

Department:
Number:

Date Approved:
Date Effective:
Review Date:

MEDICAL DOCUMENT

Document Number: PRO-011.00-F.05

Part 1: Health Care Practitioner Information (Please complete this section)

Title/Profession:

Name (surname, given name):

Clinic Business Name:

Medical Licence Number:

Province medical licence was issued in:

Address Line 1:

City:

Address Line 2:

Province:

Telephone #:

Postal Code:

Fax #:

Email Address:

Address of Consultation (If different from business location)

Address Line 1:

City:

Address Line 2:

Province:

Telephone #:

Postal Code:

Fax #:

Part 2: Patient Information

Patient's Name (surname, given name):

Gender:

Male

Female

Undisclosed

Date of Birth (MM/DD/YYYY):

Part 3: Written Order

Medical Diagnosis (optional):

Quantity of dried cannabis (g):

Frequency:

Duration:

* The maximum quantity of cannabis a Client may possess at any cannot exceed 150 grams or 30 times the prescribed daily amount (whichever is lesser).

* The duration of use cannot exceed one year and begins from the date the Applicant is registered with a holder of a licence for sale.

I, _____, attest that the information contained in this document is
(Printed name of Health Care Practitioner)

correct and complete.

Health Care Practitioner's Signature: _____ Date: _____