NATIONAL ACCESS CANNABIS

Medical Document

This medical document is to be completed by a Prescribing Physician.

Patient Information

Patient Name: _____ _____
First Name Last Name

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

Email: _____ Diagnosis: _____

Prescription

The maximum quantity of dried cannabis a patient may possess cannot exceed 30 times the daily amount prescribed, or 150 grams (whichever is lesser) as per the Access to Cannabis for Medical Purposes Regulations (ACMPR).

◯ Number of grams per day: _____ grams.

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

☐ **THC LIMIT: _____**

☐ **CBD LIMIT: _____**

☐ **ONLY OILS**

☐ **NO LIMIT**

Prescribing Physician 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 at the business address as stated above, via telemedicine or in person.

◯ The consultation took place via telemedicine or in person at 5401 Temple DR NE, Calgary AB, T1Y 3R7

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

Signature of Prescribing Physician: _____ Date: (MM/DD/YY) _____ / _____ / _____

ADDRESS: 5401 Temple Dr NE. Calgary AB T1Y 3R7 Unit 201. **PHONE**: (587) 779-6420 **FAX:** (403) 452-4355 **EMAIL:** CALGARY@NATIONALACCESSCANNABIS.