Form 02:

HEALTHCARE PRACTITIONER INFORMATION

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(Please Print)

IMPORTANT NOTICE

The original copy of this document is to be completed, signed and dated by the Healthcare Practitioner; must be submitted with the patient's application for registration as client of a Licensed producer under the Cannabis Act regulations.

HEALTHCARE PRACTITIONER INFORMATION

Last Name:	**First:**	**Middle:**
Profession:		
Province authorized to practice in:		
Healthcare Practitioner License Number:		

HEALTHCARE PRACTITIONER BUSINESS ADDRESS

Clinic Name:		**Clinic Address:**	
P.O. Box:	**City:**	**Province:**	**Postal Code:**
Phone number: ( )		**Fax number:** ( )	

PATIENT/CLIENT INFORMATION

Last Name:	**First:**	**Middle:**
Date of birth: YYYY MM DD / /	**Sex:** ☐M ☐F	

LOCATION OF CLINIC THE PATIENT/CLIENT CONSULTED THE ABOVE HEALTHCARE PRACTITIONER (IF DIFFERENT FROM ABOVE HEALTHCARE PRACTITIONER ADDRESS)

Clinic name:			
Clinic address:			
P.O. Box:	**City:**	**Province:**	**Postal code:**
Phone number: ( )		**Fax number:** ( )	

WRITTEN ORDER

Note: The maximum quantity of dried cannabis a client may possess cannot exceed maximum regulatory daily amount, as per Cannabis Act/Regulations. The period of use cannot exceed one year & will begin on the day that the document is signed by the health care practitioner

Number of grams		**Per day for number of month(s) (up to 12)**	**THC %:**	**CBD %:**

I……(Health Care Practitioner) attest that the information contained in this document is correct & complete.