



Lori A. Shibinette
Commissioner

Patricia M. Tilley
Director

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES
THERAPEUTIC CANNABIS PROGRAM

29 HAZEN DRIVE, CONCORD, NH 03301-3857
603-271-9333 1-800-852-3345 Ext. 9333
TDD Access: 1-800-735-2964
Email: tcp@dhhs.nh.gov

WRITTEN CERTIFICATION
For the Therapeutic Use of Cannabis

INSTRUCTIONS FOR MEDICAL PROVIDERS

Information about the Therapeutic Cannabis Program, including the law ([RSA 126-X](#)), the 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. The medical provider must complete ALL information on this Written Certification. Failure to complete this form in its entirety will cause your patient’s application to be incomplete and the Written Certification to be returned to you.
2. Give the completed Written Certification to your patient to submit to the Program. DO NOT send the form directly to the Program; it should accompany the Patient Application.
3. 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.
4. The Program will notify you in writing once a determination has been made regarding your patient’s application.
5. In order to certify a patient for the Program, you must be a “provider” as defined in NH law:
 - (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 (PA) licensed under RSA 328-D, with the express consent of the supervising physician; or
 - (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 the patient’s qualifying medical condition.All providers must have an active registration from the US DEA to prescribe controlled substances.
6. Your patient must have a “qualifying medical condition” as defined in NH law. See page 2 for a complete list of qualifying medical conditions.
7. You must have a “provider-patient relationship” with your patient. See page 3 for a description of the requirements of a provider-patient relationship.
8. The Program will accept a Written Certification up to 6 months from the date of your signature.
9. You may send dispensing instructions/recommendations to your patient’s Alternative Treatment Center (ATC). The ATC must comply with any such instructions. See the “Medical Provider Information Sheet” for more information.

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

WRITTEN CERTIFICATION FOR THE THERAPEUTIC USE OF CANNABIS

To be completed by the certifying medical provider

- Initial Certification
 Renewal Certification

Note to Patient: These items are required to be submitted with this Certification:

1. A completed Patient Application
2. A \$50 application fee (check/money order, payable to "Treasurer – State of NH")
3. Proof of NH residency (NH license/State ID, current lease, recent utility bill, etc.)

PATIENT INFORMATION

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

PROVIDER INFORMATION

Name of Provider	First	Last	Middle
Name of Medical Practice			
Office Mailing Address	Street		Suite
	City	State	Zip Code
Office Phone/Fax Number	Phone	Extension	Fax
	E-Mail Address (optional)		
State License Number	<input type="checkbox"/> Physician (MD, DO) <input type="checkbox"/> Physician Assistant (PA) <input type="checkbox"/> Advanced Practice Registered Nurse (APRN)		
DEA Number			
Medical Specialty			

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

IMPORTANT INSTRUCTIONS – PLEASE READ:

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

**Patient's
Name**

A. Condition / Symptom (Check all that apply)

I certify that I am treating the patient named above, who has the following condition(s):

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

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:

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

OR

B. Condition Only (Check all that apply)

I certify that I am treating the patient named above, who has the following condition(s):

- Autism spectrum disorder (age 21 and older)
- Autism spectrum disorder (under age 21) (*See additional certification requirement on page 3*)
- 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

**Provider's
Signature**

Date

PROVIDER'S CERTIFICATION OF A PROVIDER-PATIENT RELATIONSHIP

A **provider-patient relationship** is 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.

Per He-C 401.06(b)(4), 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 documented diagnosis of the patient's current medical condition; and the development or documentation of a treatment plan for the patient appropriate for the provider's specialty.

Telemedicine. Per He-C 402.06(b)(4)a., the **in-person physical examination** of the patient shall not be via telemedicine for the initial certification. Telemedicine is allowed for follow-up visits and for recertifications by the same provider.

YOU MUST CHECK ONE BUTTON BELOW.

- This Certification is based on an **in-person** physical examination. (Note: This is required for initial certifications.)
- This Certification is based on an examination conducted via **telemedicine**.

Autism Spectrum Disorder Certification for Patients Under Age 21 (if applicable). I certify that I have consulted with a certified provider of child and/or adolescent psychiatry, developmental pediatrics, or pediatric neurology, who has confirmed that the autism spectrum disorder has not responded to previously prescribed medication or for which other treatment options produced serious side effects, and who supports certification for the therapeutic use of cannabis.

I certify that:

I have completed a full assessment of my patient's medical history and current medical condition in accordance with He-C 401.06(b)(4) made in the course of a provider-patient relationship.

I certify that:

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 APRN, or a PA licensed in New Hampshire to prescribe drugs to humans under RSA 329, 326-B:18, or 328-D, respectively, and who possesses an active registration from the US DEA to prescribe controlled substances

OR

A physician or an APRN licensed in Maine, Massachusetts, or Vermont to prescribe drugs to humans under the relevant state licensing laws, who possesses an active registration from the US DEA to prescribe controlled substances, and who is primarily responsible for my patient's care related to my patient's qualifying medical condition.

I certify that:

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 false statements made on this Written Certification are punishable as unsworn falsification under RSA 641:3.

**Provider's
Signature**

Date

DURATION OF WRITTEN CERTIFICATION

Your patient's Registry ID Card will be effective for one year from the effective date of the card. 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 effective date of the card.