The Department will accept applications from course providers with at least two-years of experience providing medical or pharmacy education.

The course may provide continuing education credits. If continuing education credits are offered, the course provider must disclose the name of the accrediting organization on the application where noted.

Please review all information prior to completing your application to determine if you can meet the terms of the providership and create a course consistent with the required content outlined in 10 NYCRR §1004.1(b).

After completing the application, please send the application and any additional attachments, if applicable, via e-mail to mmp@health.ny.gov, as stated on the application form.

If approved, you will receive a letter from the Department with a provider number assigned to you or your organization. This provider number is used when issuing certificates of completion of the course to your attendees. It designates the approval of the course by the Department. The letter will also specify the target population that you have been approved to train and the terms of your approval.

Once you have been issued a provider number and your course work is developed you may begin training.

If you are not approved as a provider, you will receive a letter stating the reasons for the determination.

Thank you for your interest in becoming a Medical Use of Marijuana course provider. This course enables New York State’s professionals to learn important and current information about the medical use of marijuana, allows qualifying practitioners to meet the education requirement to register as a practitioner with the Medical Marijuana Program, and allows pharmacists and practitioners to counsel patients in dispensing facilities. Should you have any questions regarding this application, please e-mail mmp@health.ny.gov or call 1-844-863-9312.
Course Provider Information

Name of Provider ____________________________________________

Type of Provider (check one):

☐ Healthcare Organization ☐ Educational Institution ☐ Individual

☐ Other (describe) __________________________________________

Address ____________________________________________________

City __________________________ State _______________ Zip ______ County __________

Contact Person ____________________________________________

Title ______________________________________________________

Phone __________________________ Fax ________________________ Email __________________

Course Details

Target Audience (Check all that apply):

☐ Physicians ☐ Physician Assistants ☐ Nurse Practitioners ☐ Pharmacists

☐ Other (describe) __________________________________________

Course Delivery Method (Check all that apply):

☐ Live ☐ Online ☐ Print ☐ Other (Describe): __________________________

Course Duration (must be between two to four hours): __________________________

Will continuing education (CE) credits be offered? __________________________

If CE credits will be offered, please answer the questions below.

How many credits will be offered? __________________________

Who will be accrediting the course for CE (please see page 1 for a list of accepted accrediting organizations)?

______________________________
Instructor Information  (Person(s) responsible for teaching the course):

Instructor Name ___________________________________________ Title ___________________________________________

Phone ___________________________________________ Email ___________________________________________

Qualifications

Please disclose any potential conflicts of interest.

Please attach additional instructor information if necessary.
Terms of Agreement: Please initial each line to accept the terms. All terms must be accepted.

1. ___ The provider agrees to provide a course that is two to four hours in duration.

2. ___ The provider agrees that the course will cover the educational content specified in 10 NYCRR §1004.1; pharmacology of marijuana; contraindications; side effects; adverse reactions; overdose prevention; drug interactions; dosing; routes of administration; risks and benefits; warnings and precautions; abuse and dependence; and such other components as determined by the commissioner.

3. ___ The provider agrees that the course will define each of New York’s qualifying conditions and will be updated according to a schedule provided by the Department when additional conditions are added to the program.

4. ___ The provider will avoid content that is inconsistent with the laws and regulations governing the New York State Medical Marijuana Program (Title V-A of Article 33 Public Health Law and NYCRR Title 10 Part 1004).

5. ___ The provider will include content that is intended to help practitioners learn about medical marijuana and must be unbiased, peer-reviewed, edited based upon current medical and scientific evidence and relevant guidelines and referenced, when citing studies. Relative merits of the use of medical marijuana must be balanced with associated risks.

6. ___ The provider agrees that the course will be tailored to meet the needs of the target audience and will be current, relevant and scientifically accurate.

7. ___ The provider will have a detailed outline of the course content for Department review upon request. The Department reserves the right to request edits to the educational content.

8. ___ During the term of this agreement, the provider shall periodically review the educational content of the medical use of marijuana course and provide updates to the educational content, when substantive research or related findings dictate change.

9. ___ The provider has at least two years of experience providing medical or pharmacy education, and agrees that the instructional staff will possess the training, experience, or earned degrees necessary to insure that the educational goals of the program are met, and will describe such in the Qualifications section of the application form.

10. ___ The provider agrees to issue a Certificate of Completion to training participants, only to those participants who have completed the course and a course evaluation. The provider agrees to assume the cost of reproducing this or any other training related material. Any other costs incurred by the provider will be the sole responsibility of the provider and will not be reimbursed by the Department. The Department has no ownership of the course; however, the provider shall make the full course content available to the Department at the Department’s request.

11. ___ The provider will notify the Department electronically of practitioners and pharmacists who completed a course.

12. ___ The provider agrees to maintain a record of course participants and course evaluation forms completed by course participants for no less than five (5) years from the date of the completion of the course. These records shall be subject to the review of the Department and the provider agrees to make these records available to the Department or its designee(s) during regular business hours. The provider also agrees to respond to inquiries from the Department regarding these documents.
Terms of Agreement: Please initial each line to accept the terms. All terms must be accepted.

13. ___ The provider agrees that the Department may review and evaluate the course offered and that termination of the provider’s approved status may result if the Department determines that the course content is inadequate, incomplete, inaccurate or otherwise unsatisfactory.

14. ___ The provider understands and agrees that failure to comply with this agreement may result in termination of the provider agreement by the Department.

Attestation and Signature

As an authorized representative of the course provider, I the undersigned attest that the course provider agrees to comply with all terms listed in this application. All the information provided is true and correct to the best of my knowledge, and I acknowledge that a false statement made herein is punishable under section 210.45 of the Penal Law. I understand that the course provider and all instructors must comply with the terms above and non-compliance could result in revocation of any course approvals.

Signature of Authorized Representative __________________________________________________________

Print Name ____________________________ Title __________________________

Date __________________________

Please e-mail the completed form to mmp@health.ny.gov.