# Medical Document

**SECTION A: Client Information**

□Mrs. □Miss □Ms. □Mr.

Name: _____ / _____ / _____
Last First Middle

Date of Birth: _____ / _____ / _____
Day Month Year

Daily quantity of dried marihuana to be used by the patient:_____g/day

The period of use is_____day(s)_____week(s)_____month(s).

**NOTE: The period of use cannot exceed one year**

**SECTION B: Health Practitioner Information**

Health Care Practitioner's Full Name: _____

Provincial Medical License Number: _____ Province of Registration: _____

Please check applicable: ☒ Physician □ Nurse Practitioner

Medical Specialization (if applicable): _____

Business Address:_____Suite Number: _____

City:_____Province:_____Postal Code: _____

Telephone: (____) _____Fax: (____) _____

Email (if applicable): _____

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

_____
Physician Signature

STAMP

_____DD / MM / YYYY_____
Date

☒ _____ Check and initial here if you are submitting the medical document directly via secure electronic /fax systems. By initialing, Practitioner acknowledges that the Medical Document faxed constitutes the original Medical Document and that he/she has retained a copy of the Medical Document for his/her records. Practitioner also attests that the Medical Document will not be faxed or provided to any other party.