IOWA | Health and Human Services
Division of Compliance and Administration

Medical Cannabis Registration Card Instructions

Required documentation

- Completed Health Care Practitioner Certification Form (attached), submitted to Bureau of Cannabis Regulation within 60 days of healthcare practitioner's signature.
- Copy of your valid Iowa driver's license or Iowa non-operator's identification card.
- Pay registration fee ($100.00 or $25.00 if proof for a reduced fee is provided).
- Proof for reduced fee (if applicable) includes a copy of your Medicaid card, social security disability award letter, Supplemental Security Insurance award letter, or government document indicating veteran status.

Steps

1. Your provider must complete the Health Care Practitioner Certification Form.
2. Gather required documentation.
3. Submit your patient application online by scanning the QR code below or visiting: hhs.iowa.gov/health-prevention/medical-cannabis
   You will be prompted to take pictures or upload the required documents and pay the registration fee.
4. HHS will review your application and communicate with you within seven days.

Scan here to submit your patient application:

Contact us with questions at medical.cannabis@hhs.iowa.gov, or call 877-214-9313.

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Medical Cannabis Health Care Practitioner Certification

PATIENT INFORMATION	
Name (First, Middle, Last)	
Permanent Iowa Address (Street, Apt. #)	
Address (City, State, ZIP Code)	
Phone	**Email**

HEALTH CARE PRACTITIONER CERTIFICATION		
INSTRUCTIONS: The patient's health care practitioner must complete this form. Please print clearly. Incomplete or illegible forms may result in denial of an application. This application must be received by the Bureau of Cannabis Regulation within **60 days** of the health care practitioner's signature date.		
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 Check all that apply.	
☐	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 characteristics of epilepsy
☐	AIDS or HIV as defined in Iowa Code, section 141A.1
☐	Crohn's disease
☐	Ulcerative colitis
☐	Amyotrophic lateral sclerosis
☐	Parkinson's disease
☐	Chronic Pain
☐	Severe, intractable autism with self-injurious or aggressive behaviors
☐	Corticobasal Degeneration
☐	Post-Traumatic Stress Disorder (PTSD)
☐	Terminal illness with a probable life expectancy of under one year and severe or chronic pain
☐	Terminal illness with a probable life expectancy of under one year and nausea or severe vomiting
☐	Terminal illness with a probable life expectancy of under one year and cachexia or severe wasting

HEALTH CARE PRACTITIONER CERTIFICATION	
I developed a patient- provider relationship with the patient identified above.	_____ Initial
I am a primary care provider involved in the diagnosis and 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.	_____ Initial
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 cannabis under Iowa Code, chapter 124E.	_____ Initial
I provided this patient with the explanatory information provided by the Iowa Department of Health and Human Services on the therapeutic use of medical cannabis and the possible risks, benefits, and side effects of the proposed treatment.	_____ Initial
I agree to determine, on an annual basis, if the patient continues to suffer from a debilitating medical condition.	_____ Initial
I agree to comply with all requirements established by the Iowa Department of Health and Human Services pursuant to rule 641 IAC 154 and provide information as requested.	_____ Initial

HEALTH CARE PRACTITIONER ATTESTATION
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 Cannabis 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

Only complete this section if a caregiver has been designated for the patient.

To file caregiver designation, scan the QR code or visit hhs.iowa.gov/health-prevention/medical-cannabis.

CAREGIVER DESIGNATION

"Caregiver" or "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 cannabis.

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 cannabis. I authorize this caregiver to assist me in the transportation, storage and use of medical cannabis. This person will be responsible for applying through a separate application form for their own Medical Cannabis Registration Card as my caregiver.

Designated Caregiver	**Caregiver Name** (First, Middle, Last)
	Caregiver Address (Street, Apt. #, City, State, Zip)
	Caregiver Mailing Address (if different than above) (Street, Apt. #, City, State, Zip)

HEALTH CARE PRACTITIONER PRIMARY CAREGIVER DESIGNATION

Only complete if a Caregiver is designated.

I designate _____, as the above-named patient's Primary Caregiver to manage the patient's well-being with respect to the use of medical cannabis pursuant to the provisions of Iowa Code chapter 124E.

_____ _____

Health Care Practitioner Signature Date