STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND REGULATORY SERVICES

Medical Use of Marijuana Program

Physician Certification

Must be on Tamper Resistant Paper

SECTION 1: Physician Information			
Name:			
DEA Number:	Indicate if M.D. or D.O.:	Telephone No.: ( )	
Street Address:			
City:	State:	Zip:	County:
Mailing Address:			
City:	State:	Zip:	County:

SECTION 2: Patient Information			
Name:			Date of Birth:
Address (According to Physician's Records):			
City:	State:	Zip:	County:

SECTION 3: Expiration
Date of expiration of certification (12 months from date of physician's signature):

SECTION 4: Declaration

Patients must have specific diagnoses or conditions to be certified for the Medical Use of Marijuana Program. Those conditions include cancer, glaucoma, ALS, crohn's, HIV positive status, hepatitis C, agitation of Alzheimer's disease, nail-patella syndrome, intractable pain, or a chronic or debilitating disease or medical condition or its treatment that produces cachexia, severe nausea, seizures (such as those characteristic of epilepsy) or severe and persistent muscle spasms (such as those characteristic of multiple sclerosis). If your patient does not have one of these qualifying conditions, you may contact the department for information on how to petition for the inclusion of additional conditions.

Evidence of your assessment, diagnosis and treatment of the condition for which you certify this patient for the use of medical marijuana must be found in the patient's medical record. By signing this form, you certify that you are the physician for the above-named patient, and have a bonafide physician/patient relationship. Based on your assessment, diagnosis and treatment of this patient, it is your conclusion that the applicant may benefit from the medical use of marijuana and has a qualifying debilitating condition. You agree to monitor the patient's medical condition. You agree you have cautioned this patient not to engage in hazardous activities while under the influence of marijuana.

_____	_____	_____
Print name of physician	**Signature of physician**	**Date**

For questions regarding this program and/or application, please contact the following:

Department of Health and Human Services
Licensing and Regulatory Services
Maine Medical Use of Marijuana Program
41 Anthony Ave
11 State House Station
Augusta, ME 04333-0011

Tel: (207) 287-4325 Fax: (207) 287-2671 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: medmarijuana.dhhs@maine.gov