State of Vermont
Marijuana Registry
45 State Drive
Waterbury, Vermont 05671-1300
www.dps.vermont.gov

[phone] 802-241-5115
[fax] 802-241-5230
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Department of Public Safety

HEALTH CARE PROFESSIONAL VERIFICATION FORM

INSTRUCTIONS: This form must be completed by the patient applicant's health care professional. This form must be signed within the last 6 months to be accepted. **This form must be completed and accompanied with a completed Registered Patient Application.** The definitions below are provided to assist the health care professional completing this form.

DEFINITIONS:

"Bona fide health care professional-patient relationship" means:

A treating or consulting relationship of not less than six months duration, in the course of which a health care professional has completed a full assessment of the registered patient's medical history and current medical condition, including a personal physical examination. The six-month requirement shall not apply if a patient has been diagnosed with:

A) a terminal illness;
B) cancer with distant metastases; or
C) acquired immune deficiency syndrome.

A patient applicant may be approved, notwithstanding the six-month requirement, if the debilitating medical condition is of recent or sudden onset and a previous health care professional was unable to verify the nature of the disease and its symptoms.

"Health care professional" means an individual who is:

A) licensed as a physician or osteopathic physician under 26 V.S.A Chapter 23 or Chapter 33;
B) licensed as a naturopathic physician under 26 V.S.A. Chapter 81, who has a special license endorsement authorizing the individual to prescribe, dispense, and administer prescription medicines to the extent that a diagnosis provided by a naturopath under this chapter is within the scope of his or her practice;
C) certified as a physician's assistant under 26 V.S.A. Chapter 31; or
D) licensed as an advanced practice registered nurse under 26 V.S.A. Chapter 28.

This definition includes professionally licensed individuals under substantially equivalent provisions in New Hampshire, Massachusetts, or New York, *except for naturopaths*.

"Debilitating medical condition" means a disease, medical condition, or its treatment, that is chronic, debilitating, and reasonable medical efforts have been made over a reasonable amount of time without success to relieve the symptoms, for the following diagnoses:

A) cancer, acquired immune deficiency syndrome, positive status for human immunodeficiency virus, multiple sclerosis; or
B) any other diagnoses that produces chronic, debilitating and severe, persistent and one or more of the following intractable symptoms: cachexia or wasting syndrome, severe pain, severe nausea, or seizures.

A patient applicant without a "debilitating medical condition" is not eligible for a Marijuana Registry identification card.

THIS FORM *MUST* BE ACCOMPANIED WITH A COMPLETED PATIENT APPLICATION!

VERMONT

HEALTH CARE PROFESSIONAL VERIFICATION FORM

The Marijuana Registry will contact the health care professional completing this form for the purposes of confirming the accuracy of the information contained on this form.

ALL SECTIONS OF THIS FORM MUST BE COMPLETED
AND SUBMITTED WITH A REGISTERED PATIENT APPLICATION!

PATIENT APPLICANT'S INFORMATION (Please print legibly)

Full Legal Name: Last ______________________________ First __________________________________ M.I. ________

Date of Birth: ______________________________ Telephone Number: ____________________________________

HEALTH CARE PROFESSIONAL INFORMATION (Please print legibly)

Full Legal Name: Last ___________________________________ First ________________________________ M.I. _____

Office Mailing Address: ____

City, State, Zip: ____ Telephone Number: _________________________

HEALTH CARE PROFESSIONAL LICENSE INFORMATION:

License Number: ______________________________ Issuing State (circle one): VT NH MA NY

LICENSURE CATEGORY

☐ Doctor of Medicine

☐ Physician Assistant

☐ Osteopathic Physician

☐ Advanced Practice Registered Nurse

☐ Naturopathic Physician

VERIFICATION OF A DEBILITATING MEDICAL CONDITION

The patient applicant I am treating or consulting:

☐ Does not have a debilitating medical condition as defined.

☐ Has been diagnosed with **cancer**.

☐ Has been diagnosed with **acquired immune deficiency syndrome**.

☐ Has been diagnosed with **human immunodeficiency virus**.

☐ Has been diagnosed with **multiple sclerosis**.

☐ Has been diagnosed with a disease, medical condition, or its treatment that is chronic, debilitating, and produces severe, persistent and one or more of the following intractable symptoms listed below in subdivision B.

* This selection **REQUIRES** subdivision A and B below be completed:

(A) Indicate specific diagnosis: ____

(B) Indicate specific symptom (*circle all that apply*): cachexia severe pain severe nausea seizures

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OFFICE USE ONLY – NOTES:

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BONA FIDE HEALTH CARE PROFESSIONAL-PATIENT RELATIONSHIP STATEMENT

☐ I **HAVE** a bona fide health care professional-patient relationship with the patient as defined on page 1.

☐ I do **NOT** have a bona fide health care professional-patient relationship with the patient as defined on page 1, but the medical condition **IS** of recent or sudden onset and the patient has not had a previous health care professional who is able to verify the nature of the disease and its symptoms.

☐ I do **NOT** have a bona fide health care professional-patient relationship with the patient as defined on page 1, and the medical condition **IS NOT** of recent or sudden onset and a previous health care professional was able to verify the nature of the disease and its symptoms.

ATTESTATION OF INFORMATION

I certify:

1) I am a health care professional;

   A) licensed as a *physician* or *osteopathic physician* under 26 V.S.A Chapter 23 or Chapter 33;
   B) licensed as a *naturopathic physician* under 26 V.S.A Chapter 81, who has a special license endorsement authorizing the individual to prescribe, dispense, and administer prescription medicines to the extent that a diagnosis provided by a naturopath under this chapter is within the scope of his or her practice;
   C) certified as a *physician's assistant* under 26 V.S.A Chapter 31; or
   D) licensed as an *advanced practice registered nurse* under 26 V.S.A Chapter 28,

   in good standing with the state (VT, NH, MA, or NY) regulating my professional license, and that the facts stated above are true and accurate to the best of my knowledge and belief.

2) Reasonable medical efforts have been made over a reasonable amount of time without success to relieve the patient's symptoms.

3) I understand, notwithstanding any law to the contrary, a person who knowingly provides false information on this application may be guilty of perjury and imprisoned for not more than one year or fined not more than $1,000.00 or both. This penalty shall be in addition to any other penalties that may apply.

This form is to verify the nature of the disease and its symptoms; this is not a prescription or medical recommendation for the use of marijuana.

Health Care Professional's Signature: ____ Date: _____________________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the health care professional named on this form to release my protected medical information to the Marijuana Registry to verify and confirm the accuracy of the information contained within this form. I authorize the named health care professional to:

- Disclose the nature, symptoms, and duration of the medical condition identified on this form for the purpose of determining that it meets the legal definition of a debilitating medical condition on page 1 of this form;
- Disclose whether the named health care professional and I have a bona fide health care professional-patient relationship, as defined by law and on page 1 of this form;
- Confirm the accuracy of the information contained in this form.

I understand that any information released to the Registry will be used solely to confirm the accuracy of the information contained in this form. While the information will no longer be covered by the HIPAA Privacy Rule, Vermont law requires the Registry to keep all information confidential, except for the prosecution of false swearing. I understand this authorization is valid for one year from the date the Registry receives this form, unless a written communication revoking this authorization or a new authorization is received by the Registry. I understand that I have the right to revoke this authorization at any time by notifying both the health care professional named on this form and to the Registry in writing.

Patient Applicant Signature REQUIRED: ____ Date: ____________

*If the patient applicant is **under the age of 18** or has a **court appointed guardian** the section below must be completed:*

Parent or Guardian Signature: ____ Date: ____________

THIS FORM *MUST* BE ACCOMPANIED WITH A COMPLETED PATIENT APPLICATION!