Medical Authorization for a Marihuana for Medical Purposes Certificate

Patient's Given Name and Surname: ______________________________________

Patient's Date of Birth (DD/MM/YYYY): ______________________________

Daily quantity of dried marihuana to be used by the patient: _______ g/day.

The period of use is: ________________________ ***Note: the period of use cannot exceed one year***

Health care practitioner's given name & surname: __________________________________

<u>Practitioner's Statement</u>: This patient has reported to me that his/her symptoms are helped by cannabis and therefore I believe he/she should have legal access to it. By signing this document, I attest that the information contained herein is correct and complete.

Health care practitioner's business address: ____________________________________

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Full business address of the location at which the patient consulted the health care practitioner

(if different than above): _________________________________

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Phone Number: _________________________________

Email Address: _________________________________

Province(s) Authorized to Practice in: _________________________________

Health Care Practitioner's Licence #: _________________________________

Health Care Practitioner's Signature: _________________________________

Date Signed (DD/MM/YYYY): ______________________________

Note: this form is adapted from and complies with the Sample Medical Document for the Marihuana For Medical Purposes Regulations from Health Canada: http://www.hc-sc.gc.ca/dhp-mps/alt_formats/pdf/marihuana/info/med-eng.pdf