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PICKERING, ON
L1V 6P7
CONTACT@WEEDME.CA
T: 1-866-410-4040
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MEDICAL DOCUMENT

TO BE COMPLETED BY YOUR HEALTH CARE PRACTITIONER.
ORIGINAL MUST BE MAILED OR FAXED FROM CLINIC.

1. HEALTH CARE PRACTITIONER INFORMATION

First Name*

Last Name*

Profession

Business Address*

Telephone*

City*

Province*

Postal Code*

Fax Number*

Email Address *(If applicable)*

Medical License Number*

2. PATIENT INFORMATION

First Name*

Last Name*

Date of Birth*

(DD/MMM/YYYY)

Telephone*

Location of Consultation (If different from business address)*

3. PRESCRIPTION INFORMATION

The period of use must not exceed one year.

Grams/Day*

THC Limit (Optional)

Period of Use

Days ☐ Weeks ☐ Months ☐

Diagnosis

Notes

4. ACKNOWLEDGEMENT OF PRACTITIONER

I attest that the information provided in this document is correct and complete.

Signature*

Date*

(DD/MMM/YYYY)

5. INITIAL HERE IF SUBMITTING THE MEDICAL DOCUMENT BY SECURE FAX

I have chosen to submit the original Medical Document via Secure ePortal Fax. The faxed document received is now the original Medical Document and this document will be a copy, retained for my records only.