emerald HEALTH BOTANICALS

STEP 2: Medical Document

FORM MAY BE FILLED OUT IN ACROBAT READER AND PRINTED FOR SIGNING AND COMPLETION.

HEALTHCARE PRACTITIONER INFORMATION

TITLE (REQUIRED) ☐ DOCTOR ☐ NURSE PRACTITIONER

***IMPORTANT:* FORM MUST BE COMPLETELY FILLED IN OR APPLICATION WILL BE REFUSED**

GIVEN NAME ▼ | SURNAME ▼

PROFESSION (IE: GENERAL PRACTITIONER, SURGEON, ETC. PLEASE SPECIFY) ▼ | CLINIC / BUSINESS NAME ▼

CLINIC / BUSINESS ADDRESS ▼

CITY / TOWN ▼ | PROVINCE ▼ | POSTAL CODE ▼

PROVINCE LICENSE HELD IN ▼ | LICENSE # ▼

PHONE NUMBER ▼ | FAX NUMBER ▼ | EMAIL ADDRESS ▼

FILL IN THIS SECTION ONLY IF CONSULTATION ADDRESS IS DIFFERENT THAN ADDRESS ABOVE

CONSULTATION ADDRESS *(FILL IN IF DIFFERENT THAN ADDRESS ABOVE / OR SKYPE)*

UNIT # ▼ | STREET ADDRESS ▼

CITY / TOWN ▼ | PROVINCE ▼ | POSTAL CODE ▼

☐ **CHECK BOX IF CONSULT DONE VIA SKYPE**

PLEASE INDICATE PREFERRED METHOD OF CONTACT FOR MEDICAL DOCUMENT VERIFICATION: ☐ PHONE ☐ FAX

PATIENT INFORMATION

GIVEN NAME ▼ | SURNAME ▼

BIRTHDATE ▼

YEAR | MONTH | DAY

IS THIS PATIENT PALLIATIVE? ☐ YES ☐ NO *NOTE: Palliative and lower income patients may qualify for compassion pricing discount, please enquire.*

AUTHORIZATION DETAILS

Billing fee for verification is not required.

GRAMS ▲ # OF GRAMS PER DAY — FOR — MONTH(S) ▲ # OF MONTHS (MAXIMUM 12) — **OR** — DAY(S) ▲ # OF DAYS — **OR** — WEEK(S) ▲ # OF WEEKS

INDICATION (OPTIONAL)

NOTE: A Medical Document is valid for the period of use specified. [ACMPR Section 130] **The period of use begins on the day on which the Medical Document was signed by the health care practitioner.**

I hereby attest that the information contained within this document is correct and complete.

HEALTHCARE PRACTITIONER SIGNATURE ▼ | PRINT NAME BELOW ▼ | **DATE SIGNED** YEAR MONTH DAY

X

IF DOCTOR / HEALTHCARE PRACTITIONER INTENDS TO RECEIVE MEDICAL MARIHUANA FOR THIS PATIENT, AN ATTESTATION ON THE APPLICATION (STEP 1 DOCUMENT) MUST BE SIGNED BY THE DOCTOR (SECTION 3).

In compliance with ACMPR Section 130 and QA_011 / QA_012 Client Registration and Ordering.

EHB_2_MED_r15_2017.10.29

MAIL (OR FAX) THIS DOCUMENT TO: EMERALD HEALTH BOTANICALS INC.
4420 West Saanich Road, PO Box 24076, Victoria BC Canada V8Z 7E7

NOTE: Doctors' office may fax the Medical document (and application) to 1.855.623.3325

www.emerald.care | clients@emerald.care
toll free: 1.800.757.3536 | fax: 1.855.623.3325