



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: (____) ____ - ____

K#: _____ Condition: _____

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)
- Prescriber Instructions (Optional): _____

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

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) ____ / ____ / ____

let's talk **answers**