MEDICAL DOCUMENT

Phone: 1-866-899-7873 | Secure Fax: 1-888-216-6798 | P.O Box 2247, Brampton, ON L6T 3Y9 | www.puresinse.com

All fields that are marked by * are mandatory unless specified. Clarification to those fields may be provided.

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Patient Information

Please contact our client care team at 1-866-899-7873 if you have any questions regarding this form. If you are a health care practitioner and would like to send us your own medical document please ensure that all the mandatory information is included to complete the registration. To avoid unnecessary delays, you may wish to use this medical document – this form must be completed by a health care practitioner such as a primary care doctor or a medical specialist; and in some provinces a nurse practitioner. **This form may be submitted to us by mailing the original version to P.O Box 2247, Brampton, ON L6T 3Y9 or by faxing a copy of the original document to 1-888-216-6798.**

***Patient Name**

Given Name ______ Surname ______

***Date of Birth**

Year ______ Month ______ Day ______

Gender ☐ Male ☐ Female

***Contact Info**
(Complete one or more)

Phone ______ Email ______ Secondary Phone ______

Health Care Practitioner Information

***Practitioner Title and Name**

Title ______ Given Name ______ Surname ______

***General Info**

Medical Profession ______ License# (CPSO,CPSBC,CMQ) ______ Province(s)Authorized to Practice in ______

***Contact Info**
(Complete one or more)

Phone ______ Email ______ Fax ______

***Business Address**

Business Address ______ Unit Number (If applicable) ______

City ______ Province ______ Postal Code ______

***Consultation Address**

☐ **Same as above**

Consultation Address ______ Unit Number (If applicable) ______

City ______ Province ______ Postal Code ______

Prescription

***Quantity/Diagnosis**

Grams/Day ______

◯ Days ◯ Weeks ◯ Months

Period of Use (Maximum of 365 days)

Medical Condition (mandatory if submitting To Veterans Affairs) ______

***Signature**

I attest that the information on in this document is correct and complete

Signature of Health Care Practitioner ______

***Date**

Year ______ Month ______ Day ______

Submission and Shipping (If Applicable)

☐ **HEALTH CARE PRACTITIONER INITIAL IF YOU ARE SUBMITTING THE MEDICAL DOCUMENT TO PURESINSE BY FAX.** I, the patient's Health Care Practitioner, have chosen to submit the original *Medical Document* via PureSinse Fax. I acknowledge that the faxed *Medical Document* is now the original *Medical Document* and the document in my possession reverts to a copy retained for record keeping purposes only.

☐ **HEALTH CARE PRACTITIONER INITIAL IF YOU WILL BE RECIEVING THE PATIENT'S MEDICAL MARIJUANA TO YOUR BUSINESS ADDRESS.** I, the patient's Health Care Practitioner, consent to receive medical marijuana on behalf of the patient at the business address on this *Medical Document.* Note: If at anytime you cease to consent to receive medical marijuana on behalf of the patient, you must send a written notice to that effect to both the patient and the licensed producer.