IOWA DEPARTMENT OF PUBLIC HEALTH
Office of Medical Cannabidiol (OMC)

IOWA MEDICAL CANNABIDIOL PROGRAM

Waiver for Increasing the Amount of 'THC per 90 Days' for a Certified Patient

Instructions – Type or print clearly and answer all of the questions.

This waiver does not constitute a prescription for medical cannabidiol.

Healthcare Practitioners - PROVIDE THE COMPLETED and SIGNED FORM TO THE PATIENT

Patients should Email the completed form to: medical.cannabidiol@idph.iowa.gov **Or mail the completed form to: Iowa Department of Public Health** **ATTN: OMC 321 E. 12th Street Des Moines, IA 50319-0075**
Please print clearly - Incomplete or unreadable forms may result in denial of the waiver
PATIENT INFORMATION
Name (First, Middle, Last)
Permanent Iowa Address (Street, Apt. #)
Address (City, State, ZIP Code)
Phone/Email (Phone number and email address)

HEALTH CARE PRACTITIONER INFORMATION		
Health Care Practitioner's Name (First, Middle, Last, Suffix)		
Medical License Number	**License State** (Must be licensed in Iowa)	**License Type** (MD, DO, PA, ARNP, DPM)
Practice Address (Street)		
Practice Address (P.O. Box, Suite #)		
Address (City, State ZIP Code)		
Phone Number	**Email Address**	
Medical Specialty (Oncology, Neurology, Pain Management, etc.)		

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NOTE: The waiver for increasing the amount of THC per 90 days for a registered medical cannabidiol patient requires a medical evaluation *after* the original certification (unless certified for a terminal illness). The medical evaluation and this waiver form must be completed by the original Healthcare Practitioner who certified the qualifying patient for participation in Iowa's Medical Cannabidiol Program.

I _____ (the Healthcare Practitioner), hereby certify that, based on the patient's medical history, in my professional judgment,_____(the registered qualifying patient), should be approved for an exception to the 4.5g THC per 90 day limit pursuant to the provisions of Iowa Code chapter 124 E. It is my professional judgment a quantity of _____g (must be indicated) per 90-day period should be approved to properly alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition.

Health Care Practitioner Signature	**Date of Signature (mm/dd/yy)**