



Department of Health and Human Services  
Licensing and Regulatory Services - MMMP  
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## Medical Marijuana Program Physician Certification

Physician's Name	DEA Number:
	Indicate if M.D. or D.O.

Physician's Address  
(street)

(city, state, zip code) Telephone: (207)

Physician's Mailing Address (if different than above)

(city, state, zip code)

### Patient Information

Patient's Name	Patient's Date of Birth:
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Patient's Address in Physician's Records

### Expiration

Date of expiration of certification (12 months from date of physician's signature): \_\_\_\_\_

Patients must have specific diagnoses or conditions to be certified for the Medical Use of Marijuana Program. Those conditions include cancer, glaucoma, ALS, crohn's, HIV positive status, hepatitis C, agitation of Alzheimer's disease, nail-patella syndrome, intractable pain, or a chronic or debilitating disease or medical condition or its treatment that produces cachexia, severe nausea, seizures (such as those characteristic of epilepsy) or severe and persistent muscle spasms (such as those characteristic of multiple sclerosis). If your patient does not have one of these qualifying conditions, you may contact the department for information on how to petition for the inclusion of additional conditions.

Evidence of your assessment, diagnosis and treatment of the condition for which you certify this patient for the use of medical marijuana must be found in the patient's medical record. By signing this form, you certify that you are the physician for the above-named patient, and have a bonafide physician/patient relationship. Based on your assessment, diagnosis and treatment of this patient, it is your conclusion that the applicant may benefit from the medical use of marijuana and has a qualifying debilitating condition. You agree to monitor the patient's medical condition. You agree you have cautioned this patient not to engage in hazardous activities while under the influence of marijuana.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_