

Department of Public Health

LOW THC OIL

Physician Certification Information

To complete a physician certification, physicians:

1. Must have an active MD or DO license in good standing with the Georgia Composite Medical Board.
2. Must have a doctor-patient relationship when certifying an individual as needing low THC oil.
3. Must be treating an individual for the specific condition requiring such treatment.
4. Must conduct a physical exam and review patient history to certify the patient has a qualifying debilitating medical condition. A new physical exam is required each year as part of the patient's renewal process.
5. Must keep a copy of the physician certification in the patient's medical record.

LOW THC OIL

Physician Certification Form

PATIENT INFORMATION (TYPE OR PRINT LEGIBLY)

Last Name (must match ID)	First Name (must match ID)	Date of Birth
Patient Address		
Patient Telephone:		Email Address:

CAREGIVER INFORMATION (TYPE OR PRINT LEGIBLY)

Caregiver means the parent, guardian, or legal custodian of an individual who is less than 18 years of age or the legal guardian of an adult.

Caregiver's Last Name	Caregiver's First Name	
Caregiver's Mailing Address		
Caregiver's Telephone:		Caregiver's Email Address:

PHYSICIAN INFORMATION (TYPE OR PRINT LEGIBLY)

License Number	Last Name	First Name	MInitial
Mailing Address			
City	State	Zip Code	
Telephone Number	Fax Number	E-mail Address	
DEA Number			

1. The above-named patient has been diagnosed with and is currently undergoing treatment for:
 - _____ Cancer, when such diagnosis is end stage or the treatment produces related wasting illness, recalcitrant nausea and vomiting
 - _____ Amyotrophic lateral sclerosis, when such diagnosis is severe or end stage
 - _____ Seizure disorders related to diagnosis of epilepsy or trauma related head injuries
 - _____ Multiple sclerosis, when such diagnosis is severe or end stage
 - _____ Crohn's disease
 - _____ Mitochondrial disease
 - _____ Parkinson's disease, when such diagnosis is severe or end stage
 - _____ Sickle cell disease, when such diagnosis is severe or end stage

2. Are you going to continue treating the patient following the use of THC oil? _____ Yes _____ No

3. Does this patient currently reside in the State of Georgia? _____ Yes _____ No

- 3a. If no, is the patient considered a legal resident of Georgia? _____ Yes _____ No

4. How long has the patient been a resident of the State of Georgia? _____

5. How long have you been treating the patient? _____

6. How long has the patient been diagnosed with the condition(s) listed in #1? _____

7. What other treatments has/does this patient receive(d):

8. Comments: (If no comments, cross through this area to prevent comments after your signature.)

Physician Attestation

I hereby certify that I am a physician duly licensed in good standing to practice medicine in Georgia. I have a bona fide physician-patient relationship with the above-named patient in compliance with state statutes. I have assessed this patient's medical history and current medical condition and have performed or reviewed appropriate diagnostic tests in making the above-indicated diagnosis. I conclude that this patient is eligible for the use of low THC oil as provided in Georgia law. This authorization is not a prescription.

Physician's Signature

Date signed