For Validation, this form must be filled in by a Doctor of Medicine (MD), Psychiatrist (PDOC), Psychologist (RP), Nurse Practitioner (NPA) a Doctor of Naturopathic Medicine (ND), a Doctor of Traditional Chinese Medicine (DTCM), or a Doctor of Dental Medicine (DMD), and faxed from the Practitioner's office.

PRACTITIONER'S STATEMENT

Patient's Name (first, last): ____________________

D.O.B.: ____________ Gender: ____________

I am writing to confirm that Mr./Mrs./Ms. ____________________

at phone number (   ) ____________ has been diagnosed with ____________________

and is presenting symptoms of ____________________

or is wishing to avoid experiencing ____________________

- ☐ I recommend cannabis to help this patient.
- ☐ This patient has reported that their symptoms are helped by cannabis and therefore, on the basis of my knowledge, they should have access to it.
- ☐ This patient has reported that their symptoms are helped by cannabis.
- ☐ This patient has reported that they have avoided or prevented certain illnesses through the use of cannabis.
- ☐ This patient is in critical condition and requires immediate attention.
- ☐ I do not recommend the use of cannabis for the reasons stated below:
    - ☐ Medical Reasons, Please Specify: ____________________
    - ☐ Legal Reasons, Please Explain: ____________________
    - ☐ Other Reasons, Please Explain: ____________________

	Practitioner's Stamp / License Number
Practitioner's Signature: ____________	
Printed Name: ____________	
Date Signed: ____________	
Practitioner's Phone: ____________	
Practitioner's Address: ____________	

PH. 778.379.9420 · FX.778.379.8420 · 1353 EAST 41ST AVE. VANCOUVER, BC V5W 1R7

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