Patient Application Process

- This application is for new applicants and current/renewing patients,
- Fill and complete the necessary application form/s. Complete entirety and gather any necessary supporting documentation. Please note that all pages of this application must be filled and signed,
- Fill and complete the Attestation Statement. Each applicant must submit this document and it must be signed,
- Once your forms are complete and you have collected all necessary documentation, contact the programme to meet with a backgrounds investigator and submit your application.

All applications must meet each of the following statutory requirements:

- Must be over 21 years of age,
- May not have any Controlled Substance felony convictions that have not been fully discharged in the ten years immediately preceding the date of application,
- May not have any other felony convictions that have not been fully discharged for five years prior to applying for your license,
- Must be resident of Uganda at the time of application and for two years immediately prior to application,
- May not have a criminal history that indicates that she or he is not of good moral character,
- May not employ, be assisted by or financed in whole or in part by any other person whose criminal history indicates he or she is not of good character and reputation,

Notes:

- You can use the checklist to be sure you have everything for your application.
- If the patient is too ill to sign, the patient and the person signing this form should consider completing a “Caregiver Application”, so that they may assist the patient with their medical cannabis.
- If the patient is under 21 years old, please include a copy of the patient’s birth certificate. The person signing the form must be a parent or guardian and must complete a “Caregiver Application”.
- Make sure your form is complete and all the information is correct.
- Clear copy of current national ID of the patient and the care giver
- Copy of all medical forms and reports
- Sign and date the form
- Copy of payment receipt

MEDICAL CANNABIS JOINT RESEARCH PROGRAMME- MCRP

FORM5: PATIENT REGISTRATION FORM To ensure confidentiality, information regarding application status will not be given over the phone. Once applications are processed, communication will be sent to the Patient's residence with further instructions for the finalization of the Registry Card. Application fees: 50,000 ugx			STAPLE TWO PHOTOS HERE
SECTION1: PATIENT INFORMATION			
FIRST NAME		**LAST NAME**	
DATE & PLACE OF BIRTH		**ADDRESS**	
TELEPHONE		**EMAIL**	
SECTION2: CARE GIVER / GUARDIAN INFORMATION			
FIRST NAME		**LAST NAME**	
DATE & PLACE OF BIRTH		**ADDRESS**	
TELEPHONE		**EMAIL**	
SECTION3: MEDICAL PROVIDER INFORMATION			
FIRST NAME		**LAST NAME**	
DATE & PLACE OF BIRTH		**ADDRESS**	
TELEPHONE		**EMAIL**	
CLINICAL LICENSURE		**Medical License #:**	
BOARD CERTIFIED SPECIALTY:		**MCRP #:**	

PATIENT'S ATTESTATION STATEMENT

Applicant Signature: I have included a copy of my national ID. By signing below, I agree that: All the information given above is complete and correct. I will follow the limits and restrictions on my right to have and use medical cannabis under the laws of The Republic of Uganda. I allow the Medical Cannabis Joint Research Programme to discuss my medical condition, including treatment records, test results and evaluations specific to enrollment in the Medical Cannabis Programme.

* All original pages of the application, a photocopy of the patient's National ID and supporting documents should be sent together. This may be done by the patient or the practitioner. A practitioner shall not be subject to arrest or prosecution, penalized in any manner or denied any right or privilege for recommending the medical use of cannabis or providing written certification for the medical use of cannabis as per statue.

PATIENT NAME:	**CARE GIVER / GUARDIAN NAME:**
SIGNATURE:	**SIGNATURE:**
DATE	**DATE**

SECTION4: PHYSICIAN CERTIFICATION

PATIENT'S INSTRUCTIONS: Have your physician complete this entire section. This section should be submitted with your completed application to the programme – partial applications will not be accepted. The patient application must be received by ministry of health, within 7 days of the physician's signature date. Faxed and electronic copies will not be accepted.

Note: This certification is provided per statute you must first see the patient in-person.

Provide the date and place of your last in-person visit here:
Based on your examination of the patient, by signing below you are certifying everything below:

- The patient's condition is chronic and debilitating,
- You have discussed the potential risks and benefits with the patient,
- You find that the potential health benefits of the medical use of cannabis likely outweigh the health risks for the patient,
- You understand the Medical Cannabis Program needs clinical records annually for verification purposes. You are licensed in Uganda to prescribe and administer drugs.

Instructions for Medical Providers

Practitioners must have a physician-patient relationship with the qualified patient. You must conduct an in-person evaluation of the qualified patient prior to issuing a certification. Certifications via telemedicine will be accepted ONLY after a patient has been seen in-person.

PLEASE PRINT CLEARLY OR TYPE THE APPLICATION – The medical form can be completed using a computer, and then printed and signed, or it can be handwritten.
Page 1 - Completed by the patient including their name, demographics, current address, current telephone number, and original signature (photocopies not accepted).
Page 2 - Filled out by a medical provider (e.g. Doctor, Nurse Practitioner, prescribing Psychologist, Dentist, etc. who is allowed by law to prescribe controlled substances in the Republic of Uganda). Please Note: Physicians and Fellows must pre-qualify and ethically cleared to join the MCRP otherwise they do not have the credentials necessary to meet regulatory requirements.

Please have attending physicians complete the certification. **Ensure the following information is present:**

1. Patient's legal name and date of birth (matching the patient's National ID);
2. Address where the examination took place and how long this patient has been in your care;
3. Reason for provider's certification (i.e., approved condition/diagnosis): Check all conditions that apply to the patient and circle the primary certifying condition.
4. Provider's information:
    - Name, clinical license held, and board specialty
    - Medical License number
    - Other Reference as may be required
    - MCRP Controlled Substance License number.
    - Office address, mailing address, phone number, and fax number
    - Original provider signature and date (photocopies not accepted)

FORM6: MEDICAL CERTIFICATION FORM

To ensure confidentiality, information regarding application status will not be given over the phone. Once applications are processed, communication will be sent to the Patient's residence with further instructions for the finalization of the Registry Card.

STAPLE TWO PHOTOS HERE

SECTION1: PATIENT INFORMATION

FIRST NAME		**LAST NAME**	
DATE & PLACE OF BIRTH		**ADDRESS**	
TELEPHONE		**EMAIL**	

DIGNOSIS	REMARKS
1. Alzheimer's Disease 2. Amyotrophic Lateral Sclerosis (ALS) 3. Autism Spectrum Disorder 4. BPH 5. Cancer 6. Cachexia or Wasting Syndrome 7. Crohn's Disease	
8. Chronic debilitating Migraines or New daily persistent headache 9. Damage to the Nervous Tissue of the Spinal Cord (with objective neurological indication of intractable spasticity) 10. Decompensated Cirrhosis 11. Epilepsy/Seizure Disorder 12. Friedreich's Ataxia	
13. Glaucoma 14. Hepatitis C Infection 15. HIV/AIDS 16. Hospice Care 17. Huntington's Disease	
18. Inclusion Body Myositis 19. Inflammatory Autoimmune-mediated Arthritis 20. Intractable Nausea/Vomiting 21. Lewy Body Disease	
22. Multiple Sclerosis 23. Obstructive Sleep Apnea 24. Opioid Use Disorder 25. Painful Peripheral Neuropathy	
26. Parkinson's Disease 27. Post-Traumatic Stress Disorder (PTSD) 28. Severe Anorexia/Cachexia 29. Severe, debilitating pain that has not responded to previously prescribed medication or surgical measure for more than three (3) months, or for which	

other treatment options produced serious side effects. 30. Seizures 31. Severe and persistent muscle spasms, including but not limited to those characteristic of Multiple Sclerosis	
32. Spasmodic Torticollis (Cervical Dystonia) 33. Spinal Muscular Atrophy 34. Terminal Illness 35. Ulcerative Colitis **36. Others**	

I have established a bona fide physician-patient relationship with……………………………………………………… (patient name) beginning ……………………… (date of first patient visit to your office). This qualifying patient is under my care, either for primary care or the debilitating medical condition listed on this form

I have completed an assessment of the qualifying patient's medical history, including medical records from other treating physicians for the qualifying condition. I have established a medical record of the qualifying patient with regards to the medical condition, continued treatment under my care, and will document follow-up to determine efficacy of the medical cannabis treatment

I have assessed this patient for history of substance use disorder.

If a history of substance abuse has been identified. The programme requests your acknowledgement of the history of substance abuse, and your confirmation that medical cannabis is an appropriate treatment option to include a commitment to monitor patient closely.

PHYSICIAN'S ATTESTATION

I……………………………………………….., (physician), hereby certify that I am a physician duly licensed to practice medicine in Republic of Uganda. It is my professional opinion that the qualifying patient is likely to receive therapeutic or palliative benefit from the medical use of cannabis to treat or alleviate the patient's qualifying debilitating medical condition or symptoms associated with the debilitating medical condition. Further, it is my professional opinion that the potential benefits of the medical use of cannabis would likely outweigh the health risks for this patient. I attest that the information provide in this written certification is true and correct.

Medical Provider Name:
MCRP No.

Signature:

Date:

Medical notes must be attached to confirm the qualifying condition(s) for the patient's application. Ensure these materials are submitted with the application.

For Official Use