



Medical Marijuana Program

450 Columbus Blvd., Suite #901, Hartford, CT 06103-1840 • (860) 713-6066
Fax: (860) 706-5361 • E-mail: dcp.mmp@ct.gov • Website: www.ct.gov/dcp/mmp



Petition to Add a Medical Condition, Medical Treatment or Disease to the List of Debilitating Conditions

INSTRUCTIONS: Please complete each section of this Petition and attach all supportive documents. All attachments must include a title referencing the Section letter to which it responds. Any Petition that is not fully or properly completed will not be submitted to the Board of Physicians.

Please Note: Any individually identifiable health information contained in a Petition shall be confidential and shall not be subject to disclosure under the Freedom of Information Act, as defined in section 1-200, Connecticut General Statutes.

Section A: Petitioner's Information

Name (First, Middle, Last):

Home Address (including Apartment or Suite #):

City:

State:

Zip Code:

Telephone Number:

E-mail Address:

Section B: Medical Condition, Medical Treatment or Disease

Please specify the medical condition, medical treatment or disease that you are seeking to add to the list of debilitating medical conditions under the Act. Be as precise as possible in identifying the condition, treatment or disease.

Section C: Background

Provide information evidencing the extent to which the condition, treatment or disease is generally accepted by the medical community and other experts as a valid, existing medical condition, medical treatment or disease.

- Attach a comprehensive definition from a recognized medical source.
- Attach additional pages as needed.

Section D: Negative Effects of Current Treatment

If you claim a treatment, that has been prescribed for your condition causes you to suffer (i.e. severe or chronic pain, spasticity, etc.), provide information regarding the extent to which such treatment is generally accepted by the medical community and other experts as a valid treatment for your debilitating condition.

- Attach additional pages as necessary.
- If not applicable, please indicate N/A.



Medical Marijuana Program



450 Columbus Blvd., Suite #901, Hartford, CT 06103-1840 • (860) 713-6066
Fax: (860) 706-5361 • E-mail: dcp.mmp@ct.gov • Website: www.ct.gov/dcp/mmp

Section E: Negative Effects of Condition or Treatment

Provide information regarding the extent to which the condition or the treatments thereof cause severe or chronic pain, severe nausea, spasticity or otherwise substantially limits one or more major life activities.

- Attach additional pages as necessary.

Section F: Conventional Therapies

Provide information regarding the availability of conventional medical therapies, other than those that cause suffering, to alleviate suffering caused by the condition or the treatment thereof.

- Attach additional pages as necessary.

Section G: General Evidence of Support for Medical Marijuana Treatment

Provide evidence, generally accepted among the medical community and other experts, that supports a finding that the use of marijuana alleviates suffering caused by the condition or the treatment thereof.

- Attach additional pages as necessary.

Section H: Scientific Evidence of Support for Medical Marijuana Treatment

Provide any information or studies regarding any beneficial or adverse effects from the use of marijuana in patients with the condition, treatment or disease that is the subject of the petition.

- Supporting evidence needs to be from professionally recognized sources such as peer reviewed articles or professional journals.
- Attach complete copies of any article or reference, not abstracts.

Section I: Professional Recommendations for Medical Marijuana Treatment

Attach letters in support of your petition from physicians or other licensed health care professionals knowledgeable about the condition, treatment or disease at issue.



Medical Marijuana Program



450 Columbus Blvd., Suite #901, Hartford, CT 06103-1840 • (860) 713-6066
Fax: (860) 706-5361 • E-mail: dcp.mmp@ct.gov • Website: www.ct.gov/dcp/mmp

Section J: Submission of Petition

In the event you are unable to answer or provide the required documentation to any of the Sections above (excluding Section D); provide a detailed explanation indicating what you believe is “good cause” for not doing so.

- Attach additional pages as necessary.

I hereby certify that the above information is correct and complete.

My signature below attests that the information provided in this petition is true and that the attached documents are authentic. I formally request that the commissioner present my petition and all supporting evidence to the Board of Physicians for consideration.

Signature:



Date Signed: