United Greeneries Ltd.
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MEDICAL DOCUMENT

This must be completed by a Physician or Nurse Practitioner who is licensed in Canada

1. HEALTH CARE PRACTITIONER INFORMATION

Title | Given First Name | Last Name | Profession

Medical License # | Province of Issue of Medical License # | Phone | Fax

Business Address | Unit # | City | Province | Postal Code

Address of Consultation (if different from Business Address):

Consultation Address | Unit # | City | Province | Postal Code

2. PATIENT INFORMATION

☐ Female ☐ Male ☐ Other ☐ Undisclosed

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

3. PRESCRIPTION

Grams/Day | Duration in Days (Note: the period of use cannot exceed one year) | Max. THC (not required) | Diagnosis/Medical Condition (not required)

4. SIGNATURE

By signing this document, I, the Health Care Provider, attest that the information contained in this document is correct and complete.

Health Care Practitioner Signature: | Date (MM/DD/YYYY):

☐ **Initial if this Medical Document is being submitted via fax to United Greeneries Ltd.** I acknowledge that the faxed Medical Document is now the original document and that i have retained a copy of the original for office records only.