

To be completed by a Health Care Practitioner. Mail, secure fax, encrypted email or courier documents to head office, below.

Patient Information

First Name: Last Name:
Birth Date: Health Card Number:
Phone: Email Address:
Purpose of use: Period of use: Daily Quantity:
Optional # of Months, cannot exceed 1 year # grams / day

Health Care Practitioner

Name:
Title First Name Last Name

Profession: Clinic Name:
Province of Practice: License Number:

Contact:
Phone Fax Email

Business Address:
City Province Postal Code

Consultation Address:
City Province Postal Code

Signature:
*Signature is attestation that information is correct and complete Year Month Day Practitioners Initials
*For faxing only: initials acknowledge MD is original and a copy is retained for physicians records.

Contact Us

Once completed, securely mail, fax or email this form to your local Cannabis Supply Co. clinic, or drop it off in person. If you are from outside of Ontario, please send to the head office location to the right:

Head Office:
Mail: 5B-164 Colborne Street West,
Brantford, ON, N3T 1L2
Phone: (519)-304-3420
Fax: (519)-304-3421
info@cannabissupplyco.ca