AGMEDICA BIOSCIENCE INC.
111 Heritage Road, Suite 200 | Chatham, ON N7M 5W7
tf. 1-844-5MY-CARE (1-844-569-2273) f. 1-866-927-8847
e. clientcare@agmedica.ca www.agmedica.ca

MEDICAL DOCUMENT

*Thank you for selecting **AgMedica Bioscience Inc.** as your licensed producer of choice! This Medical Document is to be completed only by a Physician or Nurse Practitioner. If you wish to have additional information sent, contact our Client Care Team at **1-844-5MY-CARE (1-844-569-2273)** or visit our website at **www.agmedica.ca***

Confidential Health Information Enclosed. Health care information is personal and sensitive. It is being submitted to you after appropriate authorization from the individual or under circumstances that do not require individual authorization. You, the recipient, are obligated to maintain this information in a safe, secure and confidential manner. Re-disclosure without additional consent or authorization of the individual or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain the confidentiality of this information could subject you to penalties under Federal and/or Provincial law.

INSTRUCTIONS TO THE PHYSICIAN OR NURSE PRACTITIONER:

We appreciate you taking the time to consider whether ***AgMedica Bioscience Inc.*** meets the needs of your patient. To preserve the integrity of the information provided below, we ask that **no stamps** be used to fill out this Medical Document.

TWO WAYS TO SEND:

MAIL: ATTN: AgMedica Bioscience Inc. Client Care Team
111 Heritage Road, Suite 200 | Chatham, ON N7M 5W7
FAX: 1-866-927-8847

MAIL: If sending via mail, ensure the Medical Document is completed and signed by your doctor or nurse practitioner and is the **original** copy.

FAX: If sending via secure fax, ensure it is faxed directly from your doctor or nurse practitioner's office and initialed at the bottom declaring it the original.

If you need any assistance, our Client Care Team is always happy to help.

Yours on this incredible journey,

The AgMedica Team

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This form is to be completed by your doctor or nurse practitioner **(Please fill out required fields, do not use stamp)**

CLIENT INFORMATION

Client Contact Information

Given Name | Middle Name | Surname

Date of Birth (MM/DD/YYYY)

☐ Male ☐ Female
☐ Other ☐ Undisclosed

Email

Primary Contact #
☐Cell ☐Home ☐Fax
☐OK to leave voicemail
☐Morning ☐Afternoon ☐Evening

Secondary Contact #
☐Cell ☐Home ☐Fax
☐OK to leave voicemail
☐Morning ☐Afternoon ☐Evening

HEALTHCARE PRACTITIONER INFORMATION

Practitioner

Title | Given Name | Surname

General Information

Profession | License # (CPSO, CPSBC, CMQ) | Province(s) authorized to practice in

Contact Info (Complete one or more)

Phone | Email | Fax

Business Information

Practitioner's Business Address | Unit Number

City | Province | Postal Code

Consultation Address (if different from Practitioner's business address)

Name & Address | Unit Number

City | Province | Postal Code

Phone | Email | Fax

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OR SCAN & EMAIL TO: clientcare@agmedica.ca

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PRESCRIPTION

NOTE: The period of use cannot exceed one year

Grams/Day	THC Limit (%) (optional)	Day(s)	Week(s)	Month(s)

Primary Condition

By signing this document, the Healthcare Practitioner is attesting that the information contained in this document is correct and complete.

Signature of Healthcare Practitioner

Date (MM/DD/YYYY)

Authorized to practice in: ____________
Province

Initials of Healthcare Practitioner — I, the Healthcare Practitioner, certify that the information contained in this document is correct and complete.

Initials of Healthcare Practitioner — Initial if this Medical Document is being submitted via secure fax to AgMedica Bioscience Inc. I acknowledge that the faxed Medical Document is now the original document and that I have retained a copy for office records only. I further attest that I am a licensed practitioner not named under Secion 59 of the Narcotic Control Regulations that has not been retracted under Section 60 of those regulations.

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