STEP 2:
MEDICAL DOCUMENT

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 (Cannabis Regulations Section 273). 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.)*