Initial Application for Authorization to Provide Written Certifications for the Use of Medicinal Cannabis

This form is available in a "pdf" format, with fillable fields, on the KBML's website, https://kbml.ky.gov/Pages/Medical-Cannabis.aspx. Once completed, it must be printed, signed and returned to the KBML. Original signatures are required. Incomplete applications will be returned.

Name: _____ KY MD/DO License No. _____

Primary practice address: _____

Telephone No. _____ E-mail address: _____

I, _____, M.D./D.O., hereby certify that I am the person named in the application, and being duly cautioned and sworn, I hereby affirm under oath as follows:

1) My medical/osteopathic license is not probated, limited, restricted, suspended, revoked, or subject to peer assistance in the Commonwealth of Kentucky or in any other state, federal or international jurisdiction.

2) I have never been subject to disciplinary action by a licensing entity of any state, federal or international jurisdiction, including the board or the U.S. Drug Enforcement Administration (DEA), that was based, in whole or in part, on the inappropriate prescribing, dispensing, diverting, administering, supplying or selling a controlled substance or other dangerous drug.

3) To the best of my knowledge, there are no pending investigations against my medical license in the Commonwealth of Kentucky or any other state, federal or international jurisdictions.

4) I hold an active and valid DEA permit. (My DEA # is _____)

5) I am currently registered to use any and all electronic prescription drug monitoring program systems for monitoring scheduled controlled substances and medicinal cannabis currently in use in the Commonwealth of Kentucky (i.e. KASPER) pursuant to KRS 218A.202.

6) I do not hold an ownership or investment interest in or compensation agreement with a cannabis business licensed under KRS Chapter 218B. I agree not to obtain ownership or investment interest in or enter into a compensation agreement with a cannabis business licensed under KRS Chapter 218B while authorized to provide written certifications for the use of medicinal cannabis;

7) As evidence by the attached (*attach documentation), I have completed at least six (6) hours of Category I continuing medical education in a course or courses approved by the board specific to the following:

- Diagnosing qualifying medical conditions;
- Treating qualifying medical conditions with medicinal cannabis; and
- The characteristics of medicinal cannabis and possible drug interactions.

8) I have read, I understand and I agree to comply with all provisions of the board's regulation, 201 KAR 9:067.

Attestation

By submitting this application and signing below, I understand and agree that any false or misleading statements provided in conjunction with this application and/or my failure to abide by the attestations contained herein may result in discipline, including up to revocation, against my license to practice medicine or osteopathy in the Commonwealth of Kentucky pursuant to KRS 311.595(1), (9), and/or (10).

Date: _____ Signature: _____

Printed Name: _____

Please submit a non-refundable fee of **$100** with this application. Choose one of the following:

___ Check (payable to the Kentucky Board of Medical Licensure)
Check No. _____

___ Money Order
Order No. _____

___ Credit Card
Type (Visa, Mastercard, etc.): _____
Card Holder's Name (as printed on card): _____
Billing address: _____
_____
Phone No. _____
Card No.: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __
Expiration Date: __ __ / __ __ /__ __ __ __
Security Code: _____

***** Original signatures required/Faxes Not Accepted *****

Return original to:
KBML
Attn: Medicinal Cannabis
310 Whittington Parkway, Suite 1B
Louisville, KY 40222

**** For KBML use only ****

___ Fee
___ KBML Rec.
___ CME Doc.
___ KPHF
___ OIG/CHFS

Application Approved: ____
Date Effective: _____
Expiration: March 1, 20____
KBML Staff: _____