

OUT-OF-STATE MEDICAL PROVIDER FORM

PATIENT NAME:

CANNABIS CARD ID:

DATE OF BIRTH: ____/___/

STATE/PROVINCE OF CANNABIS CARD:

CONDITION/ SYMPTOM CERTIFICATION

TO BE FILLED OUT BY YOUR MEDICAL PROVIDER

I certify that this patient meets the requirements for a qualifying medical condition established by the State of New Hampshire for participation in the Therapeutic Cannabis program.

A. <u>**Condition/ Symptom**</u> (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

- Multiple sclerosis
- Muscular dystrophy
- One or more injuries or conditions that
 has resulted in one or more qualifying
 symptoms listed below
- Parkinson's disease

- Ehler's-Danlos syndrome
- Epilepsy
- Glaucoma
- Hepatitis C
- □ Lupus

- 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

- Moderate to severe vomiting
- Seizures
- □ Severe pain
- Severe, persistent muscle spasms

Elevated intraocular pressure

Moderate to severe insomnia







Revised 11/20/23



TO BE FILLED OUT BY YOUR MEDICAL PROVIDER

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)
- Moderate or severe post-traumatic stress disorder
- □ Moderate or severe chronic pain
- □ Severe pain

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

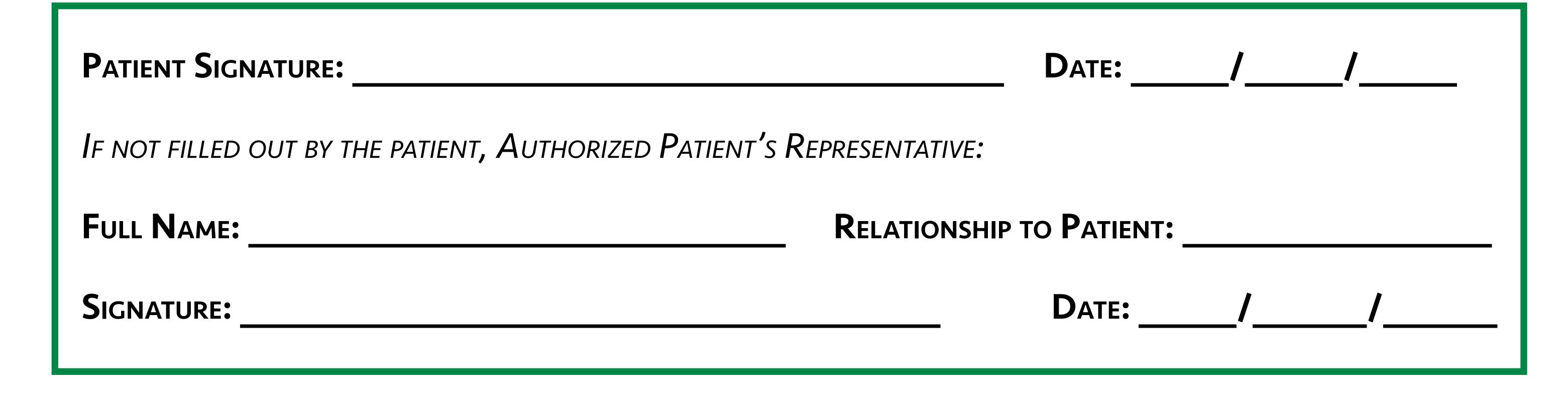
Opioid use disorder with associated symptoms of cravings and/or withdrawal

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

CERTIFICATION BOARD NAME:

CERTIFICATION **N**UMBER:

	TO BE FILLED OUT BY YOUR MEDICAL PROVIDER			
MEDICAL PROVIDER NAME:		Date:		
Aedical Provider Signature:		.IC #:		



Note: This form is intended to facilitate compliance with New Hampshire law for visiting patients who are registered in another state or province. It is not intended to be a prescription or recommendation for the

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