



*Sea to Sky Alternative Healing Society
6636 Fraser St. Vancouver BC
Phone (604) 420-5559 Fax (604) 336-1212*

FOR VALIDATION, THIS FORM MUST BE FILLED IN BY AN MD, ND, NP, or TCM

Name of Patient: _____

Date of Birth: _____

I am willing to confirm that the above patient has a working diagnosis of _____
_____ and is presenting symptoms of _____

This patient's symptoms warrant access to cannabis

<p><input type="checkbox"/> This patient has reported that his/her symptoms are helped by cannabis</p> <p><input type="checkbox"/> This patient has not recently tried cannabis and would like access to discover its effects on their condition</p>
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This patient's symptoms do not warrant access to cannabis

<p>I do not recommend the use of cannabis for the reasons stated below:</p> <p><input type="checkbox"/> Medical: Please specify _____</p> <p><input type="checkbox"/> Legal: Please explain _____</p> <p><input type="checkbox"/> Other: Please explain _____</p>

This patient is in a critical stage of their illness or treatment and requires immediate attention.

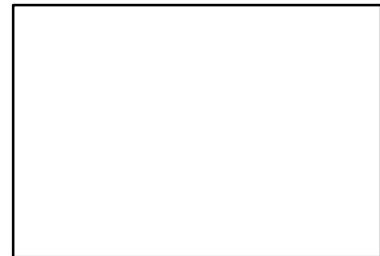
PRACTITIONER'S SIGNATURE: _____

PRINTED NAME: _____

DATE SIGNED: _____

PRACTITIONER'S PHONE #: _____

PRACTITIONER'S ADDRESS: _____



PRACTITIONER'S
STAMP/LICENSE #