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**

- ☐ This patient has reported that his/her symptoms are helped by cannabis
- ☐ This patient has not recently tried cannabis and would like access to discover its effects on their condition

☐ **This patient's symptoms do not warrant access to cannabis**

I do not recommend the use of cannabis for the reasons stated below:

- ☐ Medical: Please specify_____
- ☐ Legal: Please explain _____
- ☐ Other: Please explain _____

☐ **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 #