Medical Document

Patient Information

First Name: Last Name:

Gender: Date of Birth (MM/DD/YYYY):

Health Care Provider Information

Title: First Name: Last Name:

Profession:

License/Registration Number:

Province(s) Authorized to Practice In:

Business Address:

City: Province: Postal Code:

Address of Consultation (if different than above):

City: Province: Postal Code:

Phone Number: Fax Number:

Email Address:

Preferred Contact Method: ☐ Email ☐ Phone ☐ Fax

Authorized Dosage of Medical Cannabis

Maximum Quantity (grams per day): Period of Use: day(s) week(s) month(s)

Note: The period of use cannot exceed one year.

Diagnosis (optional):

Product Recommendations (optional):

Additional Comments (optional):

I hereby certify that the information in this document is accurate and complete.

Date: **Signature:**