Medical Document

(Section 129, MMPR) Version 2.0 January 2017

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

Peace Naturals Referral Program

Health Care Practitioner Information

Title / Profession	Given Name	Surname
Profession		Medical License No.
Clinic / Business Name		
Address		
City	Province	Postal Code
Telephone No.	Fax No.	

Patient Information

Title	Given Name	Surname
Date of Birth MM / DD / YYYY	Telephone Number (Optional)	Email Address (Optional)

Address of Consultation if Different from Business Location: **Same As Above Address** ☐

Address		
City	Province	Postal Code
Telephone No.	Fax No.	

Written Order

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™

Mail or courier completed form to:
P.O. Box 999 | Stayner, ON | L0M 1S0

Toll Free: 1.888.64.PEACE (73223) | Secure Fax: 1.855.888.9973