MEDICAL DOCUMENT

To be completed by your Health Care Practitioner
All fields with an asterisk (*) are mandatory.

Acreage Pharms Ltd.
PO Box 51, Peers, AB. T0E 1W0
clientcare@acreagepharms.ca

Phone: 1-888-386-0149
Fax: 1-780-693-0167

PATIENT INFORMATION

***PATIENT NAME:** _____
Given Name(s) Surname

***DATE OF BIRTH:** _____
Month / Day / Year

GENDER: ☐ Male ☐ Female OR ☐ Other (please specify) _____

***CONTACT INFO:** _____
Phone #

HEALTH CARE PRACTITIONER INFORMATION

***PRACTITIONER TITLE AND NAME:** _____
Title Given Name(s) Surname

***GENERAL INFO:** _____
Profession License # Authorized Province of Practice

***BUSINESS INFO:** _____
Phone Number Fax Number Email Address (if applicable)

_____
Business Address Unit Number

_____
City Province Postal Code

CONSULTATION ADDRESS:
(if different from above)

_____
Consultation Address Unit Number

_____
City Province Postal Code

WRITTEN ORDER FOR MEDICAL MARIHUANA

Note: The maximum quantity a patient may possess **cannot exceed 150 g or 30 times the daily amount of dried marihuana or its equivalency**, whichever is less, as per the Cannabis Act **The period of use cannot exceed one year.**

***This Patient may access _____ grams per day for ____ Days ____ Weeks ____ Months**
(please select one)

This Medical Document is valid for the period of use specified above.
By signing this document, the Health Care Practitioner attests that the information in this document is correct and complete.

***SIGNATURE:** _____ ***DATE:** _____
Signature of Health Care Practitioner Month / Day / Year

If applying for Veterans Affairs, Health Care Practitioner must specify diagnosis:_____

Your Medical Document may be submitted to Acreage Pharms Ltd. by mailing the original version or by faxing a copy of the original directly from the Practitioner's office.

Initial if Applicable:

☐ **IF YOU ARE SUBMITTING THE MEDICAL DOCUMENT TO ACREAGE PHARMS LTD. VIA FAX**
I, the Health Care Practitioner, acknowledge that the faxed medical document is now the original medical document and that I have retained a copy of this document for my own records. (The original will not be released to the patient.)

☐ **IF YOU WILL BE RECEIVING THE PATIENT'S MEDICAL MARIHUANA TO YOUR BUSINESS ADDRESS**
I, the patient's Health Care Practitioner, consent to receive medical marihuana on behalf of the patient at the business address on this medical document.
Note: If you choose to withdraw consent to receive medical marihuana on behalf of the patient, you must send written notice to that effect to both the patient and the LP.