IOWA | Health and Human Services
Division of Compliance and Administration

Provider Cancellation of Patient/Caregiver Certification

Health Care Practitioner Information

Health Care Practitioner Name:_____

Medical License Number: _____ License Type:_____

Practice Address: _____

Phone Number: _____ Email Address: _____

Patient and/or Caregiver Information

Patient Name: _____ D.O.B. _____

Caregiver Name: _____ D.O.B. _____

Date of Certification (if known): _____

Effective

I hereby request that the Iowa Department of Health and Human Services, Bureau of Cannabis Regulation rescind the medical cannabis certification for the above-named:

☐ Patient

☐ Caregiver

Note: Cancellation of the patient and/or caregiver's medical cannabis registration card is effective 30 days from the date of signature to allow time to use or dispose of any medical cannabis products currently in patient's or caregiver's possession.

Health Care Practitioner Signature: _____

Date: _____

Email completed form to medical.cannabis@hhs.iowa.gov.