Fax: 1-902-895-3783
Online Registration: optimuscannabis.ca

This document must be mailed or faxed to:
339 Unit A Willow St.
Truro, NS B2N 5A6 Canada
Phone: 902-895-7683
Email: patientcare@optimuscannabis.ca

Medical Document

Health Care Practitioner Information

Name: Given Name | Surname

Profession: | Fax No. | Phone No.

Medical License No.: | **Province of Authorization:**

Clinic/Business:

Address:

Consultation address (if different than above address)

Patient's Name:

Given Name | Surname

Date of Birth: Month | Day | Year

Mailing Address (if different from primary residence)

Address Line 1

City | Province | Postal Code

Phone Number

Medical Diagnosis:

(Optional)

Number of Grams **per day for** ☐ Days ☐ Weeks ☐ Months

Special Instructions:

Note: The period of use cannot exceed one year & will begin on the day that the document is signed by the health care practitioner

I, attest that the information contained in this document is correct & complete.

Health Care Practitioner Full Name

Health Care Practitioner's Signature **Date**

I, the health care practitioner, acknowledge that the faxed or electronic medical document is now the original medical document and that I have retained a copy of this document for my records only: ***Initial only if Submitting via FAX:***

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Verified by: Date: Signature: Verified: ☐