Cannabis Control Commission
COMMONWEALTH OF MASSACHUSETTS

Application: Certifying Healthcare Providers

This form is for use by Certifying Healthcare Providers ("Healthcare Providers") pursuant to 935 CMR 501.000: Medical Use of Marijuana. Please note that the information contained within this document, and any publicly available guidance, is not legal advice. Please consult an attorney if you have any questions regarding the laws and regulations that apply to the medical use of marijuana.

General Information

Pursuant to 935 CMR 501.006, 935 CMR 501.007, and 935 CMR 501.008, Healthcare Providers may request to register with the Commission for the purposes of certifying qualified patients for the medical use of marijuana. For the purposes of this request, Healthcare Providers include nurse practitioners, physicians, and physician assistants.

Healthcare Providers are required to have an active license, with no prescribing restrictions, to practice as nurse practitioners, physicians, and physician assistants, as applicable. Additionally, all individuals must possess a Massachusetts Controlled Substances Registration from the Department of Public Health (DPH). Nurse practitioners and physician assistants applying to be a Healthcare Provider must also possess board authorization by the Massachusetts Board of Registration of Nursing or Physician Assistants, as applicable, to practice as a nurse practitioner or physician assistant, as well as an attestation from a supervising physician stating that there is a mutually agreed upon relationship regarding the proposed Healthcare Provider's prescriptive practices.

All individuals applying to be registered as a Healthcare Provider must have at least one established place of practice in Massachusetts.

Instructions

The application contains the following three (3) sections that must be fully completed:

I. Healthcare Provider Information;

II. Required Documentation; and
III. Required Attestations

Please ensure that all responses are typed into the application. All attachments should be labeled to reference the document that is required. Please use the reference label that will be associated with each required document (i.e. "Document A"). This reference label should be on the top right corner of each page of the document. Every section and numbered item of this application is required to be filled in with the required information. No section or numbered item should be left blank.

Please note that there is no application or registration fee associated with this application.

Completed Request

Once completed, the application and all required information shall then be combined into a single PDF document and emailed to **licensing@cccmass.com**. Once received, the application will be reviewed for completeness. If the Commission requires additional information, a notice will be sent to the email address stated on the application.

When approved, you will receive an automatic notice from the Medical Use of Marijuana Online System ("MMJOS") with your username and the need to create a password. Once an account is established in MMJOS, you may certify a patient, search your patients, update your registration information, and generate reports.

I. Healthcare Provider Information

1. Healthcare Provider Name *(first, middle, and last)* and Email Address:

2. Healthcare Provider Name of Practice, Business Address *(Massachusetts location)*, and Business Phone Number:

3. Healthcare Provider's Main Area of Specialty:

4. Healthcare Provider Type *(select only one)*:

   ☐ Physician

   ☐ Nurse Practitioner

   ☐ Physician Assistant

5. Professional Active License Number *(Board of Registration in Medicine ("BORIM"), Board of Registration in Nursing ("BORIN"), or Board of Registration of Physician Assistants ("BORPA"), as applicable)*:

6. Massachusetts Controlled Substances Registration ("MCSR") Number:

II. Required Documents

As part of this application, the following documentation is required to be provided to the Commission for an effective determination to be made on the request. Please provide the following documents and clearly label them using the indicated text:

a. Documentation showing that the applicant has an active license (BORIM, BORIN, or BORPA) to practice *(this may include a website printout)* ("Document A").

b. Documentation showing that the applicant has an active MCSR number *(this may include a website printout)* ("Document B").

c. Documentation in the form of the Articles of Incorporation from the Massachusetts Secretary of the Commonwealth's office (or comparative document) demonstrating that the applicant is practicing from the stated organization with the business address stated above ("Document C").

d. Attestation from supervising Physician stating that the Nurse Practitioner or Physician Assistant is certifying patients for medical use of marijuana pursuant to the mutually agreed upon relationship between the Nurse Practitioner or Physician Assistant and the Physician supervising the proposed Healthcare Provider's prescriptive practice *(required only for Nurse Practitioners and Physician Assistants)* ("Document D").

e. Optional Documentation (*Nurse Practitioners only*): Nurse Practitioners may submit a waiver from the requirement in "Document D" if they can demonstrate compliance with 244 CMR 4.07. If the applicant intends to submit a waiver in connection with this provision, the waiver should be completed and included as part of this request. The waiver form can be found on the Commission's website here: **https://masscannabiscontrol.com/public-documents/forms-templates/**. ("Document E").

III. Required Attestations

Please attest to the following statements by initialing the corresponding box:

☐ a. The Healthcare Provider applicant has reviewed and understands the requirements under 935 CMR 501.006, 935 CMR 501.007, or 935 CMR 501.008, as applied to the individual.

☐ b. The Healthcare Provider applicant has reviewed and understands the requirements under 935 CMR 501.110 regarding the written certifications of a debilitating medical condition for qualified patients.

☐ c. All requested information and documentation have been provided and are accurate and true.

By signing this document, I, the stated Healthcare Provider affirm that all the information provided above is accurate and true.

Healthcare Provider Signature:

Signature Date:

If you have any questions regarding the Healthcare Provider process or requirements, please contact the Commission at licensing@cccmass.com.

Note: Please ensure this form, along with all required and supplemental documentation, is combined into a single PDF document. The final PDF document will represent your application. Your application should be sent to licensing@cccmass.com for consideration.