



**State of Vermont
 Marijuana Registry**
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Department of Public Safety

MENTAL HEALTH CARE PROVIDER FORM

Instructions: This form *must* be completed and submitted for all applicants with Post-Traumatic Stress Disorder (PTSD) identified as a debilitating medical condition on the Health Care Professional Verification Form. Vermont law requires the Vermont Marijuana Registry to confirm applicants with PTSD are undergoing psychotherapy, or counseling with a licensed mental health care provider. The Vermont Marijuana Registry may contact the mental health care provider completing this form to confirm the accuracy of the information contained on this form.

“**Mental Health Care Provider**” means:

“A person license to practice medicine who specializes in the practice of psychiatry; a psychologist, a psychologist-doctorate, or a psychologist-master as defined in 26 V.S.A. § 3001; a clinical social worker as defined in 26 V.S.A. § 3201; or a clinical mental health counselor as defined in 26 V.S.A. § 3261.”

1. Patient Information

Last Name: _____ First Name: _____ M.I. _____

Date of Birth: _____ Telephone Number: _____

2. Mental Health Care Professional Information

Last Name: _____ First Name: _____ M.I. _____

Business Mailing Address: _____

City, State, Zip Code: _____ Telephone Number: _____

3. Licensure Information (Subsections A and B MUST be completed**)**

- A. Psychologist Psychologist-doctorate Psychologist-master
 Psychiatrist Clinical social worker Clinical mental health counselor

B. License Number: _____

4. Verification

I certify I am providing psychotherapy and/or counseling to the aforementioned patient. I declare under pains and penalty of perjury that the information provided on this form in its entirety is true and accurate.

SIGNATURE: _____ **DATE:** _____

OFFICE USE ONLY: Processed: Date: _____ Initials: _____ Notes: _____

