



MEDICAL PRACTITIONER RECOMMENDATION FOR MEDICAL CANNABIS

Patient's Name: _____ Date of Birth: ____/____/____
(MM/DD/YYYY)

Phone Number (____) _____ has been diagnosed with _____

- I recommend cannabis to help my patient with his/her symptoms.
- This patient has reported that his/her symptoms are helped by cannabis and therefore, on the basis of my knowledge, he/she should have access to it.
- This patient has reported that his/her symptoms are helped by cannabis.
- I do not recommend the use of cannabis for the reasons stated below:
 - Medical: Please explain _____
 - Legal: Please explain _____
 - Other: Please explain _____
- This patient is in a critical stage of his/her illness or treatment and requires immediate attention.
- Daily recommended amount _____

PRACTITIONER'S SIGNATURE: _____

PRINTED NAME: _____

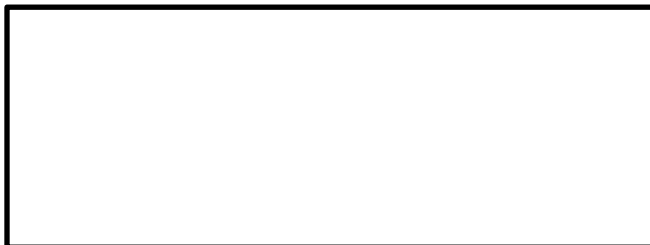
DATE SIGNED: _____

PRACTITIONER'S PHONE: _____

PRACTITIONER'S ADDRESS: _____

CITY: _____

PROVINCE: _____



Physician's Stamp / License #