



Submitting an Electronic Physician Certification Form as a certifying physician or nurse practitioner

The steps below provide how-to guidance for physicians and nurse practitioners to submit an Electronic Physician Certification Form (EPCF), which certifies the patient with a qualifying medical condition (QMC) for a medical marijuana ID card in Missouri.

An EPCF **must** be completed by a certifying physician/nurse practitioner that has an approved PHY# registration within their online registry portal account. If you are a certifying physician/nurse practitioner and have not yet applied for physician and nurse practitioner registration, please refer to the Physician and Nurse Practitioner Registration tutorial for more information.

Physicians and nurse practitioners must submit the EPCF on behalf their certified patients, certified patients must select and submit this form within their patient application . Physician Certification Forms must be submitted with the patient application within 30 days of the certifying physician/nurse practitioner's signature date on the submitted electronic form, therefore, certification forms must not be issued more than 30 days prior to the date the patient will submit their application.

EPCF's dated more than 30 days from the time of patient application submission will be rejected, and a new electronic form will be required. The expired electronic form will be de-activated upon processing to prevent the patient from accessing the expired form during resubmission. The certifying physician will receive a notification of deactivation to alert them that their patient may be requesting a new electronic form.

Before certifying a patient, please review the Department of Health and Senior Services (DHSS): [Guidance for Certification Appointments](#).

How-to Submit an EPCF

1. Navigate to the **Online Registry Portal website** at: <https://mo-public.mycomplia.com>
2. Enter your **Username (email)** and **Password**.
3. Check the **Accept Terms and Conditions** box if it is not already checked.
4. Click **I'm not a robot**. Click **Sign In**.

The image shows a 'Sign-in' form with a dark header. Below the header are two input fields: 'Email *' and 'Password *'. Below the password field is a checkbox for 'Accept Terms and Conditions'. Below that is a reCAPTCHA widget with the text 'I'm not a robot'. At the bottom are two green buttons: 'SIGN IN' and 'FORGOT PASSWORD'. Red boxes highlight the email and password fields, and red arrows point to the 'Accept Terms and Conditions' checkbox and the reCAPTCHA widget.

1. Click 'Create New Application'.

The image shows an account selection screen. At the top, it says 'Selected Account: John Doe' next to a person icon. Below that is a 'Switch Account' dropdown menu. At the bottom, there is a green button with a plus sign and the text '+ CREATE NEW APPLICATION'. A red box highlights the '+ CREATE NEW APPLICATION' button.

2. For the Application Type, click the 'I am a' drop down box, and select 'Physician/Nurse Practitioner'.

The image shows a 'New Application' form. At the top, it says 'You are creating a new application for: John Doe'. Below that is a dropdown menu labeled 'I am a *'. The dropdown menu is open, showing the following options: 'Physician / Nurse Practitioner', 'Consumer', 'Patient', 'Caregiver', 'Agent', and 'Show All'. A red box highlights the 'I am a *' dropdown, and another red box highlights the 'Physician / Nurse Practitioner' option. A 'CREATE APPLICATION' button is visible on the right side of the form.

5. Select 'Electronic Physician Certification'. Click 'Create Application'.

On the **Physician Registration Number** tab:

6. Click the **Registration Number** drop down. Select the **Physician Registration Number**. Click 'Save'.

Note: If no registration number is available, the certifying physician or nurse practitioner will need to complete a registration application prior to being allowed to submit an EPCF.

7. Click 'Save and Next' to save the data fields and move to the next tab.

On the **General Information Tab**:

8. Enter the **Patient's First Name** and **Last Name**.

9. Enter the **Patient's Date of Birth**, **Email address**, and **Social Security Number**.

Note: The patient's social security number and date of birth **MUST** be accurate for the patient to see and select the EPCF within their application. Changes cannot be made after the ECF is submitted.

10. Click '**Yes**' or '**No**' to indicate whether the patient is 18 years or older.

11. Enter the **Date of Patient Examination**.

The screenshot shows the 'GENERAL INFORMATION' tab of the 'Applications / Electronic Physician Certification' system. The form contains the following fields and controls:

- Patient First Name *
- Patient Middle Name
- Patient Last Name *
- Patient Date of Birth *
- Patient's email address *
- Patient Social Security Number *
- Is the Patient 18 years or older?* (Radio buttons for Yes and No)
- Date of Patient Examination *
- Qualifying Condition section with dropdowns for Recommended Amount (30 Day Period) * and Qualifying Medical Condition *
- Buttons: SAVE, SAVE & NEXT, CANCEL

12. Under **Qualifying Condition**, click the **Recommended Amount (30 Day Period)** drop down, and select the amount for a 30-day period.

- If you are recommending the standard amount, choose **6 ounces**.
- If you are recommending a higher amount, choose **Specify Amount** and enter the amount you are recommending for the 30-day period.

The screenshot shows a close-up of the 'Qualifying Condition' section. The 'Recommended Amount (30 Day Period) *' dropdown menu is open, displaying the following options:

- Specify Amount (highlighted)
- 6 Ounces
- Specify Amount

13. Click the **Qualifying Medical Condition** drop down and select the qualifying medical condition.

Note: Depending on the medical condition you select, you may be asked to further specify the condition as required in rule.

Qualifying Condition
Recommended Amount (30 Day Period) * Specify Amount
Qualifying Medical Condition *



- Cancer
- Epilepsy
- Glaucoma
- Intractable migraines unresponsive to other treatment
- A chronic medical condition that causes severe, persistent pain or persistent muscle spasms, including but not limited to those associated with multiple sclerosis, seizures, Parkinson's disease, and Tourette's syndrome

14. Click **'Save & Next'**.

 SAVE	 SAVE & NEXT	CANCEL
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15. On the **Physician Information Tab**, all the physician’s information will auto-populate from the verified Physician Registration Number license. All information on this page can be edited and if the address is changed, it will need to be verified by clicking **‘Verify Address’**.

Applications / Electronic Physician Certification

PHYSICIAN REGISTRATION NUMBER GENERAL INFORMATION **PHYSICIAN INFORMATION** ATTESTATIONS REVIEW

Physician First Name *
Jim

Physician Last Name *
Doe

Physician License Type *
M.D

Physician License Number *
24680

Physician Phone *
(123)456-7890

Physician Email *
Jim.Doe@health.mo.gov

Physician Office Address

Street *
1000 Doctors Blvd

Unit No. / Apt No.

City *
Here

State *
Missouri

Zip Code *
12345

Address Verified? * Yes **VERIFY ADDRESS**

SAVE **SAVE & NEXT** **CANCEL**

16. Select either the **‘Entered Address’** or **‘Verified Address’**. Click **‘Done’**

Address Selection

Please select the address you wish to update in the application by clicking on the respective sections below.

Entered Address ✓

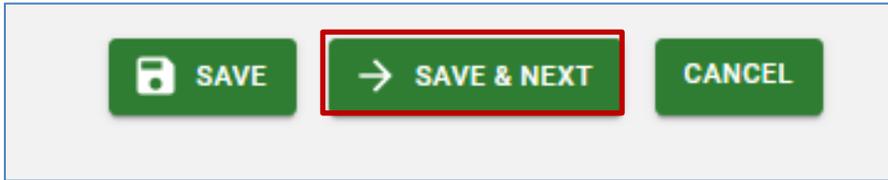
1000 Doctors Blvd
Here
MO
12345

Verified Address ⚠

Invalid City.

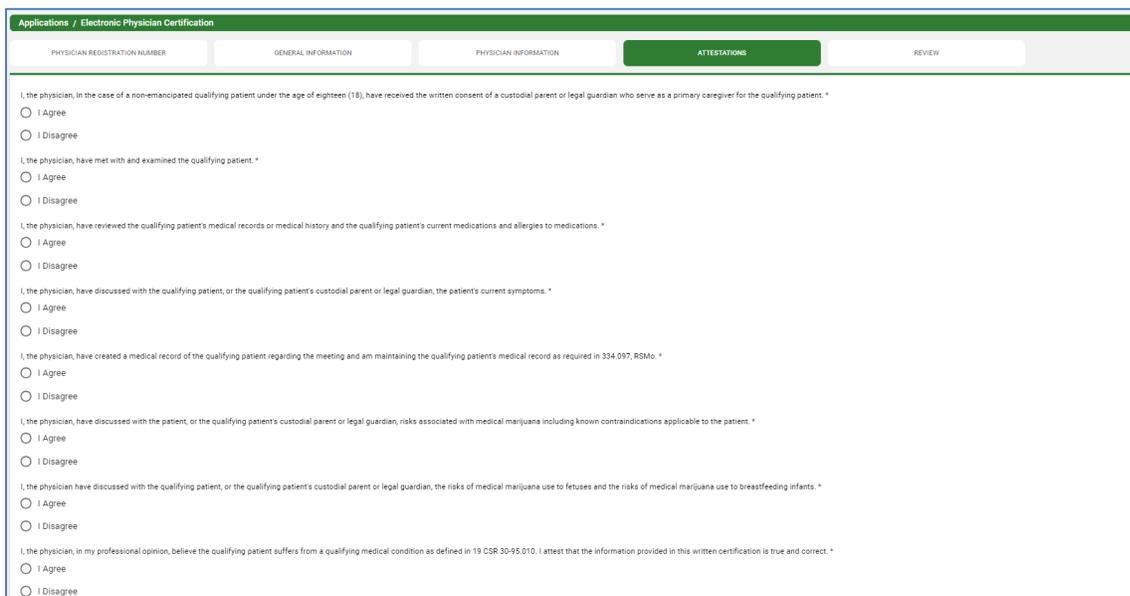
CANCEL **DONE**

17. Click **'Save & Next'**.

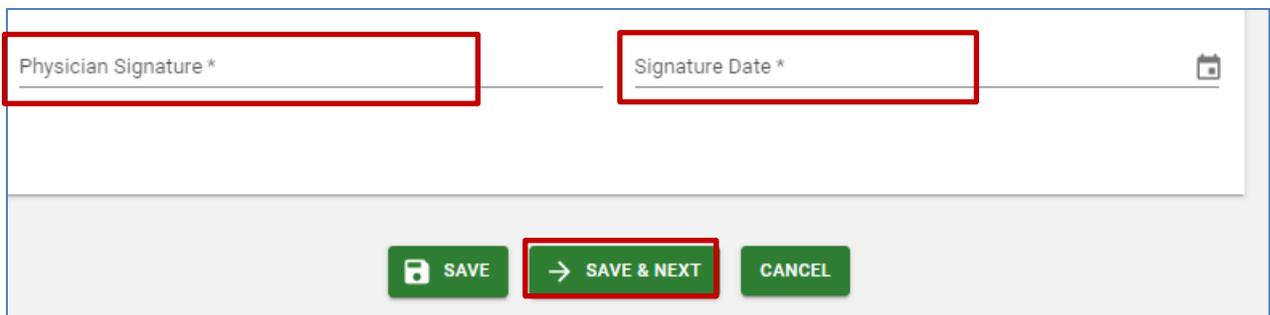


As part of the **Physician Certification Form**, physicians will be required to attest that certain statements are true. This provides a framework for the certification process and is the primary way in which the Department has conveyed the standard of care it expects medical marijuana patients will receive.

18. You must either **Agree** or **Disagree** to each of the attestation statements.

A screenshot of a web application interface for 'Applications / Electronic Physician Certification'. The interface has a green header bar and a navigation menu with tabs for 'PHYSICIAN REGISTRATION NUMBER', 'GENERAL INFORMATION', 'PHYSICIAN INFORMATION', 'ATTESTATIONS' (which is active), and 'REVIEW'. Below the navigation, there are several attestation statements, each followed by two radio buttons labeled 'I Agree' and 'I Disagree'. The statements include: 'I, the physician, in the case of a non-emancipated qualifying patient under the age of eighteen (18), have received the written consent of a custodial parent or legal guardian who serve as a primary caregiver for the qualifying patient. *', 'I, the physician, have met with and examined the qualifying patient. *', 'I, the physician, have reviewed the qualifying patient's medical records or medical history and the qualifying patient's current medications and allergies to medications. *', 'I, the physician, have discussed with the qualifying patient, or the qualifying patient's custodial parent or legal guardian, the patient's current symptoms. *', 'I, the physician, have created a medical record of the qualifying patient regarding the meeting and am maintaining the qualifying patient's medical record as required in 334.097, RSMo. *', 'I, the physician, have discussed with the patient, or the qualifying patient's custodial parent or legal guardian, risks associated with medical marijuana including known contraindications applicable to the patient. *', 'I, the physician have discussed with the qualifying patient, or the qualifying patient's custodial parent or legal guardian, the risks of medical marijuana use to fetuses and the risks of medical marijuana use to breastfeeding infants. *', and 'I, the physician, in my professional opinion, believe the qualifying patient suffers from a qualifying medical condition as defined in 19 CSR 30-95.010. I attest that the information provided in this written certification is true and correct. *'. Each statement has an 'I Agree' radio button selected.

19. Type your name in the **'Physician Signature'** field and enter the **'Date of your Signature'**. Click **'Save & Next'**.

A screenshot of a form section for signature and date. It features two input fields: 'Physician Signature *' and 'Signature Date *'. The 'Signature Date *' field includes a calendar icon on its right side. Below these fields are three green buttons with white text and icons: 'SAVE' with a floppy disk icon, 'SAVE & NEXT' with a right-pointing arrow icon (highlighted with a red border), and 'CANCEL'.

On the **Review Tab**:

20. Review all items to make sure they have green check marks.
21. If there is a red **X**, that means there is missing information in the application. Go back through each of the previous pages and correct the missing information.

Applications / Electronic Physician Certification

PHYSICIAN REGISTRATION NUMBER GENERAL INFORMATION PHYSICIAN INFORMATION ATTESTATIONS REVIEW

Please review the application for accuracy and completeness. If you have any items marked with a red X, your application will not be accepted. Please review these items to ensure accuracy
WARNING: Once your application is submitted, it cannot be modified. Please make sure your application is final and complete before submitting.

Physician Registration Number

✓ Registration Number: PHY000161

General Information

✗ Patient First Name: Patient Middle Name: ✗ Patient Last Name:

✗ Patient Date of Birth: ✗ Patient's email address: ✗ Patient Social Security Number:

✗ Is the Patient 18 years or older?: ✗ Date of Patient Examination:

Qualifying Condition

✗ Recommended Amount (30 Day Period):

✗ Qualifying Medical Condition:

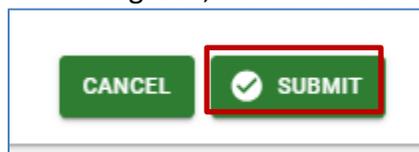
Physician Information

✓ Physician First Name: Jim ✓ Physician Last Name: Doe ✓ Physician License Type: M.D.

✓ Physician License Number: 24680 ✓ Physician Phone: 1234567890 ✓ Physician Email: Jim.Doe@health.mo.gov

Physician Office Address

22. When all check marks are green, scroll to the bottom of the page, and click **'Submit'**.



There is no fee required for electronic physician certification form submissions. A confirmation email will be sent from the Division of Cannabis Regulation to the physician verifying the submission and providing an application ID.

EPCF Errors

If an EPCF is submitted with errors in the patient's Personal Identifiable Information, such as birth date, social security number or spelling of name, the patient, certifying physician/nurse practitioner, or an authorized user on the physician/nurse practitioners' account must contact DCR and request the correction.

For corrections, DCR may be reached:

- By email (Monday through Friday) – 8:00 am – 5:00 pm at: CannabisInfo@health.mo.gov
- By phone (Monday through Friday) – 9:00 am – 4:00 pm CST at: **1-866-219-0165**

When contacting DCR, please have the following information available:

- The PHY# Number
- Physician or Nurse Practitioner Name
- The name of the person making contact (if not the physician, the person making contact will need to be verified as an authorized user before account details can be discussed)
- Nature of the update/request/topic of discussion

Once the person contacting DCR has been verified, a team member that is trained in this area will assist with the request.

Updated 2/26/2025