MEDICAL DOCUMENT

(to be completed by the Health Care Practitioner)

MMG
PO Box 20070 RPO
Edward Street
St. Thomas, ON N5P 4H4
Phone: 1-833-444-4664
Fax: 1-833-222-2664
Email: ClientCare@medmg.ca
www.medmg.ca

1. PATIENT INFORMATION

☐ Male ☐ Female

Given First Name | Last Name | D.O.B (MM/DD/YYYY)

2. HEALTH CARE PRACTITIONER INFORMATION

Title | Given First Name

Last Name | Profession

Physician License # | Phone

Fax | Email

Business Address

Unit # (If applicable) | City

Province | Postal Code

☐ **HEALTH CARE PRACTITIONER: Initial if you agree to receive the patient's medical cannabis to your business address listed on this document.** I, the patient's Health Care Practitioner, agree to have the patient's medical cannabis shipped to the business address specified on this Medical Document.

3. CONSULTATION ADDRESS

CONSULTATION ADDRESS

☐ Same as Business Address

Consultation Address

Unit # (If applicable) | City

Province | Postal Code

4. PRESCRIPTION

Grams/Day | Duration in Days (Max. 365 days)

Max. THC (Not required) | Diagnosis/ Medical Condition (Not required)

Notes

☐ Mandatory If Checked

5. SIGNATURE

Health Care Practitioner Signature:

Date (MM/DD/YYYY): | **Province Authorized to Practice In:**

By signing this Medical Document, you consent to MMG's collection, use, and disclosure of the personal information contained in it, in accordance with MMG's privacy policy, available at www.medmg.ca. If the personal information in the Medical Document pertains to someone other than you, you represent and warrant that you have obtained their consent and/or have authority to consent on their behalf. Consent may be withdrawn at any time, but such withdrawal will: not have retroactive effect; may have implications to you and/or the subject individual and will not affect the collection, use, and disclosure is permitted or required by law without consent.

☐ **HEALTH CARE PRACTITIONER: Intial if this Medical Document is being submitted via fax to MMG**
I acknowledge that the faxed Medical Document is now the original document and that I have retained a copy for office records only. I also confirm that I am a licensed practitioner not named under Section 59 of the Narcotic Control Regulations that has not been retracted under Section 60.

☐ **HEALTH CARE PRACTITIONER: Intial if you agree that all the information on the Medical Document is true and correct.**
I, the patient's Health Care Practitioner certify that the information on this document is correct and complete.

Please fax this completed document to: 1-833-222-2664
or scan and email to: ClientCare@medmg.ca

OR

Mail original document to:
MMG, ATTN: Client Care
PO Box 20070, RPO Edward Street, St. Thomas ON N5P 4H4