MEDICAL DOCUMENTATION

CANNA FARMS

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PLEASE NOTE: In order to complete the registration, all fields marked with an **asterisk (*) *must* be completed**. This information must match the Registration Application. Incomplete forms will cause a delay in registration. This document will only be processed if received in **original form**. Copies, faxes or emails will not be accepted.

HEALTH CARE PRACTITIONER (HCP) INFORMATION*

*Under the MMPR, once the Licensed Producer (LP) receives this Medical Document, we are **required to validate the details** with the office of the issuing **Health Care Practitioner. Please indicate if you prefer to be contacted for the validation via phone, fax or email.** If no option is selected, validation requests will be sent via **fax**.*

Title	**Given Name***	**Surname***	
Profession ☐ **Physician** ☐ **Nurse Practitioner**	**Clinic Name**		
Business Street Address*			
City*	**Province***	**Postal Code***	**Preferred Method of Contact*** ☐ **Phone** ☐ **Fax** ☐ **Email**
Phone Number	**Fax Number**	**Email**	
Address of Consultation (if different from above)	**City**	**Province**	**Postal Code**

APPLICANT INFORMATION*

Title	**Given Name***	**Surname***	
Date of Birth* (MM/DD/YYYY)	**Gender*** ☐ **MALE** ☐ **FEMALE** ☐ I do NOT identify or associate with either gender		

WRITTEN ORDER AND AUTHORIZATION FOR MEDICAL MARIJUANA*

This Applicant may access ☐ **GRAMS PER DAY*** for ☐ ☐ **DAYS** ☐ **WEEKS** ☐ **MONTHS**

(Must be specific – cannot be a range) *(select one option)*

This Medical Document is valid for the period of use specified above. The period of use cannot exceed 12 months and will commence from the date the document is signed.

I, _____*, hereby attest that the information contained herein is correct and complete.

*Name of Healthcare Practitioner**

SIGNATURE*: _____ **DATE*:** _____

*Signature of Healthcare Practitioner** *(MM / DD / YYYY)**

HCP's LICENSE NUMBER*: _____ **PROVINCE OF REGISTRATION*:** _____

☐ **Initial here if an *existing agreement is in place between the HCP and CFL*, and you are submitting this Medical Document directly via a Secure Fax system. If there is no existing agreement in place, this Medical Document may not be submitted via fax. By initialling, the HCP acknowledges that this Medical Document is now deemed the Original Medical Document, and that he/she has retained a copy of this Medical Document for his/her records. HCP also attests that this Medical Document will not be faxed or provided to any other party.**