



Medical Marijuana Program

165 Capitol Avenue, Room 147, Hartford, CT 06106-1630 • (860) 713-6066
Fax: (860) 706-5361 • E-mail: dcp.mmp@ct.gov • Website: www.ct.gov/dcp/mmp



Physician Decertification Form

1. You may only use this form to decertify a patient if you were the patient's certifying physician. If you have concerns about a patient that was certified for the palliative use of marijuana by a different physician, please address your concerns with that physician.
2. Please type or neatly print all required sections of the form.
3. After completing this form, you must sign and date it.
4. Upon receiving this form, the Department will contact your patient and their caregiver, if applicable, to inform them that their medical marijuana certification is no longer in effect and that they have been decertified. Your patient will have 30 days from when they receive notice from the Department to provide a new, valid physician certification before their registration will be rescinded.
5. Please mail, e-mail or fax this form to the Department of Consumer Protection, Attention Medical Marijuana Program, at one of the above addresses.

Physician Information		
Last Name:	First Name:	Middle Initial:
CT Medical License Number:		
Mailing Address:		
City:	State:	Zip Code:
Patient Information		
Last Name:	First Name:	Middle Initial:
Date of Birth:		
Were you the patient's certifying physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	In your professional opinion, should the above named patient discontinue their palliative use of marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please write a brief statement explaining why you seek to decertify this patient.

Certification:	
I have reviewed this form and, to the best of my knowledge, it is accurate and complete. I certify under penalty of law (Connecticut General Statute Section 53a-157b) that the above information is the truth to the best of my knowledge.	
I understand that the Department of Consumer Protection may contact me to confirm the information in this form.	
Physician Signature: 	Date Signed: