

## MEDICAL DOCUMENT

VERSION 1.0

### Patient Info

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth (dd/mm/yy): \_\_\_\_\_ Contact: *Phone or email* \_\_\_\_\_

### Practitioner Info

Profession: MD  NP

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

License # \_\_\_\_\_ Province(s) Authorized to Practice In: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Business Address: \_\_\_\_\_ Suite No.: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Consultation Location: If different than business address \_\_\_\_\_

### Authorization Details

Number of Grams Per day: \_\_\_\_\_ Duration: (*max 1 year*) \_\_\_\_\_ Days  Weeks  Months  1 Year

Max amount of THC% or mg/mL (optional) \_\_\_\_\_ Patient can use - Check all that apply: (optional)  
Is the max THC Limit Suggested  Mandatory  Oils  Dried  Is This? Suggested  Mandatory

Additional Info (optional) Naive Patient  Experienced Patient

Diagnosis: \_\_\_\_\_

*I hereby certify that the information in this document is correct and complete.*

Signature of Practitioner: \_\_\_\_\_ Date (dd/mm/yy): \_\_\_\_\_

Initial Here:

I, the health care practitioner, acknowledge that the faxed medical document is now the original medical document and that I have retained a copy of this document for my records only.