Weeds Kelowna Compassion Society

Phone 778-478-9339
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For validation this form must be filled in by a MD, ND, or DR. TCM, and faxed the practitioner's office to Weeds Kelowna, or have the original document delivered to Weeds Kelowna.

Patient's name: _____

Patient's date of birth:_____

I am willing to confirm that (patient's name) _____

at (phone number) _____,

has been diagnosed with_____

and is presenting symptoms of _____.

☐ I recommend medical marijuana to help my patient with his / her symptoms

☐ This patient has reported that his / her symptoms are helped by medical marijuana and therefore, on the basis of my knowledge , he / she should have access to it.

I recommend _____ grams of medical marijuana for this patient per day.

Practitioner's Signature:_____Date:_____

Practitioner's Name:_____

Practitioner`s Phone:_____

Practitioner`s Address:_____