

Medical Document | (Section 8, ACMPR)

Health Care Practitioner Information

Name:
Given Name Surname

Profession: **Fax No.** **Phone No.**

Medical License No.: **Province of Authorization:**

Clinic/Business:

Address:

Consultation address (if different than clinic address):

Patient's Name:
Given Name Surname

Date of Birth: Month Day Year

Mailing Address (if different from primary residence) Where you receive correspondence from THC BioMed™

Address Line 1

City Province Postal Code

Phone Number

Medical Diagnosis: (Optional)

Number of Grams **per day for**
Days Weeks Months

Special Instructions:

Note: The period of use cannot exceed one year & will begin on the day that the document is signed by the health care practitioner

I, attest that the information contained in this document is correct & complete.
Health Care Practitioner Full Name

Health Care Practitioner's Signature _____ **Date**

I, the health care practitioner, acknowledge that the faxed medical document is now the original medical document and that I have retained a copy of this document for my records only: Initial only if Submitting via FAX:

For Internal Use:

Verified by: _____ Date: Signature: _____ Verified: