Medical Document ☐ Check if Telemedicine Appointment

CannabisSupplyCo.ca

To be completed by a Health Care Practitioner. Mail or deliver documents to head office, below.

Patient Information

First Name: ..... Last Name: .....

Birth Date: ..... (Month) ..... (Day) ..... (Year) Health Card Number: .....

Phone: ..... Email Address: .....

Purpose of use: ..... (Optional) Period of use: ..... (# of Months, cannot exceed 1 year) Daily Quantity: ..... (# grams / day)

Additional Notes: .....

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) ..... (Month) ..... (Day) ..... (Year) ..... (Practitioners Initials)

*For faxing only: initials acknowledge MD is original and a copy is retained for physicians records.

Contact Us

Once completed, securely mail or deliver this form to your local Cannabis Supply Co. clinic. 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