

FORM MAY BE FILLED OUT IN ADOBE 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 LOW INCOME? 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 FOR MONTH(S) OR DAY(S) OR WEEK(S)

▲ # OF GRAMS PER DAY ▲ # OF MONTHS (MAXIMUM 12) ▲ # OF DAYS ▲ # 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, and it may not exceed 365 days (1 year).

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

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).