MEDICAL DOCUMENT (Section 129)

FAX this Document from your Doctors Office to: **BeKind / Sweet Leaf Farm**

P: (250) 594-FARM (3276)

F: (250) 594-3275

Health Care Practitioner Information

To be completed by the Health Care Practitioner

Name: _____

Title / Profession Given Name Surname

Profession _____ Medical License No. _____

Clinic/Business Name _____

Address (line 1) _____

Address (line 2) _____

City _____ Province _____ Postal Code _____

Telephone # _____ Fax # _____

Patient Information

Patient's Name _____

Given Name Surname

Date of Birth (DD/MM/YYYY) _____ Gender M = ☐ F = ☐

Address of Consultation (If different from business location) Check box if same as above ☐

Address (line 1) _____

Address (line 2) _____ Phone No. _____

City _____ Province _____ Postal Code _____

Written Order

Note: The maximum quantity of dried marihauana a client may possess cannot exceed 150g or 30 times the daily amount, whichever is lesser, as per the MMPR

Medical diagnosis (optional) _____

STRAIN: **Indica** ☐ or **Sativa** ☐ # of grams _____ per day for ☐ months (upto 12)

NOTE: The period of use cannot exceed 12 months & will begin on the day that this document is signed by the Health Care Practitioner

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

Print Name

Health Care Practitioner Signature _____ Date _____