CANADA'S ISLAND GARDEN INC.
7 INNOVATION WAY
CHARLOTTETOWN, PRINCE EDWARD ISLAND, CANADA C1E 0B7

PHONE: (902) 370-5500 FAX: (902) 370-5501
EMAIL: *info@canadasislandgarden.com*

To be completed by Canada's Island Garden Inc. only
MEDICAL DOCUMENT NUMBER

MEDICAL DOCUMENT

PLEASE COMPLETE ALL SECTIONS OF THIS DOCUMENT. *The original of this document completed, signed and dated by the patient's authorized health care practitioner, must be included with the patient's application for registration as a client of a licensed producer.*
Please Note*: All Medical Document details are required, under the MMPR, to be verified with the office of the issuing medical practitioner. Please indicate your preferred method of contact.*

SECTION 1: HEALTH CARE PRACTITIONER INFORMATION

To be completed by the Health Care Practitioner.

First Name(s)	Middle Name (if applicable)	Last Name
Profession	Medical License Number(s)	

Province(s) Licensed in ☐ AB ☐ BC ☐ MB ☐ NB ☐ NL ☐ NS ☐ NT ☐ NU ☐ ON ☐ PE ☐ QC ☐ SK ☐ YT

Business Address

City	Province	Postal Code
Phone	Fax	Email

Preferred Contact Method for Medical Document Verification (phone, fax, email):

CONSULTATION ADDRESS

The clinic/business address of the location at which the patient consulted with the health care practitioner.

☐ Check if Consultation Address is the same as the Business Address provided above.

Business Address

City	Province	Postal Code
Phone	Fax	Email

SECTION 2: PATIENT INFORMATION

To be completed by the Health Care Practitioner

First Name(s)	Middle Name *(if applicable)*	Last Name
Date of Birth *(mm/dd/yyyy)*		Gender ☐ Male ☐ Female

SECTION 3: WRITTEN ORDER

NOTE: The maximum quantity of dried marihuana for medical purposes possessed by a client at any time cannot exceed the least of the following amounts: 150 g or 30 times the daily maximum amount prescribed below, as per the Marihuana for Medical Purposes Regulations (MMPR).

NOTE: The Prescription period cannot exceed one year, and will begin on the day this document is signed by the Health Care Practitioner.

Daily Prescribed Maximum Quantity of Dried Marihuana: _____ gram(s) per day

Prescription Period *(maximum 365 days)* _____ Days

By signing this document, the health care practitioner attests that the information contained in this document correct and complete.

Signature of Health Care Practitioner _____ Date*(mm/dd/yyyy)* _____

SECTION 4: SUBMISSION

☐ **Secure Fax –** Fax submissions must be initialed below and sent from the Health Care Practitioner's office.

_____ (Initials of Health Care Practitioner) By initialing, the Health Care Practitioner acknowledges that the faxed copy sent to Canada's Island Garden Inc. constitutes the original Medical Document, and that he/she has retained a copy of this document for their records. The Health Care Practitioner also attests that this Medical Document will not be faxed or provided to any party other than Canada's Island Garden. Fax #: (902) 370-5501

☐ **Mail –** Mailed submissions must contain the ORIGINAL of this document and the completed Application Form.
Mail to ***Canada's Island Garden Inc. 7 Innovation Way, Charlottetown PE C1E 0B7***

FORM-013-00 Effective Date: 2016-Jul-11