MedReleaf
THE MEDICAL GRADE STANDARD™

**MEDICAL DOCUMENT** - To be completed by a Health Care Practitioner

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## SECTION 1: PATIENT INFORMATION

First Name:

Last Name:

Date of Birth (DD/MM/YY):

Email:

## SECTION 2: HEALTH CARE PRACTITIONER

Title:

First Name:

Last Name:

Profession:

License #:

License Province:

Health care practitioner's business address

or

Full business address of the location at which the patient consulted the health care practitioner (if different)

NOTE: STAMP OR STICKER IS ACCEPTABLE HERE

Phone #:

Extension #:

Fax #:

Email:

## SECTION 3: ORDER FOR MEDICAL MARIHUANA (CANNABIS)

Quantity (grams per day):

Duration - # of Days: (365 Day Max.)

Name of Health Care Practitioner:

Attest that the information contained herein is correct & complete

Diagnosis:

Additional Information: (strain recommendations, THC restrictions):

Mandatory if checked:

Specify Type of Cannabis: Oil: Dried: Both:

Healthcare Practitioner's Signature:

Date Signed (DD/MM/YY):

**PLEASE INITIAL HERE IF SUBMITTING THIS DOCUMENT TO MEDRELEAF BY FAX**

I have chosen to submit the original Medical Document to MedReleaf via MedReleaf's secure fax. I acknowledge that the faxed Medical Document is now the original Medical Document and that I have retained a copy of this document for my records only.