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FOR VALIDATION THIS FORM MUST BE FILLED IN BY AN MD, ND, OR DR. TCM

FIRST LAST DATE OF BIRTH

Patient's name:____/_______/______
d m y

I am willing to confirm that Mr./Mrs./Ms.____

at phone number (______)___________________has been diagnosed with__________________________________

and is presenting symptoms of____

____

☐ I recommend cannabis to help my patient with her/his symptoms.

☐ This patient has reported that her/his symptoms are helped by cannabis and therefore, on the basis of my knowledge, s/he should have access to it.

☐ This patient has reported that her/his symptoms are helped by cannabis.

☐ I do not recommend the use of cannabis for the reasons stated below:

- ☐ Medical: Please specify____
  ____
- ☐ Legal: Please explain ____
- ☐ Other: please explain ____

☐ **This patient is in a critical stage of their illness or treatment and requires immediate attention.**

PRACTITIONER'S SIGNATURE:____

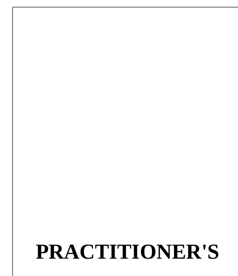
PRINTED NAME:____

DATE SIGNED:____

PRACTITIONER'S PHONE:____

PRACTITIONER'S ADDRESS:____

____



PRACTITIONER'S

STAMP/LICENSE#