Department of Corrections
WASHINGTON STATE

USE OF MEDICAL CANNABIS VERIFICATION

Name _____ Date of birth _____ DOC Number _____

Dear Health Care Professional:

The above named individual is on community supervision with the Washington State Department of Corrections. By state statute, the Department has the authority to impose conditions related to this individual's risk and needs. This individual indicates that the individual has a condition for which the use of medical cannabis has been recommended. The accompanying Authorization for Disclosure of Health Information allows you to provide the Department with current and future information related to this issue.

Please complete the following questions to assist the case manager in determining the approval of medical cannabis use. Thank you in advance for your assistance. If you have questions, you may contact the Assistant Secretary for Community Corrections at (360) 725-8787.

1. Is this individual under your care? ☐ Yes ☐ No
2. Are you recommending medical cannabis for this patient due to a diagnosis of Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No
   a. If the answer to question 2 is **Yes**, does he/she have anorexia? ☐ Yes ☐ No
   b. If the answer to question 2a is **Yes**, does he/she have weight loss? ☐ Yes ☐ No
3. Are you recommending medical cannabis for this patient due to nausea and vomiting associated with cancer chemotherapy? ☐ Yes ☐ No
   a. If the answer to question 3 is **Yes**, has the patient failed to respond to conventional antiemetic treatments? ☐ Yes ☐ No
   b. If the answer to question 3a is **Yes**, please describe what those treatments were (medication, dose, duration): _____
   _____
   c. What is the planned schedule of chemotherapy? _____
4. If you answered **No** to items 2 & 3, what is the reason you are recommending medical use of cannabis?
   _____
5. Do you agree to notify the Department's Assistant Secretary for Community Corrections of any changes in your answers? ☐ Yes ☐ No

Health care professional name _____ Signature _____ Date _____

License number _____ License type _____ Phone number _____

Address _____

Please return this and the Authorization for Disclosure of Health Information within 15 business days or as soon as possible to the supervised individual.

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.

Distribution: **ORIGINAL** - Case manager
COPY - Field Administrator/Appointing Authority