



# Cannabis Control Division Physician Statement for a Debilitating Medical Condition

PSDMC  
V4 5/2022

Registered cardholder applicants with a debilitating medical condition must use this form when applying for a Cannabis Control Division card. A *medical doctor or doctor of osteopathy* must complete this form for the registered cardholder applicant.

**Completion of this form does not constitute a prescription for marijuana.**

**Physician and Patient: Read This Checklist Before Sending This Form to the Department**

- The physician completing this form must respond to items one, two, and three on page two in the space provided or in attached documentation.
- Forms must be filled out completely and may not be modified or edited in any way.
- A patient application is also required with this form. Patients should go to the Department of Revenue Transaction Portal (TAP) at <https://tap.dor.mt.gov> to submit their application
- The Physician Statement must be submitted with a patient’s application within 60 days of the date of the physician’s assessment. Registry Identification cards will be issued based on the date of application approval for the period of time specified by the physician on page 3. Physician statements submitted more than 60 days after the date of assessment will not be accepted.

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_  
Last First MI

**This information must match the information on file with the Montana Board of Medical Examiners:**

Physician’s Name: \_\_\_\_\_ Montana License Number: \_\_\_\_\_

Physician Office Physical Address, City, State, ZIP: \_\_\_\_\_

Physical Address of Patient Assessment: \_\_\_\_\_

Physician Mailing Address, City, State, ZIP: \_\_\_\_\_

Physician’s Telephone Number: \_\_\_\_\_

**Initial one or two below:**

1. \_\_\_\_\_ I am the patient’s treating physician and this patient has been under my ongoing medical care as part of a bona fide professional relationship.

**OR;**

2. \_\_\_\_\_ I am the patient’s referral physician AND I have assumed primary responsibility for providing management and routine care of the patient’s debilitating medical condition after obtaining a comprehensive medical history and conducting a physical examination, including a personal review of any medical records maintained by other physicians and that may have included the patient’s reaction and response to conventional medical therapies ([16-12-509 \(2\)\(d\), MCA](#)).

**Please indicate the condition for which you are recommending marijuana. You may check more than one condition:**

- Cancer, glaucoma, or positive status for human immunodeficiency virus, or acquired immune deficiency syndrome when the condition or disease results in symptoms that seriously and adversely affect the patient's health status
- Cachexia or wasting syndrome
- Severe chronic pain that is persistent pain of severe intensity that significantly interferes with daily activities as documented by the patient's treating physician
- Intractable nausea or vomiting
- Epilepsy or an intractable seizure disorder
- Multiple sclerosis
- Crohn's disease
- Painful peripheral neuropathy
- A central nervous system disorder resulting in chronic, painful spasticity or muscle spasms
- Admittance into hospice care
- Post-traumatic stress disorder (PTSD)

**In a statement or in attached documentation:**

1. Specify the patient's debilitating medical condition. Describe the condition, why it is debilitating, and to what extent it is debilitating.
2. Describe medications, procedures, and other medical options used to treat the condition.
3. List restrictions to the patient's activities due to the use of marijuana.

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*Physician Statement for a Debilitating Medical Condition (continued)*

Specify the time period for which the use of marijuana would be appropriate (not to exceed one year per [16-12-509 \(2\)\(j\), MCA](#):

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Should there be a need to identify this time period for longer than one year, please indicate this in a response to question #1 on page 2 of this form. Per [16-12-503\(6\), MCA](#), even if the physician recommends more than one year, the registry identification card will expire 1 year after the date of issuance unless a physician has provided a written certification stating that a card is valid for a shorter period of time.

This patient assessment was conducted via telemedicine in accordance with [16-12-502\(2\)](#) and [16-12-509\(2\)\(d\), \(4\)](#), MCA.

Yes     No

**In signing this form, I certify:**

- a. I am a physician duly licensed to practice medicine in Montana under [MCA Title 37, Chapter 3](#).
- b. I am this patient's treating physician or referral physician and I have assumed primary responsibility for providing management and routine care of this patient's debilitating medical condition that qualifies the patient for this recommendation.
- c. Having completed a full assessment of the patient's medical history and current condition and as a result of the medical care and supervision I have provided, I verify that this patient has a debilitating medical condition as described above.
- d. I have reviewed all prescription and non-prescription medications and supplements used by this patient and have considered any potential drug interactions with marijuana.
- e. I have a reasonable degree of certainty that this patient's condition would benefit from the use of marijuana and that the potential benefits of marijuana will likely outweigh the health risks for this patient.
- f. I have described the potential risks and benefits of the use of marijuana to this patient.
- g. I will continue to serve as this patient's treating physician and will supervise the use of marijuana and evaluate the efficacy of the treatment.
- h. The information provided in this written certification is true and correct

Physician's Signature: \_\_\_\_\_ Date of assessment: \_\_\_\_\_

**Questions?** Call us at (406) 444-6900, or Montana Relay at 711 for the hearing impaired.

**Please give the completed original form to the patient**