NATIONAL ACCESS CANNABIS

Medical Document

This medical document is to be completed by a Healthcare Practitioner.

Patient Information

Patient Name: _____ _____
First Name Last Name

Date of Birth: (MM/DD/YY) _____ / _____ / _____ Telephone: (_____) _____ - _____

Email: _____ Diagnosis: _____

Prescription

Note that the maximum quantity of dried marijuana a patient may possess cannot exceed 150 grams per month, or 30 times the daily amount prescribed (whichever is lesser) as per the Marijuana for Medical Purposes Regulations (MMPR).

◯ Number of grams per day: _____ grams.

◯ Duration of prescription: _____ months (maximum 12 months)

Health Care Practitioner Information

Name: _____ _____
First Name Last Name

Profession: _____ Name of office or Clinic: _____

Business Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: (____) ____ - _____ Fax: (____) ____ - _____ Email: _____

Medical License Number: _____ Province(s): _____

Consultation Address: (the address at which the consultation took place)

Check one of the following:

◯ The consultation took place the business address, as stated above.

◯ The consultation took place via telemedicine at 1111 Wellington St. W, Ottawa Ontario.

I _____ attest that the information contained in this document is correct and complete.
Printed name of Healthcare Practitioner

Signature of Healthcare Practitioner: _____ Date: (MM/DD/YY) _____ / _____ / _____

let's talk answers