aqualitas

MEDICAL DOCUMENT

To be completed by a Health Care Practitioner

SECTION 1: PATIENT INFORMATION

First Name: | Middle Name: | Last Name: | Date of Birth (DD/MM/YY):

Email: | Phone #:

SECTION 2: HEALTH CARE PRACTITIONER

Title: | First Name: | Last Name:

Profession: | Licence #: | Licensing Province:

Health Care Practitioner's Address
OR
Consultation Address

NOTE: STAMP OR STICKER IS ACCEPTABLE HERE

Phone #: | Extension # | Fax #:

Email:

SECTION 3: MEDICAL DOCUMENT FOR MEDICAL CANNABIS

Quantity (grams per day): | Period of Use - # of Days: (up to 365)

Diagnosis: | Additional Information: (THC restrictions):

I, _____ attest that the information contained herein is correct and complete.

Health Care Practitioner's Signature:

Date Signed (DD/MM/YY):

Initial here if submitting this document to Aqualitas by secure fax

I have chosen to submit the original Medical Document to Aqualitas Inc. via Aqualitas' Secure eFax line. 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.

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For Health Canada link: https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/dhp-mps/alt_formats/pdf/marihuana/info/med-eng.pdf