



**STATE OF NEW HAMPSHIRE**  
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
***DIVISION OF PUBLIC HEALTH SERVICES***  
***THERAPEUTIC CANNABIS PROGRAM***

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29 HAZEN DRIVE, CONCORD, NH 03301  
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**WRITTEN CERTIFICATION EXTENSION**

If a Written Certification has been previously issued for less than 3 years, the **same certifying provider** who issued that Written Certification may extend the certification by completing and submitting this form.

- A Written Certification may be extended more than once, but the total duration of the Written Certification, including any extensions, shall not exceed 3 years.
- This “Written Certification Extension” form does not require the submission of a new Written Certification, a new Patient Application, or an Application Fee.
- If an extension duration is indicated below which exceeds the maximum of 3 years from the original effective date, the extension duration shall default to the maximum duration allowed.

**EXTENSION REQUIREMENTS.** If the following requirements are not met, the patient will need to renew their card, by submitting a new Written Certification, a new Patient Application, and the Application Fee:

1. This form must be signed by the same provider that signed the current Written Certification.
2. This form must be signed and dated no later than the expiration date of the patient’s current card.
3. The Therapeutic Cannabis Program allows a limited 30-day grace period after your patient’s Registry ID Card expires to receive this form.

**There are no exceptions to these extension requirements.**

Mail or fax the completed form to:      NH Department of Health and Human Services  
 Therapeutic Cannabis Program  
 29 Hazen Drive  
 Concord, NH 03301  
Fax: (603) 271-8134

*Please type or print clearly.*

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Certifying Provider Name: \_\_\_\_\_ Practice Fax: \_\_\_\_\_

Certifying Provider State License Number: \_\_\_\_\_ Practice Phone: \_\_\_\_\_

Expiration Date of Patient’s Current Registry ID Card (if known): \_\_\_\_\_

Length of Extension:     One year     Maximum allowed     Other duration \_\_\_\_\_

\_\_\_\_\_  
**Signature of Certifying Provider**

\_\_\_\_\_  
**Date**