FORM MAY BE FILLED OUT IN ACROBAT READER AND PRINTED FOR SIGNING AND COMPLETION

STEP 2:

MEDICAL DOCUMENT

INSTRUCTIONS TO THE PATIENT

This Medical Document is to be completed by your healthcare practitioner (family physician, specialist, or, in some provinces, a nurse practitioner). To complete your registration as a client of Apothecary., please mail or fax this form together with your Registration Form (unless completed online) to:

- ✓ **Registration Form** (Step 1)
  (Unless completed online)
- ✓ **Original Medical Document** (Step 2)
  (Completed and signed by your healthcare practitioner)

APOTHECARY BOTANICALS
116-1776 BROADWAY ST
PORT COQUITLAM BC V3C 2M8

INSTRUCTIONS TO THE HEALTHCARE PRACTITIONER

The Government of Canada's Cannabis Regulations have simplified the process for patients to access medical marijuana. Under the new system, only two documents must be provided to a Licensed Producer.

The Cannabis Regulations stipulate that the Licensed Producer must verify that the patient has consulted with a licensed Health Care Practitioner, that the information set out in the Medical Document is correct and complete, and must confirm these matters with the office of the healthcare practitioner. Billing fee for verification is not required.

We appreciate you taking the time to help ensure that the Government of Canada's Cannabis Regulations prescription compliance requirements are met. If you have any questions or require further information to help you make an informed decision as to whether medical marijuana is appropriate for your patient, please refer to our website at www.apothecarybotanicals.ca or contact us via email info@apothecarybotanicals.ca or call us at +1.604-474-1795

The Government of Canada Cannabis Regulations information may be reviewed at:
https://laws-lois.justice.gc.ca/eng/regulations/SOR-2018-144/

Please completely fill out and sign the Medical Document on Page 2

HEALTHCARE PRACTITIONER INFORMATION

Healthcare Practitioner Title ☐ Doctor ☐ Nurse Practitioner

First Name

Last Name

Phone Number

Fax Number (*If Applicable*)

Email Address

Profession

Clinic / Business Name

License #

Province License is Held In

Business Address (Stamp or Label Acceptable)
Or List Street Address, City / Town, Province, Postal Code.

Consultation Address (If Different Than Business Address)
Or List Street Address, City / Town, Province, Postal Code.

☐ **Check the box** if the consultation address is the same as the business address.

☐ By checking this box, I consent to receive medical cannabis on behalf of the applicant *(if applicable)*.

Please indicate preferred method of contact for medical document verification: ☐ Phone ☐ Fax ☐ Email

PATIENT INFORMATION

First Name

Last Name

Birthdate (YYYY/MM/DD)

Gender ☐ Male ☐ Female ☐ Other

Unit #

Street Address

City / Town

Province

Postal Code

Phone Number

Email Address

Is this Patient Palliative? ☐ Yes ☐ No

Does this Patient Have a Permanent Disability? ☐ Yes ☐ No

* Note: palliative and permanently disabled patients may qualify for compassion pricing discount.

PRESCRIPTION

- **Dosage Range NOT acceptable (ie. 1-3 g).**
- **Grams are noted as # per day.**
- **Max number of months is 12.**

GRAMS		MONTH(S)		DAY(S)		WEEK(S)
	For		Or		Or	

Indication (Optional)

* Note: Billing fee for verification is not required. Prescription expires at the end of the period of validity of this Medical Document. The period of use begins on the day on which your registration with Apothecary is approved. Prescription must be registered with Apothecary Botanicals within 30 days of writing.

I hereby attest that I am responsible for the Applicant listed above *(sign, print name and date).*

Signature

x _____

Print Full Name

_____

Date (YYYY/MM/DD)