MEDICAL DOCUMENT

Thank you for selecting Northern Green Canada (NGC). Our primary goal is to provide safe and secure support to our clients. We have the knowledge, and the research behind it, to empower their decision to use cannabinoids to improve their quality of life.

NGC has developed cannabis products backed by research by our team of scientists, doctors and cultivation experts.

We appreciate you taking the time to consider whether medical cannabis meets the needs of your patient. To preserve and adhere to the guidelines set forth by Health Canada, we ask that no stamps be used to fill out this medical document.

If you have any questions, concerns or wish to request additional information, please contact us:

Client Services Team: clientservices@northerngreencanada.com
Our Website: www.NorthernGreenCanada.com

All fields are mandatory unless specified with an * and relative notes. Clarification to those fields may be provided.

PATIENT INFORMATION

Patient Name: _____ Patient Date of Birth: _____

HEALTH CARE PRACTITIONER INFORMATION

Practitioner Name: _____ Profession: _____

Province(s) Authorized to Practice: _____ Licensee Number(s): _____

Business Address: _____ Apt/Suite: _____ City: _____

Province: _____ Postal Code: _____ Telephone No.: _____

E-mail: _____ Fax No.: _____

CONSULTATION BUSINESS INFORMATION

Place of business where the Patient consulted with the Health Care Practitioner (leave blank if same as above)

Address: _____ Apt/Suite: _____ City: _____

Province: _____ Postal Code: _____ Telephone No.: _____

E-mail: _____ Fax No.: _____

PRESCRIPTION INFORMATION

Daily Quantity of Dried Marihuana to be used by Patient: _____ Grams/Day

Period of Use: _____ Day(s) _____ Week(s) _____ Month(s)

Note: Period of Use cannot exceed one (1) year

*Medical Condition: _____

Note: Medical Condition is required if billing is being submitted directly to Veterans Affairs Canada

*Maximum THC Percentage: _____ % *Maximum CBD Percentage: _____ %

Note: Max THC & CBD percentages are optional

*Consent to receive dried marihuana from Northern Green Canada on behalf of your patient.

Note: Only if applicable

I, _____ , consent to receive dried marihuana on behalf of: _____

Health Care Practitioner *Patient*

Health Care Practitioner's Signature: _____ Date: _____

MEDICAL DOCUMENT

This document must be fully completed by the applicant's authorized health care practitioner as defined by Health Canada in the Access to Cannabis for Medical Purposes Regulations (ACMPR). An authorized health care practitioner includes medical practitioners and nurse practitioners where prescribing medical cannabis for medical purposes is permitted under their scope of practice. For detailed outline regarding required information to ACMPR, click here.

By signing this document, you confirm you are a licensed health care practitioner not named in a notice issued under section 59 of the Narcotic Control Regulations that has not been retracted under section 60 of those Regulations; you consulted with the applicant and you attest that the information contained in this document is correct and complete.

SUBMITTING TO NORTHERN GREEN CANADA

To submit, please secure this form with your Registration Form along with any other required documents, and send by mail to:

ATTN: Northern Green Canada, Client Services
RPO City Centre
Brampton, ON L6T 5M2
PO Box 51075

Health Care Practitioner Name: _____ Date: _____

Health Care Practitioner's Signature: _____

Please keep a copy of this document for your records as Northern Green Canada is legally obliged to verify the accuracy of the information contained in the document upon receipt.