

**Renewal 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) Since I last applied, I have not been subjected 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) Since I last applied and as evidence by the attached (*attach documentation), I have completed at least three (3) 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 reviewed, 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) ___ Money Order
 Check No. _____ 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: _____