Name)

- ☐ Acquired immune deficiency syndrome
- ☐ Alzheimer's disease
- ☐ Amyotrophic lateral sclerosis
- ☐ Cancer
- ☐ Chronic pancreatitis
- ☐ Crohn's disease
- ☐ Ehlers-Danlos syndrome
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hepatitis C
- ☐ Lupus
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ One or more injuries or conditions that has resulted in one or more qualifying symptoms listed below
- ☐ Parkinson's disease
- ☐ Positive status for human immunodeficiency virus
- ☐ Spinal cord injury or disease
- ☐ Traumatic brain injury
- ☐ Ulcerative colitis

AND who has a severely debilitating or terminal medical condition, or its treatment, that has produced at least one of the following qualifying symptoms or side effects:

- ☐ Agitation of Alzheimer's disease
- ☐ Cachexia
- ☐ Chemotherapy-induced anorexia
- ☐ Constant or severe nausea
- ☐ Elevated intraocular pressure
- ☐ Moderate to severe vomiting
- ☐ Seizures
- ☐ Severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects
- ☐ Severe, persistent muscle spasms
- ☐ Wasting syndrome

OR

B. Condition Only (Check all that apply)

I certify that I am treating _____ who has the following condition(s):
(Patient Name)

- ☐ Moderate or severe post-traumatic stress disorder
- ☐ Moderate to severe chronic pain
- ☐ Severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects

SIGNATURE

_____ _____

Signature of Certifying Provider **Date**

PROVIDER'S CERTIFICATION OF A PROVIDER-PATIENT RELATIONSHIP

"Provider-patient relationship" means a medical relationship between a licensed provider and a patient during which the provider has conducted a full assessment of the patient's medical history and current medical condition.

Pursuant to He-C 401.06(b)(2), a full assessment shall include an in-person physical examination of the patient; a medical history of the patient, including a prescription history; a review of laboratory testing, imaging, and other relevant tests; appropriate consultations; a diagnosis of the patient's current medical condition; and the development of a treatment plan for the patient appropriate for your specialty.

You must initial the following box.	
	I have completed a full assessment of the patient's medical history and current medical condition in accordance with He-C 401.06(b)(2) [described above] made in the course of a provider-patient relationship.

You must initial the following box.	
	I have explained the potential health effects of the therapeutic use of cannabis to my patient. If my patient is a minor, I have explained to my patient's custodial parent or legal guardian with responsibility for health care decisions for the patient both the potential health effects and the potential risks and benefits of the therapeutic use of cannabis.

I certify that I am:

A physician, an advanced practice registered nurse, or a physician assistant licensed in New Hampshire to prescribe drugs to humans under RSA 329, RSA 326-B:18, or RSA 328-D, respectively, and who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances

OR

A physician or an advanced practice registered nurse licensed in Maine, Massachusetts, or Vermont to prescribe drugs to humans under the relevant state licensing laws, who possesses an active registration from the United States Drug Enforcement Administration to prescribe controlled substances, and who is primarily responsible for my patient's care related to his or her qualifying medical condition.

I possess an active license in good standing with the State of New Hampshire, or the State of Maine, Massachusetts, or Vermont, and the facts as stated in this Written Certification are accurate to the best of my knowledge and belief. I understand that any false statements made on this Certification are punishable as unsworn falsification under RSA 641:3.

_____ _____

Signature of Certifying Provider **Date**

DURATION OF WRITTEN CERTIFICATION

Your patient's Registry ID Card will be effective for one year from the date of issuance. If the patient's card should be valid for a period shorter than one year, indicate the number of months the card shall remain valid.

The Registry ID Card shall remain valid for _____ months from the date of issuance.

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