IOWA DEPARTMENT OF PUBLIC HEALTH
Office of Medical Cannabidiol (OMC)

IOWA MEDICAL CANNABIDIOL PROGRAM

Waiver for Increasing the Amount of 'THC per 90 Days' for a Certified Patient

Instructions – Type or print clearly and answer all of the questions.

This waiver does not constitute a prescription for medical cannabidiol.

Healthcare Practitioners - PROVIDE THE COMPLETED and SIGNED FORM TO THE PATIENT

Patients, use your phone's camera to scan the QR code and submit the completed waiver online.

Please print clearly - Incomplete or unreadable forms may result in denial of the waiver

PATIENT INFORMATION
Name (First, Middle, Last)
Permanent Iowa Address (Street, Apt. #)
Address (City, State, ZIP Code)
Phone/Email (Phone number and email address)

HEALTH CARE PRACTITIONER INFORMATION		
Health Care Practitioner's Name (First, Middle, Last, Suffix)		
Medical License Number	**License State** (Must be licensed in Iowa)	**License Type** (MD, DO, PA, ARNP, DPM)
Practice Address (Street)		
Practice Address (P.O. Box, Suite #)		
Address (City, State ZIP Code)		
Phone Number	**Email Address**	
Medical Specialty (Oncology, Neurology, Pain Management, etc.)		

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NOTE: The waiver for increasing the amount of THC per 90 days for a registered medical cannabidiol patient requires a medical examination *after* the original certification (unless certified for a terminal illness). The medical examination and this waiver form must be completed by the original Healthcare Practitioner who certified the qualifying patient for participation in Iowa's Medical Cannabidiol Program.

I _____ (the Healthcare Practitioner), hereby certify that, based on the patient's medical history, in my professional judgement, _____ (the registered qualifying patient), should be approved for an exception to the 4.5g THC per 90-day limit pursuant to the provisions of Iowa Code chapter 124 E. It is my professional judgement a quantity of _____g (must be indicated) per 90-day period should be approved to properly alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition.

Health Care Practitioner Signature	**Date of Signature (mm/dd/yy)**

If you are unable to submit the completed form online, please mail to:

IDPH attn. OMC
321 E 12th St.
Des Moines, IA 50319

Rev. 08/21