OPTICANN®

MEDICAL DOCUMENT

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To be completed by the applicant's authorized health care practitioner.

SECTION 1: HEALTH CARE PRACTITIONER INFORMATION

Full Name		**Profession**
Business Address		
Medical License/Registration No.	**Province(s) Licensed in**	**Location of Consultation**
		☐ In-Person ☐ Via Phone ☐ Via Telemedicine
Phone	**Fax**	**Email**

SECTION 2: PATIENT INFORMATION

The patient must submit a separate Registration Form to accompany this document. This can be done at: opticann.ca/patient-registration

First Name		**Last Name**
Date of Birth (MM/DD/YYYY)	**Phone**	**Email**

SECTION 3: PRESCRIPTION INFORMATION

Quantity (grams/day)	**Prescription Period** (max. 365 days)	**Product Recommendations** (optional)
Diagnosis/Medical Condition (required only if document will be submitted to Veterans Affairs Canada)		

SECTION 4: SIGNATURE

Signature of Health Care Practitioner *I hereby certify that the information in this document is accurate and complete.*	**Date Signed**

SUBMISSION

☐ **HEALTH CARE PRACTITIONER: Initial if this Medical Document is being submitted via fax to Opticann.**
I acknowledge that the faxed Medical Document is now the original document and the document in my possession reverts to a copy retained for record keeping purposes only.

☐ **HEALTH CARE PRACTITIONER: Initial if you consent to receive medical cannabis on behalf of the patient.**
I, the patient's Health Care Practitioner, agree to have the patient's medical cannabis shipped to the business address specified on this Medical Document.

Please fax us this completed document to: (437) 826-9005 OR mail original document to our mailing address above.

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