



**Department of Health**  
**Center for Professional Licensing**  
Room 105A - 3 Capitol Hill  
Providence, RI 02908-5097  
401-222-3752 - [www.health.ri.gov/hsr/mmp](http://www.health.ri.gov/hsr/mmp)

**PRACTITIONER WRITTEN CERTIFICATION FORM  
FOR USE WITH AUTISM SPECTRUM DISORDER DIAGNOSIS**

NOTE: A patient who has been diagnosed with Autism Spectrum Disorder based on diagnostic criteria listed in DSM-V – Diagnosis Code 299.00 may qualify for registration as a patient in the Rhode Island Medical Marijuana Program only if the patient presents with one or both the following symptoms. Please check symptom(s) that apply.

- Repetition of self-stimulatory behavior of such severity that the physical health of the persons with ASD or others is jeopardized, and/or
- Avoidance of others or inability to communicate with others to such severity that the physical health of the person with ASD is jeopardized.

For patients who meet the above diagnostic criteria, the practitioner signing this form is certifying that all of the following treatment considerations and practices have been met:

I have considered FDA-approved medications for this patient, including the off-label use of the pharmaceutical grade forms of pure CBD, prior to initiating medical marijuana therapy. If use of these medications was not implemented, I have documented the reason in the patient's medical record. \_\_\_\_\_ (Initial here)

If this patient is a minor, I have consulted with a pediatric sub-specialist in child psychiatry, pediatric neurology, or developmental pediatrics prior to signing this form, and the results of that consult is documented in the patient's medical record. \_\_\_\_\_ (Initial here)

I hereby certify that I will assess this patient (if he/she is a minor) at least three (3) months after initiation of medical marijuana therapy, in consultation with a pediatric sub-specialist in child psychiatry, pediatric neurology, or developmental pediatrics. This assessment and consultation will be documented in the patient's medical record. \_\_\_\_\_ (Initial here)

I hereby certify that I will discontinue medical marijuana therapy if there is no improvement in the patient's presenting symptom/s as listed above or if there is a worsening of those symptoms. If this is the case, I agree to contact the RIDOH Medical Marijuana Program to withdraw this Certification. (NOTE: Another trial of medical marijuana therapy will be allowed only after the passage of at least three (3) months after the previous trial of medical marijuana has been discontinued.) \_\_\_\_\_ (Initial here)

Practitioner's Printed Name: \_\_\_\_\_

Practitioner's Signature \_\_\_\_\_ DATE: \_\_\_\_\_