

**SUITABILITY FOR MEDICAL CANNABIS USE**

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| **TO BE COMPLETED BY THE SUPERVISED INDIVIDUAL** |

Name (last, first, middle initial) DOC number Location

[ ]  Yes [ ]  No [ ]  N/A Are you eighteen years of age or older?

[ ]  Yes [ ]  No [ ]  N/A Do you have a valid authorization for medical cannabis?

[ ]  Yes [ ]  No [ ]  N/A Have you attached a copy of your valid authorization for medical cannabis to this request?

 What is the expiration date of the authorization?

[ ]  Yes [ ]  No [ ]  N/A Have you attached a completed DOC 13-035 Authorization for Disclosure of Health Information?

[ ]  Yes [ ]  No [ ]  N/A Have you attached a completed DOC 14-053 Use of Medical Cannabis Verification?

[ ]  Yes [ ]  No [ ]  N/A If you have a court-ordered condition for mental health treatment, have you successfully fulfilled the terms of treatment?

 If no, does your mental health treatment provider support your use of THC/cannabis while you are in treatment? [ ]  Yes [ ]  No

[ ]  Yes [ ]  No [ ]  N/A If you have a court-ordered condition for substance abuse treatment or chemical dependency treatment, have you successfully fulfilled the terms of treatment?

 If no, does your substance abuse or chemical dependency treatment provider support your use of THC/cannabis while you are in treatment?

 [ ]  Yes [ ]  No

To the best of my knowledge, I agree that the information I have provided above is accurate:

Signature Date

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| **TO BE COMPLETED BY THE CASE MANAGER** |

[ ]  Yes [ ]  No [ ]  N/A The verbal notice of intent and/or receipt of a valid authorization copy has been documented as a chrono in the individual’s electronic file.

[ ]  Yes [ ]  No [ ]  N/A Verified active case(s) eligibility for cannabis use through any applicable jurisdiction.

[ ]  Yes [ ]  No [ ]  N/A Verified the healthcare provider identifiedis permitted to authorize the issuance of cannabis?

[ ]  Yes [ ]  No [ ]  N/A Verified that the mental health treatment provider will support use of THC/cannabis while in treatment with a cannabis authorization?

[ ]  Yes [ ]  No [ ]  N/A Verified that the substance abuse treatment or chemical dependency treatment provider will support use of THC/cannabis while in treatment with a cannabis authorization?

[ ]  Yes [ ]  No [ ]  N/A Verified there are no specific supervision conditions that are contrary to the supervision of the individual?

Comments:

Case manager Email address Date

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| **TO BE COMPLETED BY THE APPOINTING AUTHORITY/FIELD ADMINISTRATOR** |

[ ]  Yes [ ]  No Are all question responses or sub-questions answered?

[ ]  Yes [ ]  No The individual has signed and dated attesting to the accuracy of the information provided.

[ ]  Yes [ ]  No All case manager responses are completed.

[ ]  Yes [ ]  No The individual has a valid authorization for medical cannabis use.

[ ]  Yes [ ]  No There are no specific supervision conditions that are contrary to the supervision of the individual.

[ ]  Yes [ ]  No The following documents are complete and included for this review:

* + - DOC 13-035 Authorization for Disclosure of Health Information
		- DOC 14-053 Use of Medical Cannabis Verification
		- DOC 14-055 Suitability for Medical Cannabis Use

**Appointing Authority/Field Administrator Determination:**

Medical Cannabis Use Suitability: [ ]  Approved [ ]  Denied [ ]  Documentation incomplete

If approved, the Appointing Authority/Field Administrator will notify the case manager to remove the “Department cannabis imposed condition or prohibition” in the individual’s electronic file.

Comments:

      

Name Signature Date

**The records contained herein are protected by Federal Confidentiality Regulations 42 CFR Part 2. The Federal rules prohibit further disclosure of this information to parties outside of the Department of Corrections unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.**

Distribution: **ORIGINAL** - Case manager

**COPY** - Assistant Secretary for Community Corrections, Community Corrections Supervisor