MEDICAL CANNABIS VERIFICATION FORM

Office of the Secretary of State Department of Administrative Hearings

Mail this form to:
Secretary of State
Department of Administrative Hearings
Support Services Section
501 S. 2nd St., Room 212, Howlett Building
Springfield, IL 62756

Phone #: 217-782-7065

ilsos.gov

TO BE COMPLETED BY THE PETITIONER:

Petitioner (Please Print): ______________________________

Driver's License No.: ______________________________

I, the undersigned, hereby affirm that I am enrolled in the Compassionate Use of Medical Cannabis Pilot Program ("Program") pursuant to the recommendations of my physician and that the following is correct:

(1) My physician prescribed Medical Cannabis for a recognized medical condition or illness.

(2) I have been issued a Medical Cannabis card by the Illinois Department of Public Health.

(3) I have abided by all requirements and conditions of the Program to date.

(4) Please check as appropriate:

______I am stable in the Program.

______ While I hold a Medical Cannabis card, as of the date below, I have not used Medical Cannabis.

______________________________ ______________________________
Petitioner's Signature Signature Date

TO BE COMPLETED BY THE PHYSICIAN'S OFFICE:

Physician's Name (Please Print): ______________________________

Physician's Address: ______________________________

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Physician's Telephone: ______________________________

Medical License Number/Specialty: ______________________________

I, the undersigned, hereby affirm that I am the Petitioner's physician who recommended or who is reviewing the Petitioner's participation in the Medical Cannabis Program pursuant to the terms and conditions of the Program and the following is correct:

(1) The Petitioner has been stable on Medical Cannabis since ______________________________.

(2) The Petitioner is prescribed Medical Cannabis for the following condition or illness ______________________________.

(3) I expect the Petitioner to continue to use Medical Cannabis for the next ______________________________.

(4) The Petitioner's use of Medical Cannabis will not affect his or her ability to drive safely in the future.

______________________________ ______________________________
Physician's Signature Signature Date

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TO BE COMPLETED BY THE PRIMARY SUBSTANCE ABUSE/ALCOHOLISM TREATMENT PROVIDER:
(This section must be completed only after completion of the first two sections.)

Counselor's Name (Please Print):____

Agency's Name: ____

Agency's Address: ____

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Agency's Telephone: ____

Counselor's Treatment License #:____

I, the undersigned, hereby affirm that I am the Petitioner's primary treatment provider and I am fully aware of the contents of the instant form and that the following is correct:

(1) The Petitioner is currently classified by the evaluator as _______________________________.

(2) The Petitioner has successfully completed all treatment requirements and is not in need of further treatment.

(3) The Petitioner's use of Medical Cannabis will not affect his or her prognosis of alcohol-related arrests and Petitioner's prognosis remains _______________________________.

_______________________________ _______________________________
Counselor's Signature Signature Date

PLEASE NOTE THE FOLLOWING:

If the Petitioner is currently in a Medical Cannabis program at the time of the hearing, the completed form must be submitted at the time of hearing or the case will be continued to obtain this form.

All driving relief is contingent upon submission of said form at the hearing, and failure to report involvement in the Program at the time of the hearing will result in denial of driving relief, unless the hearing officer reopens the record to submit this form.

Only Petitioners classified High-Risk Dependent must demonstrate at least 12 months of stable use of Medical Cannabis prior to the date of hearing.