CENTRAL
PLAINS
CANNABIS

Medical Document - To be completed by a Health Care Practitioner

1. Patient Information

First Name _____ Last Name _____ Date of Birth _____

Email _____

Phone Number _____

☐ Male ☐ Non-binary

☐ Female ☐ Prefer not to say

2. Health Care Practitioner Information

Please print clearly in full. (No abbreviations)

Title _____ First Name _____ Last Name _____

Profession _____ License # _____ Province _____

Phone _____ Extension _____ Email _____

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

3. Prescription

Quantity (grams) _____ Duration _____ ☐ Days ☐ Weeks ☐ Months

Diagnosis _____

THC Limitation _____ Additional Notes _____

Health Care Practitioner Signature _____ Date _____

Please initial here if submitting to Central Plains Cannabis by Fax ☐

I have chosen to submit the original Medical Document to Central Plains Cannabis via 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

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