MEDICAL DOCUMENT - TO BE COMPLETED BY HEALTH CARE PRACTITIONER

Note: To complete your application, an original medical document is also required.

PATIENT INFORMATION

First Name _____ Last Name _____

Date of Birth _____ Gender ☐ Male ☐ Female ☐ Other

Primary Phone _____ Email Address _____

HEALTH CARE PRACTITIONER INFORMATION

Title/Profession _____ Name of Clinic _____

First Name _____ Last Name _____

Medical License Number _____ Province of Issue _____

Provinces Licensed In

☐ Alberta ☐ Nova Scotia ☐ Prince Edward Island

☐ British Columbia ☐ Northwest Territories ☐ Quebec

☐ Manitoba ☐ Nunavut ☐ Saskatchewan

☐ New Brunswick ☐ Ontario ☐ Yukon

☐ Newfoundland and Labrador

Business Address _____ Consultation Address _____

_____ _____

Telephone _____ Fax _____ Email _____

WRITTEN ORDER

Medical Diagnosis (Optional) _____

Grams per Day _____

Duration (Months) _____

Other Prescription Information _____

Note: The period of use cannot exceed 12 months and will begin on the day that this document is signed by the health care practitioner. The maximum quantity of dried cannabis that a client may possess cannot exceed 150 g or 30 times the daily dosage.

I, _____ attest that the information contained in this document is correct and complete.

Health Care Practitioner's Signature _____

Date _____