



Physician Certification Instructions

1. Complete the entire form, sign and date.
2. If you make a mistake on this form, please complete a new form. **Do not write over, white-out or cross-out information. This will void the form.**
3. Please keep a copy of the form in the patient's medical record. To avoid fraud, the Registry verifies all physician signatures. You will receive a verification letter for patients in the months the Registry receives Physician Certifications with your signature.
4. Please do not fax or e-mail the form to the Registry. The patient must submit the Physician Certification along with his or her complete Medical Marijuana Registry application packet.
5. This does not constitute a prescription for marijuana.
6. To sign the form, you must be an MD or DO with an active Colorado medical license. Physicians with condition or restrictions on their licenses, or out-of-state licenses, are not accepted.
7. A copy of your current DEA certification must be on file in the Registry's office. If you have not already provided this, please fax a copy to 303-758-5182. If your DEA is not on file when we receive your patient's paperwork, it will be rejected.
8. Encourage patients to submit their application packets as soon as possible after you sign the Physician Certification. **The Registry rejects Physician Certifications that are more than 60 days old.**
9. The Registry has included in the application packet, for your review, "**Regulation 8: Physician requirements; reasonable cause for referrals of physicians to the Colorado Medical Board; reasonable cause for department adverse action concerning physicians; appeal rights.**" For a link to the complete Board of Health rules, please visit our website www.cdphe.state.co.us/hs/medicalmarijuana.
10. You may contact the Registry at medical.marijuana@state.co.us or (303) 692-2184, if you have any questions.



Medical Marijuana Registry

Physician Certification

STAFF ONLY EPU Approval <input type="checkbox"/> Yes <input type="checkbox"/> No Corrections:	Patient Information			
	1. Last Name (as on ID)	2. First Name (as on ID)	3. Middle Initial	4. Date of Birth / /
	5. What is the date of physical examination for the purpose of the medical marijuana recommendation? (mm/dd/yyyy) ____/____/____			
	6. How many times during the previous 12 months have you seen this patient?			
	7. Are you available to provide follow-up care for this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	8. What is the date by which the patient should schedule a follow-up care visit? (mm/dd/yyyy) ____/____/____			
	9. In your opinion, is this patient homebound? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Physician Information			
	10. License Number DR -	11. Last Name	12. First Name	13. Middle Initial
	14. Mailing Address			
15. City		16. State	17. Zip Code	
18. Telephone Number () -	19. Fax Number () -	20. E-mail Address (optional)		
21. DEA Certification: The Registry requires a copy of your current DEA certification for their files. If you have not already provided this, FAX a copy to 303-758-5182 to prevent delays in processing this application.				
Physician's Statement				
22. The above-named patient has been diagnosed with and is currently undergoing treatment for the following chronic, debilitating medical condition. <input type="checkbox"/> a. Cancer <input type="checkbox"/> b. Glaucoma <input type="checkbox"/> c. HIV or AIDS positive or The patient has a chronic or debilitating disease or medical condition that produces one or more of the following and which, in the physician's professional opinion, may be alleviated by the medical use of marijuana. <input type="checkbox"/> d. Cachexia <input type="checkbox"/> e. Severe nausea <input type="checkbox"/> f. Seizures <input type="checkbox"/> g. Persistent muscle spasms <input type="checkbox"/> h. Severe pain (The etiology is required by law whenever severe pain is selected.) Etiology: _____ or <input type="checkbox"/> Etiology unknown.				
23. Please indicate the number of plants and ounces of marijuana you recommend for this patient. <input type="checkbox"/> Standard Amount: 6 plants/2 ounces <input type="checkbox"/> Increased Amount: ____ plants/____ ounces				
24. Comments: (If no comments, the Registry recommends crossing through this area to prevent comments after your signature.) _____ _____ _____ _____				
I hereby certify that I am a physician duly licensed in good standing to practice medicine in Colorado, and that I have a bona fide physician-patient relationship with the above-named patient. I have assessed this patient's medical history and current medical condition. I conclude that this patient may benefit from the medical use of marijuana. This assessment is not a prescription for the use of marijuana.				
25. Physician's Signature: 		26. Date Signed (mm/dd/yyyy)		