Fax: +1-888-693-0150

SiRona Pharma

Medical document supporting the use of cannabis for medical purposes under the Cannabis Regulations

Patient Information

Patient Last Name:	
Patient First Name:	**Patient Middle Name(s):**
Patient's Date of Birth:	
Patient Telephone:	**Patient Email:**

Prescription

Daily quantity of dried cannabis authorized for the patient:		Grams/Day
Authorized period of use: (Note: The period of use cannot exceed one (1) year)		☐Days ☐Weeks ☐ Months ☐ Year

Doctor Information

Health Care Practitioner's First and Last Name:	
Health Care Practitioner's License Number:	**Province authorized to practice in:**
Health Care Practitioner's Address:	
Address of Medical Consultation with Patient (if different than above):	
Telephone Number:	**Fax Number:**

By signing this document, I, the supporting health care practitioner, have been asked by my patient to send this medical document directly to a licensed seller. In sending it by fax, I acknowledge that the faxed medical document shall constitute the original medical document.

By signing this document, the health care practitioner is attesting that they are not restricted, under the laws of the province or territory in which they practice, from authorizing the use of cannabis, and that the information contained in this document is correct and complete.

Sign X_____ **DATE:**_____

PLEASE FAX FORM TO: +1-888-693-0150

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