HYDROPOTHECARY

Medical Document 1 of 2

Note: To register an applicant, Hydropothecary requires this signed original Medical Document and the signed Registration form.

REQUIRED

This document must be fully completed by the applicant's authorized health care practitioner as defined by Health Canada in the *Access to Cannabis for Medical Purposes Regulations*. *An authorized health care practitioner includes physicians in all provinces and territories, and nurse practitioners in provinces and territories where prescribing dried marijuana for medical purposes is permitted under their scope of practice.*

Patient's Name: _____ SURNAME, GIVEN NAME

Patient's Date of Birth: _____ YYYY/MM/DD

REQUIRED

Health Care Practitioner ☐ Physician ☐ Nurse Practitioner

Practitioner Name: _____ SURNAME, GIVEN NAME

Profession: _____

Province(s) authorized to practice in: _____

Licence Number(s): _____

Health Care Practitioner's Business Address

Address: _____ Suite Number: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

☐ I agree to receive Hydropothecary's newsletter containing news, updates and promotions regarding Hydropothecary's products. You can withdraw your consent at any time.

REQUIRED

Place of Business Where the Patient Consulted the Health Care Practitioner

****** LEAVE BLANK IF SAME AS ABOVE ******

Address: _____ Suite Number: _____

City: _____ Province: _____ Postal Code: _____

HYDROPOTHECARY

Medical Document continued 2 of 2

REQUIRED

Patient's Name: SURNAME, GIVEN NAME

Patient's Date of Birth: YYYY/MM/DD

Period of Use

Daily quantity of dried marijuana to be used by the patient: ____ g/day *This can **not** be a range.*

The period of use is ___ day(s) ___ week(s) ___ month(s). **cannot exceed one year**

Please keep a copy of this document *for your records as Hydropothecary is legally obliged to verify the accuracy of the information contained in the document upon receipt.*

OPTIONAL

Medical Condition*: OPTIONAL

**Mandatory if you wish to submit direct billing to Veterans Affairs Canada*

Maximum THC percentage: OPTIONAL %

Maximum CBD percentage: OPTIONAL %

Consent to receive dried marijuana from Hydropothecary on behalf of your patient (**Only if applicable**)

Address: _____ Suite Number: _____

City: _____ Province: _____ Postal Code: _____

Telephone Number: _____

I FULL NAME, POSITION, BUSINESS NAME

consent to receive dried marijuana on behalf of PATIENTS NAME

Health Care Practitioner's Signature: _____

SecureFax #
1 (888) 965-4623

REQUIRED

By signing this document, you confirm you are a licensed health care practitioner not named in a notice issued under section 59 of the *Narcotic Control Regulations* that has not been retracted under section 60 of those Regulations; you consulted with the applicant and you attest that the information contained in this document is correct and complete.

☐ **Check here if you are submitting the Medical Document to Hydropothecary by Fax attesting to the following:** *I have chosen to submit the original Medical Document to Hydropothecary via it's Secure Concierge sfax Service. I acknowledge that the faxed Medical Document is now the original Medical Document and that any retained copy of this document is for my records only.*

		YYYY/MM/DD
Print Name	*Health Care Practitioner's Signature*	*Date*