**MEDICAL DOCUMENT: Form B** - To be completed by a Health Care Practitioner

**Optimus Cannabis, Inc.**
Attn: Patient Care Team
339 Unit A
Willow St.
Truro, NS
B2N 5A6 Canada

**Phone: 902-895-7683**
**Fax: 902-895-3783**
**patientcare@optimuscannabis.ca**
**http://optimuscannabis.ca**

## SECTION 1: PATIENT INFORMATION

First Name: | Last Name: | Date of Birth (DD/MM/YYYY):

Email:

## SECTION 2: HEALTH CARE PRACTITIONER

Title: | First Name: | Last Name:

Profession: | License #: | License Province:

Health care practitioner's business address
or
Full business address of the location at which the patient consulted the health care practitioner (if different)

NOTE: STAMP OR STICKER IS ACCEPTABLE HERE

Phone #: | Extension #: | Fax #:

Email:

## SECTION 3: ORDER FOR MEDICAL CANNABIS

Quantity (grams per day): | Duration - # of Days: (365 Day Max) | Name of Health Care Practitioner:

Attest that the information contained herein is correct & complete.

Diagnosis:

Additional Information: (strain recommendations, THC restrictions):

Mandatory if checked:

Specify Type of Cannabis: Oil: Dried: Both:

Healthcare Practitioner's Signature:

Date Signed (DD/MM/YY):

PLEASE INITIAL HERE IF SUBMITTING THIS DOCUMENT BY FAX

I have chosen to submit the original Medical Document to Optimus Cannabis, Inc. via Optimus Cannabis's secure fax. I acknowledge that the faxed Medical Document is now the original Medical Document and that I have retained a copy of this document for my records only.