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MEDICAL DOCUMENT

Form 02: HEALTHCARE PRACTITIONER INFORMATION FORM

The original of this document completed, signed, and dated by the Health Care Practitioner, should be included with the patient's application for registration as a client of a Licensed Producer under the Cannabis Act regulations to be completed by the patient's authorized health care practitioner as defined in the Cannabis Act Regulations.

HEALTH PRACTITIONER INFORMATION		
Practitioner last name:	**First:**	**Middle:**
Profession:		
Province Authorized to practice in:		
Health Care Practitioner License No.:		

HEALTH CARE PRACTITIONER BUSINESS ADDRESS			
Health Care Practitioner Business Name:			
Street Address:		**Business phone no.: ( )**	
City:	**Province:**	**Country:**	**Postal Code:**
Email Address:		**Business Fax no.: ( )**	

PATIENT/CLIENT INFORMATION			
Person Or Client	**LAST NAME**	**FIRST NAME**	**MIDDLE NAME**
Date of Birth: mm/dd/yy: / /		**Gender:** ❑ **M**	❑ **F**

CLINIC ADDRESS OF THE LOCATION AT WHICH THE PATIENT CONSULTED THE HEALTH CARE PRACTITIONER			
Clinic Name:			
Clinic Address:			
Street Name and Number:	**City:**	**Country:**	**Province:**
			Postal Code:
Phone number: ( )		**Fax number: ( )**	

WRITTEN ORDER			
Note: The maximum quantity of dried cannabis a client may possess cannot exceed the 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)	

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

Healthcare Practitioner Signature: ..... Date: .....