BROKEN COAST
CANNABIS

Box 1150, Ladysmith BC, V9G 1A8
1-888-486-7579
info@brokencoast.ca

MEDICAL DOCUMENT

This form must be completed by a Physician or Nurse Practitioner who is licensed in Canada. If another document is used in place of this one, it must contain all of the information below.

Please note that fields marked with a * are mandatory. Forms with missing or incomplete mandatory fields cannot be accepted as per ACMPR regulations. Please contact us if you have any questions regarding this form.

Health care practitioner information

Place stamp within the box, or fill out the information below. If you use a stamp, please ensure that all of the mandatory information below is provided.

* Name: _____ _____
Last Name *First Name*

* Profession: _____ Name of Office or Clinic: _____

* Business Address: _____

City: _____ Province _____ Postal Code: _____

* Telephone: _____ Fax: _____ Email: _____

Medical license information

* Medical License Number: _____ * Province(s): _____
Province(s) in which you are licensed to practice

Address of consultation

* ***The address at which the consultation took place between the applicant and the health care practitioner***

◯ The consultation took place at the business address above

◯ The consultation took place via internet (Skype, etc.)

If neither of the above options apply, please provide the address at which the consultation took place below:

Address: _____

City: _____ Province _____ Postal Code: _____

Patient information

* Name: _____ _____
Last Name *First Name*

* Date of Birth: _____
Day/Month/Year

Prescription

* Number of grams to be used per day: _____ g/day

* Duration of prescription: _____ ◯ Days ◯ Weeks ◯ Months (maximum 12 months)

The period of use cannot exceed one year and will begin on the day this document was signed and dated.

I attest that the information contained in this document is correct and complete. If submitted by secure fax, the faxed document received is now the original medical document and this document will be a copy, retained for my records only.

* Signature of Health Care Practitioner: _____

* Date: _____

Submit your original medical document along with your application form by one of the following methods:

- Canada Post: Box 1150, Ladysmith, BC, V9G1A8
- Courier: 106-3695 Drinkwater Road, Duncan, BC V9L0E9
- Secure fax: 1-844-860-1194

Note: secure faxes can only be received from the office of the health care practitioner listed above.

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