

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

Patient Information

First Name: Last Name:

Birth Date: Health Card Number:

Month Day Year

Phone: Email Address:

Purpose of use: Period of use: Daily Quantity:

Optional # of Months, cannot exceed 1 year # 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: Month Day Year Practitioners Initials

*Signature is attestation that information is correct and complete *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