

**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 marihuana 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 \_\_\_\_\_