



SOUTH DAKOTA MEDICAL CANNABIS PROGRAM

600 EAST CAPITOL AVENUE
PIERRE, SD 57501-2536

Step-by-Step Guide for Practitioners/Physicians

1. Click “Enroll as a Practitioner” then “Create Account.”

Existing Users:

To login click on the grey login button in the top right-hand corner.

If your temporary password has expired or you forgot your password click on the grey button and click 'forgot my password'

Practitioners

Please Enroll to start the Practitioner Process. [Enroll](#)

Pursuant to SDCL 34-20G, physicians, physician assistants, or advanced practice registered nurses, who are licensed with authority to prescribe drugs to humans, may certify medical cannabis patients.

South Dakota Resident Interested in Patient or Caregiver Card


Please talk with your healthcare practitioner who must be enrolled in and initiate the patient card application process. You can learn more about the application process [here](#).

Nonresident Interested in Patient Card

Please Enroll to start the Nonresident Application Process. [Enroll](#)

2. Enter your email address, then hit “Send Verification Code”. This verification code serves as a two-factor authenticator and provides additional security for the enrollment process.
3. A 6-digit verification code will be sent to your email from Microsoft on behalf of the South Dakota Medical Cannabis Registry Staging and will come from the following sender: msonlineservicesteam@microsoftonline.com. Please enter it in the “verification code” field and hit “Verify Code”.
4. Once your email is verified, enter the remaining information required to create your account, then hit “Create”.

< Cancel



Email Address

Send verification code

New Password

Confirm New Password

Full Name

First Name

Last Name

Type

Create

- Once the account is created, the system will require you to log in.
- After you log in, enter information to complete your account registration. All fields with asterisks (*) are required fields.

Account Creation
Account Registration

Information

* First Name ⊙ * Last Name ⊙

Please fill out this field.

* Telephone Number (555) 555-5555 * Fax Number (555) 555-5555 * Email ⊙

License Information

* SD Medical License # * National Practitioner ID #

Provider Type and Specialty

* Type of Healthcare Provider Please select a type... ⌵ * Specialty ⌵

Address

* Business Name

* Address 1

Address 2

* City * State SD * Zipcode

[Submit Registration](#) Cancel

- Upon the completion of Account Registration, the system will automatically have your account in “pending” status until Department of Health (DOH) personnel approve your account.
IMPORTANT: Practitioners are allowed to certify patients only AFTER the practitioner account has been approved. The approval process may take several business days, so be sure to enroll early if you intend to certify patients.

My Information

Name DOH PRACTITIONER	Phone (555) 555-5555	Account Status Pending
Medical License Number 5555555	National ID Number 5555555555	

👤 Patients
👤 Certify Patient
⚙️ Account Settings

My Certifications

Name	Issue Date	Program Status	Actions
<input style="width: 90%;" type="text" value="Filter by Patient Name..."/>			

- Approval Notification: Once your account is approved, you will receive an email from noreply@sd.airlift.app. The notification may go into your junk email folder, so please be sure to check your junk folder.
- Go to <https://medcannabisapplication.sd.gov/> to log in, and click the “Certify Patient” tab.



Application Approved

Your healthcare practitioner application has been approved. Thank you.

South Dakota Medical Cannabis Program Registry
<https://medcannabisapplication.sd.gov/>

10. Practitioner Information: The practitioner information will be automatically filled out based on the account information you enter. Please review the information for accuracy. Your practitioner ID will be hidden and kept confidential from patients. Hit “Next Step”.

STANDARDIZED PRACTITIONER WRITTEN CERTIFICATION FORM (FORM D)

The purpose of this form is to collect the necessary information from practitioners certifying qualifying patients with debilitating medical conditions to become registered patients with the Department of Health pursuant to SDCL 34-20G.

Practitioner Information

Information

* First Name: SD * Last Name: DOH

* Telephone Number: (605) 773-2702 * Fax Number: (655) 555-5555 * Email: McQuestions@state.sd.us

License Information

* SD Medical License #: SD DOH 2024 * National Practitioner ID #: SD DOH Help Account 2024

Address

* Business Name: SD DOH Dr Help Account

* Address 1: 600 E Capitol Ave.

Address 2:

* City: Pierre * State: SD * Zipcode: 57501

Next Step

11. Patient Information: Fill out the required information marked with an asterisk (*) for the patient. **IMPORTANT:** Make sure that the email for the patient is their correct primary email address. The email address entered into the system will receive a notification where the patient will begin their enrollment process. Without this email address, the patient cannot complete their application. Hit “Next Step”.

Patient Information

Information

* Email

* First Name Middle Name * Last Name

* Date of Birth * Telephone Number (555) 555-5555

Address

Address 1

Address 2

City State Zipcode

Next Step

12. Medical Condition Information: Enter the required information related to the patient’s medical condition. Hit “Next Step”.
- The date when the patient’s need for the medical use of cannabis is expected to end is only applicable if the length of time the patient should have access to cannabis is less than 1 year. Please do not put an end date if the certification is intended to last one year.
 - Enter the debilitating condition and click the green + sign.
 - The system requires a minimum of 1 caregiver if the patient is younger than 18 years old.

Medical Condition Information

Information

* Date of in-person physical examination was conducted
12/5/2024

Date when patient’s need for the medical use of cannabis is expected to end (if applicable)

Debilitating Conditions

Seizures ✕

Please select a debilitating condition... +

* Number of designated caregiver’s this patient’s age or medical condition necessitates (if more than one)

– 0 +

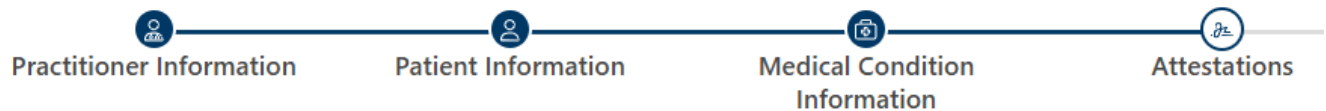
* Was the patient previously certified for 60 days or less?

Yes No

⇒ Next Step

13. Certification: Please read each certification carefully and click “Attest and Submit”

STANDARDIZED PRACTITIONER WRITTEN CERTIFICATION FORM (FORM D)



The practitioner completing this form must attest to the following:

- I certify that the patient is not pregnant.
- I certify that the patient is not currently breastfeeding or will begin breastfeeding while using medical cannabis.

⇒ Attest

STANDARDIZED PRACTITIONER WRITTEN CERTIFICATION FORM (FORM D)



The practitioner completing this form must certify the following:

1. I am a South Dakota physician, physician's assistant, or advanced care registered nurse licensed to prescribe drugs to humans. 34-20G-1(20)
2. I have conducted an in-person physical examination of the patient. 34-20G-1(2)(a)
3. I have assessed the patient's medical history and current medical condition. 34-20G-1(2)(a)
4. I have made or confirmed a diagnosis of a debilitating medical condition, as defined by 34-20G-1(8). 34-20G-1(2)(b)
5. I have discussed treatment options for the patient's debilitating medical condition, including the therapeutic or palliative benefits and risks associated with the medical use of cannabis, with the patient, or in the case of a patient under 18, the patient's parent or legal guardian. 34-20G-51(1)
6. In the case of a patient under 18, I have consulted with the patient's parents or legal guardians to determine how many designated caregivers are needed to manage the acquisition, dosage, frequency of use, and, if applicable, cultivation of cannabis and must indicate the number of designated caregivers on the written certification. 34-20G-33
7. I am available for further consultation with the patient, patients' parents, or legal guardians as required. 34-20G-1(2)(c)

Are you the patient's primary care provider or a specialty provider that is caring for the patient's debilitating condition?

Yes No

- I hereby attest that I am neither the patient's primary care provider nor a specialty provider caring for the patient's debilitating medical condition. I further certify that have provided an electronic notification of the certification issuance to the patient's primary care provider or referring practitioner.

Is the patient serving a probationary sentence under the supervision of the Unified Judicial System or on conditional release or parole from a state correctional facility under the legal custody of the Department of Corrections?

Yes No

- I hereby attest that the use of medical cannabis is:
 1. Consistent with the medical standard of care for the treatment of the individual's documented debilitating medical condition and any symptoms associated with the debilitating medical condition;
 2. Reasonable in light of the practitioner's observation and the individual's physical examination, diagnostic test results, medical history, and reported symptoms; and
 3. Reasonable in light of the risks and benefits of medical cannabis as compared to the risks and benefits of other treatment options for the individual's debilitating medical condition and any symptoms associated with the debilitating medical condition.

Attest and Submit

14. Once you complete the certification, the patient will receive an automated email stating that their account was created, and the patient can begin their portion of the application.

Please note: the patient application must be completed before the caregiver application process can start.

Dashboard: Once the patient certification is completed, your patient, along with their certification details, will show up on the "My Certification" dashboard where you can do the following:

- Edit certification details including the number of caregivers (only if the patient has not begun their application process).
- Revoke or reactivate the revoked patient.
- Download a copy of an individual patient's certification.