STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PUBLIC HEALTH SERVICES

THERAPEUTIC CANNABIS PROGRAM

Lori A. Weaver
Interim Commissioner

Patricia M. Tilley
Director

29 HAZEN DRIVE, CONCORD, NH 03301
603-271-9333 1-800-852-3345 Ext. 9333
TDD Access: 1-800-735-2964
Fax: 603-271-8134 Email: TCP@dhhs.nh.gov

WRITTEN CERTIFICATION EXTENSION

If a Written Certification has been previously issued for less than 3 years, the **same certifying provider** who issued that Written Certification may extend the certification by completing and submitting this form.

- A Written Certification may be extended more than once, but the total duration of the Written Certification, including any extensions, shall not exceed 3 years.
- This "Written Certification Extension" form does not require the submission of a new Written Certification, a new Patient Application, or an Application Fee.
- If an extension duration is indicated below which exceeds the maximum of 3 years from the original effective date, the extension duration shall default to the maximum duration allowed.

EXTENSION REQUIREMENTS. If the following requirements are not met, the patient will need to renew their card, by submitting a new Written Certification, a new Patient Application, and the Application Fee:

1. This form must be signed by the same provider that signed the original Written Certification.
2. This form must be signed and dated no later than the expiration date of the patient's current card.
3. The Therapeutic Cannabis Program allows a limited 30-day grace period after your patient's Registry ID Card expires to receive this form.

There are no exceptions to these extension requirements.

Mail or fax the completed form to:

NH Department of Health and Human Services
Therapeutic Cannabis Program
29 Hazen Drive
Concord, NH 03301
Fax: (603) 271-8134

Please type or print clearly.

Patient Name: _____ Patient Date of Birth: _____

Certifying Provider Name: _____ Practice Fax: _____

Certifying Provider State License Number: _____ Practice Phone: _____

Expiration Date of Patient's Current Registry ID Card (if known): _____

Length of Extension: ☐ One year ☐ Maximum allowed ☐ Other duration _____

_____ _____

Signature of Certifying Provider **Date**