MEDICAL DOCUMENT (PRESCRIPTION) Fax to Terra Health 1-866-837-7291

This document may be completed by the applicant's authorized Health Care Practitioner.

HEALTH CANADA -ACCESS TO CANNABIS FOR MEDICAL PURPOSES REGULATIONS (ACMPR)

HEALTH CARE PRACTITIONER INFORMATION- (must be a medical doctor licensed in Canada)

GIVEN NAME/ DR: _____ SURNAME: _____

TITLE/PROFESSION _____ MEDICAL LICENSE _____ stamp if available

PROVINCE OF REGISTRATION: ONTARIO__

CLINIC NAME: _____

ADDRESS: _____ CITY: _____ PROVINCE: _____

POSTAL CODE:_____PHONE: _____FAX: _____

DID THIS CONSULTATION TAKE PLACE AT THE ABOVE ADDRESS: YES_____ NO _____

IF "NO" PLEASE SPECIFY ADDRESS: _____

PATIENT INFORMATION

GIVEN NAME: _____ SURNAME: _____

DATE OF BIRTH: DAY _____ MONTH_____ YEAR _____ GENDER: M ____ F ____

ADDRESS: _____APT. # _____

CITY: _____ PROVINCE: _____ POSTAL CODE _____

TELEPHONE: _____ EMAIL: _____

MEDICAL CONDITION (optional) _____

Grams per day _____ (1-5) for _____ months (period of use cannot exceed 12 months)

I attest that the information contained in this document is correct and complete.

Health Care Practitioners Signature x _____

DATE:(DD/MM/YYYY) _____/_____/ 2018____

I declare that this information is accurate and complete and agree that the faxed medical document is now the original, and that I have retained a copy for my records only. *Initial* _____

TO FILL THIS PRESCRIPTION: THE PATIENT WILL BE PROVIDED WITH EDUCATION AND ADMIMISTRATIVE SUPPORT BY: TERRA HEALTH NETWORKS- 1-866-837-7251

TO REGISTER WITH A HEALTH CANADA LICENSED PRODUCER FOR THEIR SUPPLY.

REFERRED BY CANNA RELIEF CONSULTING CANADA.