OFFENDER I.D. DATA:

Medicinal Use of Cannabis Verification

To be filled out by the Community Corrections Officer (CCO):

Patient's Name	Date of Birth	DOC Number

To be filled out by a Health Care Professional:

Dear Health Care Professional:

By state statute, the Washington State Department of Corrections (DOC) has the authority to supervise and impose conditions for convicted felons related to the offender's risk and needs. This offender has claimed that s/he has a condition for which the medicinal use of cannabis has been recommended. Please complete the following questions to assist DOC in determining the legitimacy of the claim. Thank you in advance for your assistance. If you have questions, please contact the Community Corrections Assistant Secretary at (360) 725-8787.

1. Is this patient under your care? ☐ Yes ☐ No

2. Are you recommending medical cannabis for this patient due to a diagnosis of Acquired Immunodeficiency 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 above, what is the reason you are recommending medicinal use of cannabis?

5. The patient's accompanying Release of Information authorizes you to provide the Department with current and future information related to this issue. Do you agree to notify the Department's Chief Medical Officer of any changes in your answers above? ☐ Yes ☐ No

Health Care Professional's Name (Print) | Signature | Date

License #: ______________________ License type: ______________________

Health Care Professional's Address ______________________ Phone Number ______________________

Health Care Professional - please return this form and the patient's Release of Information to:

Chief Medical Officer
Health Services Division
Washington State Department of Corrections
PO Box 41123
Olympia, WA 98504-2113

To be filled out by the Chief Medical Officer/designee:

I have reviewed this verification form and find that use of medical cannabis by this patient
consistent with Department policy.

☐ is ☐ is not

(Check one)

Physician's Name (Print) | Physician's Signature | Date

Instructions to DOC Chief Medical Officer/designee:

When form is complete:

1. Email your finding above to the Assistant Secretary for Community Corrections.
2. Send this form, the accompanying Release of Information, and any other documents to the Assistant Secretary for Community Corrections.