MEDICAL DOCUMENT

Thank you for selecting Wiisag as your new holistic health home of choice!

This Medical Document is to be completed only by a Healthcare Practitioner or Nurse Practitioner.

If you wish to have additional information sent, contact our Medicinal Services Bureau Team at info@wiisag.ca.

INSTRUCTIONS TO THE HEALTHCARE PRACTITIONER:
We appreciate you taking the time to consider whether medical marihuana 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: WIISAG MEDICINAL SERVICES BUREAU
348 PORT ELGIN ROAD NEYAASHIINIGMIING, ON
N0H 2T0

EMAIL: INFO@WIISAG.CA

MAIL: If sending via mail, ensure the Medical Document is completed and signed by a Healthcare Practitioner and is the **original** copy.

EMAIL: If sending via secure e-mail, ensure it is e-mailed directly from your Healthcare Practitioner's office and initialed at the bottom declaring it the original.

We are here to assist you each step of the way during your healthcare journey.

The Wiisag Team

348 PORT ELGIN ROAD,
NEYAASHIINIGMIING, ON N0H 2T0

Email: info@wiisag.ca

If you have any questions please contact our Medicinal Services Bureau Team at info@wiisag.ca. This form is to be completed by your Healthcare Practitioner **(Please fill out required fields, do not use stamp)**

CLIENT INFORMATION

Patient Name

Given Name | (Middle Name) | Surname

Date of Birth

YYYY/MM/DD

Gender

☐ Male ☐ Female ☐ Other

Contact Information

Phone # | Email

HEALTHCARE PRACTITIONER INFORMATION – PLEASE DO NOT STAMP INFORMATION

Practitioner

Title | Given Name | Surname

General Information

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

Contact Information

Phone # | Fax # | Email

Business Information

Name & Address | Unit # (if applicable)

City | Province | Postal Code

Consultation Business Information (if different from business information)

Name & Address | Unit # (if applicable)

City | Province | Postal Code

Phone # | Fax # | Email

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 of Signature (YYYY/MM/DD)

I, the Healthcare Practitioner, acknowledge that the e-mailed medical document is now the original medical document and that I have retained a copy of this document for my records only.

HEALTHCARE PRACTITIONERS INITIAL(S)