| MEDICAL                                  | DOCUME               | MI (to be     | milea by i       | Healthcare                   | Practitioner)      |           |   |
|--|----------------------|---------------|------------------|------------------------------|--------------------|-----------|---|
| 1) Client Inf                            | ormation             |               |                  |                              |                    |           |   |
| Patient Nam                              | ie                   |               |                  |                              |                    |           |   |
|  |                      | (First        | name)            |                              | (Middle r          | ame)      | (last name)                               |
| Date of Birtl                            | h                    |               |                  |                              | Gende              | <b>,</b>  |   |
| Date of Birth                            |                      | YYYY          | MM               | DD                           | Genue              | Male      | — —<br>Female                             |
| C44                                      |                      |               | 172172           |                              |                    | 171000    |   |
| Contact                                  | D.I.                 | ne with area  | 7                |                              | Г :1               |           |   |
| 2) Healthcar                             |                      |               |                  | ll it do no                  | Email  STAMP)      |           | Fax                                       |
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| Practitioner                             | m. 1                 |               | /T:              |                              |                    |           | 1   |
| Title                                    |                      | (First name)  |                  | (Middle name)                |                    |           | (last name)                               |
|  |                      |               |                  |                              |                    |           |   |
|  |                      | Profession    |                  | License # (CPSO, CPSBC, CMQ) |                    |           | Province(s) authorized to practice in     |
| Contact                                  |                      |               |                  |                              |                    |           |   |
| Pho                                      |                      | ne with area  | code             |                              | Email              |           | Fax                                       |
| <b>Business Ad</b>                       | dress                |               |                  |                              |                    |           |   |
|  |                      |               | Name and Address |                              |                    | Unit#     |   |
|  |                      |               |                  | 1.4                          |                    |           |   |
|  |                      |               | City             |                              | Provin             | 00        | Postal Code                               |
| Consulation 1                            | Business Ir          | nformation    | •                | from husiness                |                    | ce        | r osiai Code                              |
| Constitution                             | Business ii          | 1101111441011 | (1) any cremy    | nom oustress                 | injormation        |           |   |
|  |                      |               | Name and Address |                              |                    |           |   |
|  |                      |               |                  | Name and Address             |                    |           | Unit#                                     |
|  |                      |               |                  |                              |                    |           | _   |
| ī  |                      |               | City             | 1                            | Provin             | ce        | Postal Code                               |
|  |                      |               |                  |                              |                    |           |   |
|  | Phone with area code |               |                  |                              | Email              |           | Fax                                       |
| 3) Prescripti                            |                      |               |                  |                              |                    |           |   |
| The period of use cannot exceed one year |                      |               |                  |                              |                    |           |   |
|  |                      |               |                  |                              |                    |           |   |
| Grams/Day                                |                      |               | THC limit (%     | <b>(6)</b>                   | Day(s) Week(s)     | Month(s)  |   |
| Primary Cond                             | ition:               |               |                  |                              |                    |           |   |
|  |                      |               |                  |                              |                    |           |   |
|  | is docume            | nt, the Hea   | althcare Pra     | actitioner at                | ttests that the in | formation | contained in this document is correct and |
| complete                                 |                      |               |                  |                              |                    |           |   |
| ~-                                       |                      | _             |                  |                              |                    |           | D-4.                                      |
| Signature of Healthcare Practitioner     |                      |               |                  |                              |                    |           | Date                                      |
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| retained a cop                           | py of this d         | ocument f     | or my reco       | rus only                     |                    |           |   |
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