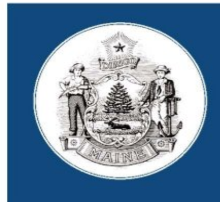
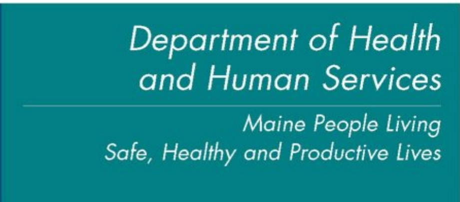
Attn: Medical Marijuana Program
DHHS Division of Licensing and Regulatory Services
11 State House Station
Augusta, ME 04333

Medical Marijuana Program
Physician Certification





John E. Baldacci, Governor
Brenda M. Harvey, Commissioner

Section 1 IDENTIFICATION INFORMATION

Physician Name

DEA Number:

Indicate if M.D. or D.O.

Physician's Address
(street)

(city, state, zip code)

Telephone: (207) -

Mailing Address (if different than above)

(city, state, zip code)

Section 2 NATURE OF PHYSICIAN/PATIENT RELATIONSHIP

Patient Name

Patient Date of Birth

Patient Address in Physician's Records

Date of last visit for the qualifying medical condition:

Part 1: Condition you are treating the patient for:

- ☐ Cancer
- ☐ ALS
- ☐ Other
- ☐ Glaucoma
- ☐ Crohn's
- ☐ HIV Positive
- ☐ Hepatitis C
- ☐ Agitation of Alzheimer's
- ☐ Nail-Patella Syndrome

If other is checked, indicate the chronic or debilitating disease or medical condition or its treatment that produces intractable pain, which is pain that has not rseponded to ordinary medical or surgical measures for more than 6 months:

If none of the above, indicate if the chronic or debilitatiang disease or medical condition or its treatment produces:

- ☐ Cachexia
- ☐ Severe Nausea
- ☐ Seizures, including but not limited to those characteristic of epilepsy
- ☐ Severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis

Diagnosis:

Part 2: If none of the above, please indicate the medical condition or its treatment that you recommend be approved for this patient:

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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. In the event you are certifying the patient for a condition not listed above, please provide the name of the condition and the basis for your certification. Other debilitating conditions will be reviewed by an Advisory Board before approval of an additional condition may be made.

Other comments: ____

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Declaration: I certify that I, a physician duly licensed to practice in the state of Maine, am the physician for the above-named patient, and have a bonafide physician/patient relationship. Based on my assessment, diagnosis and treatment of this patient, it is my conclusion that the applicant may benefit from the medical use of marijuana. It is documented in this patient's medical record. This is not a prescription for the use of medical marijuana. I will continue to monitor the patient's medical condition.

____
Printed name of physician

Expected duration of need in months:

____
Signature of Physician

Date ____________________

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Department of Health and Human Services
Division of Licensing and Regulatory Services
11 State House Station
Augusta, ME 04333

To check on the status of your certification, call (207) 287-9300