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

For the most current information regarding this application, medical cannabidiol laws in the state of Iowa and more, see the official website: https://idph.iowa.gov/omc

MEDICAL CANNABIDIOL REGISTRATION CARD - HEALTH CARE PRACTITIONER CERTIFICATION

Step 1 – The patient's health care practitioner completes this form, signs, dates it and returns to patient.

Step 2 – Patient or Caregiver submits this completed form with their application and required documents.

WE CAN NOT ACCEPT THIS FORM ALONE OR DIRECTLY FROM YOUR HEALTH CARE PRACTITIONER.

We accept electronic applications!
For online submission of registration applications go to https://idph.iowa.gov/omc

For paper applications, mail completed application and required materials to: **Iowa Department of Public Health ATTN: OMC 321 E. 12th Street Des Moines, IA 50319-0075**

Please print clearly - Incomplete or unreadable health care practitioner forms may result in denial of application.

PATIENT INFORMATION

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

PRIMARY CAREGIVER DESIGNATION

Patient or guardian completes this section only if a primary caregiver has been designated for a patient

Primary Caregiver means a person, who is a resident of Iowa or a bordering state, including but not limited to a parent or legal guardian, at least eighteen years of age, who has been designated by a patient's health care practitioner as a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol.

Patient Name
(First, Middle Initial, Last)

I, _____, (adult patient or guardian of minor), hereby authorize the following person to be my designated primary caregiver for the purpose of managing my well-being related to the use of medical cannabidiol. I authorize this caregiver to assist me in the transportation, storage and use of medical cannabidiol. This person will be responsible for applying through a separate application form for their own Medical Cannabidiol Registration Card as my caregiver.

Designated Caregiver	**Caregiver Name** (First, Middle, Last)
	Caregiver Permanent Address (Street, Apt. #, City, State, zip)
	Caregiver Mailing Address (P.O. Box, Apt. #, City, State, zip)

HEALTH CARE PRACTITIONER CERTIFICATION

INSTRUCTIONS: The patient's health care practitioner must complete this form. This should be submitted as a part of your completed application to the Office of Medical Cannabidiol. Partial applications will not be accepted. The patient application must be received by the Office of Medical Cannabidiol within **60 days** of the physician's signature date.
NOTE: THIS DOES NOT CONSTITUTE A PRESCRIPTION FOR CANNABIDIOL or MEDICAL MARIJUANA.

HEALTH CARE PRACTITIONER INSTRUCTIONS: Please print clearly. Incomplete or unreadable health care practitioner forms may result in denial of an application. Answer all of the questions with information in the patient's medical record.

Patient Name
(First, Middle, Last)

HEALTH CARE PRACTITIONER INFORMATION

Health Care Practitioner means an individual licensed under Chapter 148 to practice medicine and surgery or osteopathic medicine and surgery, a physician assistant licensed under chapter 148C, an advanced practice registered nurse under chapter 152E, who is a patient's primary care provider or a podiatrist licensed pursuant to chapter 149.

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.)

PATIENT'S QUALIFYING DEBILITATING MEDICAL CONDITION CERTIFIED BY HEALTH CARE PRACTITIONER

INSTRUCTIONS: Please indicate with a P the PRIMARY debilitating medical condition which qualifies the patient for a Medical Cannabidiol Registration Card to the left of condition below. Please mark to left of condition with an S any SECONDARY conditions.

	Cancer with severe or chronic pain
	Cancer with nausea or severe vomiting
	Cancer with cachexia or severe wasting
	Multiple sclerosis with severe and persistent muscle spasms
	Seizures, including those characteristic of epilepsy
	AIDS or HIV as defined in Iowa Code, section 141A.1
	Crohn's disease
	Ulcerative colitis
	Amyotrophic lateral sclerosis
	**Any terminal illness with a probable life expectancy of under one year and severe or chronic pain (please see bottom of page 2)*
	**Any terminal illness with a probable life expectancy of under one year and nausea or severe vomiting (please see bottom of page 2)*
	**Any terminal illness with a probable life expectancy of under one year and cachexia or severe wasting (please see bottom of page 2)*
	Parkinson's disease
	Chronic pain
	Severe, intractable autism with self-injurious or aggressive behaviors
	Corticobasal Degeneration
	Post-Traumatic Stress Disorder (PTSD)

** A Healthcare Practitioner who certifies a patient for a terminal illness must indicate the specific grams of THC per 90 days that they are certifying the patient for on the '**4.5g THC Waiver Form**.' The patient must submit this form to the Department with their application. If the Healthcare Practitioner does not complete this form, a limit of 4.5g THC per 90 days will be set for the patient.*

Patient *Name*
(First, Middle Initial, Last)

HEALTH CARE PRACTITIONER CERTIFICATION

INSTRUCTIONS: Please initial all sections. Failure to initial all sections may result in the denial of an application.

I have established a patient-provider relationship with the patient identified above.	_____ Initials
I am a primary care provider involved in the diagnosis or treatment of this patient's debilitating medical condition. "Primary care provider" means any health care practitioner involved in the diagnosis and treatment of a patient's debilitating medical condition.	_____ Initials
I have determined in my medical judgment that this patient whom I have examined and treated suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol under Iowa Code, chapter 124E.	_____ Initials
I have provided this patient with the explanatory information provided by the Iowa Department of Public Health (found on the Department's website at this web address: https://idph.iowa.gov/omc) on the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.	_____ Initials
I agree to determine, on an annual basis, if the patient continues to suffer from a debilitating medical condition and, if so, issue the patient a new certification of that diagnosis.	_____ Initials
I agree to otherwise comply with all requirements established by the Iowa Department of Public Health pursuant to rule, and provide other information as requested.	_____ Initials
I understand that I may provide, but have no duty to provide, this written certification of debilitating medical condition for the applicant patient.	_____ Initials

HEALTH CARE PRACTITIONER ATTESTATION

I designate the person(s) if named in the Primary Caregiver Section as Primary Caregiver(s) in relation to the patient to manage the patient's well-being with respect to the use of medical cannabidiol pursuant to the provisions of Iowa Code chapter 124.E.

I certify under penalty of perjury that the foregoing statements and all information provided by me on this certification are true and correct. I understand the law provides severe penalties (fine and/or imprisonment) for the willful submission of known false information. **I understand this certification does not, by itself, provide authorization for the Medical Cannabidiol Registration Card for the above named patient/and/or caregiver(s).** All other required application documentation must be submitted with this form.

Health Care Practitioner Signature	**Date of Signature**

Opt in Statement: *I hereby authorize the Iowa Department of Public Health to release my name and practice address to patients seeking certification of a qualifying debilitating medical condition for purposes of obtaining a medical cannabidiol registration card. I understand that by checking the opt in box below, my name and practice address will be provided to patients upon request. I further acknowledge that I must notify the Iowa Department of Public Health, Office of Medical Cannabidiol in the event I choose to withdraw this authorization at a future time.*

Opt in selection ☐ **(check this box and sign below if you are opting in)**

Health Care Practitioner Signature	**Date of Signature**