MEDICAL DOCUMENT (to be filled by Healthcare Practitioner)

1) Client Information

Patient Name | *(First name)* | *(Middle name)* | *(last name)*

Date of Birth *YYYY MM DD* **Gender** *Male* *Female*

Contact *Phone with area code* | *Email* | *Fax*

2) Healthcare Practitioner Informaiton (fill it, do not STAMP)

Practitioner *Title* | *(First name)* | *(Middle name)* | *(last name)*

Profession | *License # (CPSO, CPSBC, CMQ)* | *Province(s) authorized to practice in*

Contact *Phone with area code* | *Email* | *Fax*

Business Address *Name and Address* | *Unit#*

City | *Province* | *Postal Code*

Consulation Business Information *(If different from business information)*

Name and Address | *Unit#*

City | *Province* | *Postal Code*

Phone with area code | *Email* | *Fax*

3) Prescription

The period of use cannot exceed one year

Grams/Day | *THC limit (%)* | *Day(s)* *Week(s)* *Month(s)*

Primary Condition:

By signing this document, the Healthcare Practitioner attests that the information contained in this document is correct and complete

Signature of Healthcare Practitioner **Date**

I, the Healthcare Practitioner, acknowledge that the faxed/e-mailed Medical Document is the original and that I have retained a copy of this document for my records only

Initial/Date of Healthcare Practitioner