Medical Document

To be completed by the Health Care Practitioner

Version 2.0 May 2017

IMPORTANT NOTE: Please ensure that we receive the original copy of this document as it is required in order to complete client registration

PATIENT INFORMATION - This section is mandatory

Given Name	Middle Name(s)	Surname
Date of Birth MM / DD / YYYY	Gender ☐ Male ☐ Female	Telephone No.

HEALTH CARE PRACTITIONER INFORMATION - This section is mandatory

Title / Profession	Given Name	Surname
Profession	Medical License No(s).	
Provinces Licensed In ☐ AB ☐ BC ☐ MB ☐ NB ☐ NL ☐ NS ☐ NT ☐ NU ☐ ON ☐ PE ☐ QC ☐ SK ☐ YT		

Business Address (a stamp is acceptable here)	Consultation Address (if different than business address)

Telephone No.	Fax No.	Email

Please indicate the Health Care Practitioner's preferred method of contact for document verification ☐ Telephone ☐ Fax ☐ Email

WRITTEN ORDER- This section is mandatory

Note: The maximum quantity of dried marihuana a client may possess **cannot exceed 150 g or 30 times the daily amount**, whichever is the lesser, as per Marihuana for Medical Purposes Regulations.

Medical Diagnosis OPTIONAL		
Number of Grams Per Day	For Number of Month(s) (up to 12)	

Note: The period of use cannot exceed one year & will begin on the day that the document is signed by the health care practitioner.

I, _____ attest that the information contained in this documents is correct & complete.
Health Care Practitioner Full Name

Health Care Practitioner's Signature: _____ Date: _____

☐ **INITIAL HERE IF YOU ARE SUBMITTING THIS MEDICAL DOCUMENT TO PEACE NATURALS VIA FAX:**
I have chosen to submit the original Medical Document to The Peace Naturals Project via the Peace Naturals' secure fax ePortal. I 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.

"Peace is its own reward." - Gandhi

The Peace Naturals Project

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