GraniteLeaf CANNABIS

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. 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
- ☐ Ehler's-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
- ☐ Severe, persistent muscle spasms
- ☐ Wasting syndrome

OR →

OR

TO BE FILLED OUT BY YOUR MEDICAL PROVIDER

B. <u>Condition Only</u> *(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 NUMBER: ________________________________

TO BE FILLED OUT BY YOUR MEDICAL PROVIDER

MEDICAL PROVIDER NAME: ____________________________________ **DATE:** _____/_____/_____

MEDICAL PROVIDER SIGNATURE: _________________________ **DEA/LIC #:**______________________

PATIENT SIGNATURE: ____ **DATE:** _____/_____/_____

IF NOT FILLED OUT BY THE PATIENT, AUTHORIZED PATIENT'S REPRESENTATIVE:

FULL NAME: _________________________________ **RELATIONSHIP TO PATIENT:** ___________________

SIGNATURE: ____ **DATE:** _____/______/______

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 therapeutic use of cannabis.*

FOR OFFICE USE ONLY: **STAFF INITIALS:** __________ **DATE:** _____/_____/_____