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

*Department of Public Safety*

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# HEALTH CARE PROFESSIONAL VERIFICATION FORM

**INSTRUCTIONS:** This form must be completed by the patient applicant's health care professional and signed within the last 6 months. **This form *and* a Registered Patient Application *MUST* be completed and submitted for initial and renewal applicants.** The definitions below are provided to assist health care professionals when completing this form.

**DEFINITIONS:**

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

A treating or consulting relationship of not less than three 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.

(B) The three-month requirement shall not apply if a patient has been diagnosed with:

(I) A terminal illness;

(II) Cancer;

(III) Acquired immune deficiency syndrome; or

(IV) Is currently under hospice care.

(ii) A patient had been diagnosed with a debilitating medical condition by a health care professional in another jurisdiction in which the patient had been formerly a resident and the patient, now a resident of Vermont, has the diagnosis confirmed by a health care professional in this State or a neighboring state as provided in subdivision (6) of this section, and the new health care professional has completed a full assessment of the patient's medical history and current medical condition, including a personal physical examination.

(iii) A patient who is already on the registry changes health care professionals three months or less prior to the annual renewal of the patient's registration, provided the patient's new health care professional has completed a full assessment of the patient's medical history and current medical condition, including a personal physical examination.

**"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;
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.

**"Debilitating medical condition"** means reasonable medical efforts have been made over a reasonable amount of time to relieve the symptoms related to a disease, medical condition, or its treatment described in subdivision (A) or (B):

A) Cancer, acquired immune deficiency syndrome, positive status for human immunodeficiency virus, glaucoma, multiple sclerosis; or

B) A disease, medical condition, or its treatment that is chronic, debilitating and produces and one or more of the following intractable symptoms: cachexia or wasting syndrome, chronic pain, severe nausea, or seizures.

*An applicant lacking a "debilitating medical condition" is not eligible for a registry identification card.*

# ***HEALTH CARE PROFESSIONAL VERIFICATION FORM***

*The Vermont Marijuana Registry (VMR) will contact the health care professional completing this form to confirming the accuracy of the information.*

***ALL SECTIONS MUST BE COMPLETED***

**1) PATIENT APPLICANT'S INFORMATION** (Please print legibly)

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

Date of Birth: _____ Telephone Number: _____

**2) HEALTH CARE PROFESSIONAL INFORMATION** (Please print legibly)

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

Office Mailing Address: _____

City, State, Zip: _____ Telephone Number: _____

**3) HEALTH CARE PROFESSIONAL LICENSE INFORMATION:**

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

**4) LICENSURE CATEGORY**

☐ Doctor of Medicine ☐ Physician Assistant ☐ Naturopathic Physician

☐ Osteopathic Physician ☐ Advanced Practice Registered Nurse

**5) 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 **glaucoma.**

☐ Has been diagnosed with a disease, medical condition, or its treatment that is chronic, debilitating, and produces one or more of the following intractable symptoms listed below in subdivision B. ***(Subsections A and B MUST be completed***)

**(A) Indicate specific diagnosis**: _____

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

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**OFFICE USE ONLY –** HCPF VERIFIED: Yes _____ No _____ Date: _____ NOTES: _____

**6) BONA FIDE HEALTH CARE PROFESSIONAL-PATIENT RELATIONSHIP STATEMENT (Check all that apply A-F)**

**A)** ☐ I **HAVE** a treating or consulting relationship with the patient named on this form of at least *three months'* duration.

☐ I **DO NOT** have a treating or consulting relationship with the patient named on this form of at least *three months'* duration.

**B)** ☐ I **HAVE** completed a *full assessment* of the patient's medical history and current medical condition, including a personal physical examination.

☐ I have **NOT** completed a *full assessment* of the patient's medical history and current medical condition, including a personal physical examination.

**C)** ☐ The patient applicant has been diagnosed with:

**(A)** ☐ A terminal illness (or is currently under hospice care);

**(B)** ☐ Cancer; or,

**(C)** ☐ Acquired immune deficiency syndrome.

**D)** ☐ The patient applicant I am treating or consulting has been diagnosed with a debilitating medical condition in another jurisdiction where the patient was formerly a resident and the patient is now a resident of Vermont.

**E)** ☐ The patient applicant I am treating or consulting is already registered with the VMR **AND** has changed health care professionals within the last three months.

**F)** ☐ The patient's 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.

a. ☐ The patient's medical condition was diagnosed on: _____/_____/_____ (MM/DD/YYYY)

## 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;
   C) Certified as a *physician's assistant* under 26 V.S.A Chapter 31;
   D) Licensed as an *advanced practice registered nurse* under 26 V.S.A Chapter 28; or,
   E) Professional licensed under substantially equivalent provisions in NH, MA, or NY.
2) I am 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.
3) Reasonable medical efforts have been made over a reasonable amount of time to relieve the patient's symptoms.
4) 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

**THIS SECTION MUST BE COMPLETED BY THE PATIENT APPLICANT**

I hereby authorize the health care professional named on this form to release my protected medical information to the Vermont Marijuana Registry (VMR) 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 VMR 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 VMR 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 VMR receives this form, unless a written communication revoking this authorization or a new authorization is received by the VMR. 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 VMR 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!**