



Medical Document | (Section 8, ACMPR)

Version 4.0

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Health Care Practitioner Information

Name: [Title] [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 Name: [Given Name] [Surname]

Date of Birth: Month [ ] Day [ ] Year [ ]

Mailing Address (if different from primary residence) Where you receive correspondence from CannTrust™

Address Line 1 [ ]
City [ ] Province [ ] Postal Code [ ]
Phone Number [ ]

Medical Diagnosis: (Optional) [ ]

Number of Grams [ ] per day for [ ]

Special Instructions: [ ] Days Weeks Months

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 [ ]

For Internal Use:

Verified by: \_\_\_\_\_ Date: [ ] Signature: \_\_\_\_\_ Verified: [ ]

Note: \_\_\_\_\_