THC BioMed
PLANT SCIENCE

Online registration is now available at www.thcmeds.ca
This application can also been mailed or faxed
P.O. Box 20033 Town Centre
Kelowna, BC V1Y 9H2
Fax: 1.888.422.4718

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 Information

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 Information

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: ☐