Medical Document

This document may be completed by the applicant's authorized health care practitioner as defined in the Access to Cannabis for Medical Purposes Regulation. An authorized health care practitioner includes physicians in all provinces and territories, and nurse practitioners in provinces and territories where prescribing dried marihuana for medical purposes is purposes is permitted under their scope of practice.

Patient's Given Name and Surname _____

Patient's Date of Birth (DD/MM/YYYY) _____

Medical Diagnosis (optional) _____

Daily quantity of medical marihuana to be used by the patient: ___ g/day

The period of use is ___ day(s) ___ week(s) ___month(s).

NOTE: Applicant can possess a maximum of 150g or 30 times their daily amount, whichever is less. Under the Access to Cannabis for Medical Purposes Regulations, maximum authorization is a period of 12 months and begins the day the Medical Document is signed by the HCP.

Health care practitioner's given name and surname: _____

Profession: Physician

Health care practitioner's business address: _____

Full business address of the location at which the _____

patient consulted the health care practitioner _____

(if different than above):

Phone Number: _____

Fax Number (if applicable): _____

Email (if applicable): _____

Province(s) Authorized to Practice in: ___] _____

Health Care Practitioner's License number: _____

By signing this document, the health care practitioner is attesting that the information contained in this document is correct and complete.

Health Care Practitioner's Signature: _____

Date Signed (DD/MM/YYYY): _____

Initial to Indicate Submitting Medical Document to Licensed Producer by Fax: ☐

I have chosen to submit the original Medical Document to the Licensed Producer by their secure fax portal. I acknowledge that the faxed medical document is now the original Medical Document and that I have retained a copy of this document for my records only.

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