BC Pain Society
Cannabis education and consultation

www.bcpainsociety.com
Please fax completed form to 604.608.9461

Medical practitioners consent to use marijuana

Patients Information

First Name: ____ Last Name: ____

Date Of Birth: ________________ /________________/________________
(Month) (Date) (Year)

Gender: Male ☐ Female ☐

Residential Address: ____

City: ___________________________ Province: __________________ Postal Code: _________________

Phone: ___________________________________

Medical Practitioners Information

Medical practitioner's full name: ____

Provincial medical licence number: ____

Medical specialization (if applicable): ____

Business Address: ____

Suite: ______ City: ____________________ Province: ______________________ Postal Code: _______________

Telephone:_______________________ Fax: _______________________ E-mail: _______________________

STAMP (if available)

I conclude that marijuana for medical purposes is an appropriate option for the above patient.

Date: ___________________________ Signature: ____

Misc. Information

All information on this form may be verified before BC Pain Society will issue the above patient a membership and ID card. This form will remain the property of BC Pain Society and may be shown to any member of the local law enforcement if requested.