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 03301-3857
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/tcp

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 the Alternative Treatment Centers (ATCs). The ATCs 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 (www.dhhs.nh.gov/tcp-forms or (603) 271-9255)*
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 Initial
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 Initial
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		☐ Physician (MD, DO) ☐ Physician Assistant (PA) ☐ Advanced Practice Registered Nurse (APRN)		
DEA Number				
Medical Specialty				

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

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

Patient's Name:

_____

(First and last name)

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

A. Condition / Symptom (Check all that apply)

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

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

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:

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

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

I certify that I am treating the patient named above for the following condition:

- ☐ Opioid use disorder with associated symptoms of cravings and/or withdrawal

Requires a provider who is board-certified in Addiction Medicine or Addiction Psychiatry:

Certification Board Name: _____ Certification Number: _____

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.

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.

If my patient is a woman of child-bearing age, I have counseled my patient (and the custodial parent or legal guardian if a minor) about the risks of cannabis use during pregnancy and while breastfeeding.

If my patient is an adolescent 25 years of age or less, I have counseled my patient (and the custodial parent or legal guardian if a minor) about the risks of cannabis use in adolescence.

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	

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. *(Required for initial certification.)*
- ◯ This Certification is based on an examination conducted via **telemedicine**. *(Allowed for recertification by the same provider.)*

DURATION OF WRITTEN CERTIFICATION

Your patient's Registry ID Card will be effective for 12 months from the effective date of the card. If the patient's card should be valid for a period shorter than 12 months, or longer (up to a maximum of 36 months), indicate the number of months the card shall remain valid.

The Registry ID Card shall remain valid for the following duration:

☐ 3 months ☐ 6 months ☐ 12 months (default) ☐ 18 months ☐ 24 months ☐ 36 months (maximum)