CannTrust™

Medical Document | (Section 129, MMPR)

Version 3.0

Mail or secure fax completed application to:
P.O. Box 92068-9200 Weston Road
Vaughan, Ontario, L4H 3J3

1-855-RX4-CANN (794-2266) | Fax: 1-844-295-6641 | www.canntrust.ca

Health Care Practitioner Information

Name: Title | Given Name | Surname

Profession: Fax No. Phone No.

Medical License No.: **Province of Authorization:**

Clinic/Business:

Address:

Consultation address (if different than clinic address):

Patient's Name:

Given Name | Surname

Date of Birth: Month Day Year

Mailing Address (if different from primary residence)

Where you receive correspondence from CannTrust™

Address Line 1

City Province Postal Code

Phone Number

Medical Diagnosis: (Optional)

Number of Grams **per day for** ○ Days ○ Weeks ○ Months

Special Instructions:

Note: The period of use cannot exceed one year & will begin on the day that the document is signed by the health care practitioner

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

Health Care Practitioner Full Name

Health Care Practitioner's Signature _____ **Date**

For Internal Use:

Verified by: _____ Date: Signature: _____ Verified: ☐

Note: _____