1809 Underground

Medical Document

To be completed by Health Care Practitioner

1809 Underground
Ridgeville, ON
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HEALTH CARE PRACTITIONER

Name: Title | Given First Name(s) | Surname (Last Name)

Profession: | Clinic Name:

License #: Medical License Number | Province Licensed to Practice

Contact: Practitioner Phone Number | Practitioner Fax Number | Practitioner Email

Office Address: Unit # | Street Address 1 | Street Address 2 (If Applicable)

City | Province | Postal Code

☐ Same as Office Address listed above

Address of Consultation: Unit # | Street Address 1 | Street Address 2 (If Applicable)

Province | Postal Code

APPLICANT (PATIENT) INFORMATION

Patient Name: Given First Name(s) | Surname (Last Name) | Patient's Date of Birth

DATE: Day / Month / Year

WRITTEN ORDER FOR MEDICINAL MARIJUANA (CANNABIS)

*Note*a patient may NOT possess more than 150 grams, or 30 times the prescribed daily amount, whichever is smaller.

Medical Diagnosis:

# of grams (# grams) per day for # of Days (# days) OR Month(s) (Optional) (# months) (Max of 1 year)

Note the *period of use* cannot exceed 1 year & will commence from the date signed below.

I _____ attest that the information contained herein is correct & complete.

Name of Health Care Practitioner

Health Care Practitvioner's Signature: _____

DATE: Day / Month / Year

☐ Verification completed