

# MEDICAL DOCUMENT INSTRUCTIONS

The following form must be completed by a healthcare practitioner such as a family physician, medical specialist or, in some provinces and territories, a nurse practitioner.

### NOTE TO THE HEALTHCARE PRACTITIONER:

You can send us the Medical Document either by original paper copy or fax.

ORIGINAL PAPER COPY	FAX
Please mail us the original, completed and signed version of this Medical Document.	We can also accept this document when sent directly from your office by fax. Upon signing the Medical Document, you are declaring that the document you are faxing is now the original Medical Document.
<b>Emblem Cannabis</b> <b>PO Box 20087 Northville</b> <b>Paris, ON N3L 4A5</b>	<b>1-844-442-2467</b>

**Q:** *Can my physician use their own Medical Document in lieu of Emblem’s document?*

Yes, as long as the same criteria used for our Medical Document is met and the mandatory information we need to complete your registration is included. We recommend you compare our Medical Document with the doctor’s version to ensure all the information is on the form, and to prevent delays in completing your registration.



# MEDICAL DOCUMENT

## PATIENT INFORMATION

First Name:	Last Name:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Date of Birth: (YYYY/MM/DD)
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## HEALTHCARE PROVIDER INFORMATION

First Name:	Last Name:	Profession:	
License/Registration Number:		Province of License/Registration:	
Business Address:			
City:	Province:	Postal Code:	
Email:	Phone:	Fax:	
Location of Consultation (if different than Business Address):			
City:	Province:	Postal Code:	
Preferred Contact Method: <input type="checkbox"/> EMAIL <input type="checkbox"/> PHONE <input type="checkbox"/> FAX			

## AUTHORIZED DOSAGE OF DRIED MEDICAL CANNABIS

Quantity (grams per day):	Duration (maximum 1 year): _____ <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months
Product Recommendations (optional):	Patient Diagnosis (optional):
<input type="checkbox"/> SUGGESTED USE <input type="checkbox"/> MANDATORY USE	
Additional Comments:	

I hereby certify that the information in this document is correct and complete. In addition, I agree that the faxed Medical Document now becomes the original Medical Document, and that I have retained a copy of this document for my records only.

Signature of Healthcare Practitioner:	Date: (YYYY/MM/DD)
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FOR OFFICE USE ONLY:  SR