STEP 2:
MEDICAL DOCUMENT

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HEALTH THERAPEUTICS

www.emeraldhealth.ca | clients@emeraldhealth.ca
Toll Free: 1.800.757.3536 | Fax: 1.855.623.3325

Healthcare Practitioner Information

Title (Required):

Given Name: Surname:

Profession
(ie., General practitioner, surgeon, etc. Please specify.): Clinic/Business Name:

Clinic/Business Address:

City/Town: Province: Postal Code:

Province license held in: License #:

Phone Number: Fax Number: Email (Optional):

▶ FILL IN THIS SECTION ONLY IF CONSULTATION ADDRESS IS DIFFERENT THAN ADDRESS ABOVE

CONTACT ADDRESS (Fill in if different than address above/or Telemedicine.)

Unit #: Street Address:

City/Town: Province: Postal Code:

▶ ☐ CHECK BOX IF CONSULTATION DONE VIA TELEMEDICINE

Please indicate preferred method of contact for Medical Document verification: ☐ Phone ☐ Fax

Patient Information

Given Name:

Surname:

Birthdate:

IS THIS PATIENT PALLIATIVE? ☐ Yes ☐ No

LOW INCOME? ☐ Yes ☐ No

NOTE: Palliative and lower income patients may qualify for compassion pricing discount, please enquire.

Authorization Details

Billing fee for verification is not required

# OF GRAMS PER DAY		# OF MONTHS (MAX. 12)		# OF DAYS		# OF WEEKS
GRAMS	FOR	MONTH(S)	OR	DAY(S)	OR	WEEK(S)

INDICATION
(Optional)

NOTE: A Medical Document is valid for the period of use specified (ACMPR Section 8). The period of use begins on the day on which the Medical Document was signed by the healthcare practitioner, and it may not exceed 365 days (1 year).

I hereby attest that the information contained within this document is correct and complete

▼ Signature
X _____

▼ Print Name Below

▼ Date Signed
YEAR | MONTH | DAY

▶ ***IF DOCTOR/HEALTHCARE PRACTITIONER INTENDS TO RECEIVE MEDICAL CANNABIS FOR THIS PATIENT, AN ATTESTATION ON THE APPLICATION MUST BE SIGNED BY THE DOCTOR (FILL AND SUBMIT AN ADDITIONAL FORM FOUND AT EMERALDHEALTH.CA/REGISTERNOW.)***

In compliance with ACMPR Section 7-8 and QA_011 Client Registration. **[MAIL (OR FAX) THIS APPLICATION FORM TO]:**
EMERALD HEALTH THERAPEUTICS CANADA INC. 310-777 Royal Oak Drive, PO Box 24076, Victoria, BC V8X 4V1 Canada.
For the fillable form PDFs, please visit emeraldhealth.ca/registernow.
NOTE: Your **doctor's office may fax** the original **Medical Document** (and application) to 1.855.623.3325

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