Medical Document

Green Relief

To be completed by an authorized Health Care Practitioner, as defined in the Cannabis Act, for a person who is in their care. All fields required.

Patient Information Must match information on Green Relief Registration Form	
First Name	Last Name
Date of Birth (MM/DD/YYYY)	Telephone
Email	

Usage Information Please print clearly in full (no abbreviations)	
Daily Quantity Please note that within any 30 day period, Green Relief will not provide a total quantity of cannabis that exceeds 30 times the daily authorized limit. _____ grams/day	Period of Use Period must not exceed one year. _____ days _____ weeks _____ months
Additional Information (e.g. Mandatory THC limits, dosing details)	
Medical Diagnosis (Optional)	

Health Care Practitioner Information Please print clearly in full (no abbreviations)		
First Name	Last Name	
Profession	Medical License #	
Province(s) Licensed to Practice In		
Office Address		
City	Province	Postal Code
Telephone	Fax	
Email Address		
Address Where Consultation Occurred		
City	Province	Postal Code

Authorization of Health Care Practitioner	
I attest that the information in this document is accurate and complete and I have consulted with the Patient referenced above.	
Printed Name	
Signature	Date

☐ Initial here if you are submitting this Medical Document to Green Relief via fax. You acknowledge that the faxed version will become the original Medical Document and that you have retained a copy of this document for your records.

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