FORM - 004 -V2

Medical Document

This medical document is to be completed by an Authorizing Health Care Practitioner (HCP).

FAX TO: (403) 452-4355

NATIONAL ACCESS CANNABIS MEDICAL

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Patient Information

(Please complete below or affix patient label)

Patient Name: ______________________________

DOB (MM/DD/YYYY): _____ _____ ______________

Telephone: __________________ __________________
Home Mobile

Email: ______________________________

Diagnosis: ______________________________

____

AFFIX PATIENT LABEL

Authorization for Medical Cannabis

The maximum quantity of dried cannabis a patient may possess cannot exceed 30 times the daily amount authorized or 150 grams (whichever is the less) as per the Cannabis Act and its regulations.

Quantity (grams per day): _______ grams. [Mandatory Field]

Duration: ________ months (maximum 12 months). [Mandatory Field]

Limitations:

[Optional] ☐ Oral Only	[Optional] ☐ THC Limit ________ %
[Optional] ☐ Dried Flower Only	[Optional] ☐ THC Limit ________ %

Authorizing Health Care Practitioner Information

Name: ______________________________ ______________________________
First Name Last Name

Profession: ☐ Physician ☐ Nurse Practitioner Name of Office or Clinic: ____________________

Business Address: ______________________________

City: ____________________ Province: ____________________ Postal Code: ____________

Telephone: ______________ Fax: ______________ Email: ____________________

Medical License Number: ____________________ Province(s) Authorized: ____________________

Consultation Method

The consultation was conducted through [check one and complete the field]:

☐ **An in-person visit:** Business address of consultation with patient (if different than above):

____

☐ **Telemedicine.** The Health Care Practitioner was located in the province of: ____________________

Declaration & Signature

By signing this document, the Healthcare Practitioner (HCP) is attesting that the information contained in this document is correct and complete. **I, the Healthcare Practitioner (HCP), am submiting the original Medical Document via secure fax.** I acknowledge that the securely faxed Medical Document is now the original Medical Document and that I have retained a copy of this document for my records only.

Signature of Authorizing HCP: ____________________ **Date: (DD/MM/YYYY):** ____________________

Phone: (587) 779-6420 | **Fax:** (403) 452-4355 | **Email:** calgary@nacmedical.com

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Faxed to (office use only): ____________________ **Faxed by (office use only):** ______

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