Ontario Medicinal Marijuana

PRACTITIONER'S STATEMENT

For validation this form must be filled in by an MD, ND, or DR. TCM, and faxed from the practitioner's office to Organix Compassion.
Patient's name: _____
Date of Birth: _____

I am willing to confirm that
Mr./Mrs./Ms_____
at phone number (_____)_____has been diagnosed with _____
_____
and is presenting symptoms of_____
_____
_____

- I recommend cannabis to help my patient with her/his symptoms.
- This patient has reported that her/his symptoms are helped by cannabis and therefore, on the basis of my knowledge, s/he should have access to it.
- This patient has reported that her/his symptoms are helped by cannabis.
- I do not recommend the use of cannabis for the reasons stated below:

Medical: Please specify_____
Legal: Please explain_____
Other: please explain_____

I authorize my patient to use _____ grams per day

PRACTITIONER'S SIGNATURE: _____
PRINTED NAME: _____
DATE SIGNED: _____
PRACTITIONER'S PHONE: _____
PRACTITIONER'S ADDRESS: _____

PRACTITIONER'S STAMP/LICENSE