MOTACAN Compassion Society

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MEDICAL PRACTITIONER FORM

IMPORTANT INFORMATION: THIS FORM WILL ONLY BE ACCEPTED WHEN FILLED OUT BY AN MD, ND, NP OR FAMILY DR. THIS FORM MUST BE FAXED OR EMAILED FROM THE PRACTIONERS MEDICAL OFFICE TO MOTACAN COMPASSION SOCIETY

Patients Name: _____Date of Birth: Day____ Month____ Year_____

I have personally spoke with Mr./Mrs./Ms. _____ and I can confirm that they have been diagnosed with _____, this is causing them to experience symptoms of _____.

o I recommend that this patient try cannabis to help ease there symptoms.

o Based on my knowledge and discussions with this patient that cannabis can help and ease their symptoms. I therefore agree that they should be able to access cannabis as a medicinal alternative.

o **I believe this patient is in need of immediate attention, as a result of illness or treatment**

PRACTIONERS NAME: _____
PRACTIONERS ADDRESS: _____
_____
PRACTIONERS CONTACT NUMBER: _____

PRACTIONERS SIGNATURE: _____ DATE SIGNED: _____

NATUROPATH DOCTORS ONLY:

o Checking this circle and signing this form can confirm that I am the primary healthcare provide for this patient.

Naturopath Signature _____ Date: _____