WEEDMD MEDICAL DOCUMENT

Thank you for selecting WeedMD as your Licensed Producer of choice! This Medical Document is to be completed only by a Healthcare Practitioner or Nurse Practitioner.

If you wish to have additional information sent, contact our Client Services Team at **1-844-WEEDMD-6** or visit our website at **www.weedmd.com**.

INSTRUCTIONS TO THE HEALTHCARE PRACTITIONER:
We appreciate you taking the time to consider whether medical marihuana meets the needs of your patient. To preserve the integrity of the information provided below, we ask that no stamps be used to fill out this Medical Document.

TWO WAYS TO SEND:

MAIL: ATTN: WEEDMD CLIENT SERVICES
250 ELM ST.
AYLMER, ON N5H 2M8
FAX: 1-844-WEEDMD-7 (1-844-933-3637)

MAIL: If sending via mail, ensure the Medical Document is completed and signed by a Healthcare Practitioner and is the **original** copy.

FAX: If sending via secure fax, ensure it is faxed directly from your Healthcare Practitioner's office and initialed at the bottom declaring it the original.

We are here to assist you each step of the way. If you need any assistance, our Client Services Team is always happy to help.

We're in this together,
The WeedMD Team

- Toll-Free: **1-844-WEEDMD-6** (1-844-933-3636) - Toll-Free Fax: **1-844-WEEDMD-7** (1-844-933-3637)
Email: orders@weedmd.com

If you have any questions please contact our Client Services Team at 1-519-765-2440 or toll-free 1-844-WEEDMD-6 (1-844-933-3636).

This form is to be completed by your Healthcare Practitioner **(Please fill out required fields, do not use stamp)**

CLIENT INFORMATION

Patient Name

Given Name	(Middle Name)	Surname

Date of Birth

YYYY/MM/DD

Gender

☐ Male ☐ Female ☐ Other

Contact Information

Phone #	Email

HEALTHCARE PRACTITIONER INFORMATION – PLEASE DO NOT STAMP INFORMATION

Practitioner

Title	Given Name	Surname

General Information

Profession	License # (CPSO, CPSBC, CMQ)	Province(s) authorized to practice in

Contact Information

Phone #	Fax #	Email

Business Information

Name & Address	Unit # (if applicable)

City	Province	Postal Code

Consultation Business Information (if different from business information)

Name & Address	Unit # (if applicable)

City	Province	Postal Code

Phone #	Fax #	Email

PRESCRIPTION

Note: The period of use cannot exceed one year

Grams/Day	THC Limit (%) (optional)	Day(s)	Week(s)	Month(s)	Primary Condition

By signing this document, the Healthcare Practitioner is attesting that the information contained in this document is correct and complete.

_____ _____

Signature of Healthcare Practitioner **Date of Signature (YYYY/MM/DD)**

If the patient chooses to produce cannabis for their own medical purposes or you are not submitting this document via secure fax do not initial the box below. If your patient chooses to access cannabis for medical purposes via a licensed producer, this medical document can be submitted from the Healthcare Practitioner's office to the licensed producer by secure fax. If you choose to submit the medical document by secure fax, initial the statement below to acknowledge agreement.

I, the Healthcare Practitioner, acknowledge that the faxed medical document is now the original medical document and that I have retained a copy of this document for my records only.

HEALTHCARE PRACTITIONERS INITIAL(S) ☐