

BCCCS Practitioner's Statement

For Validation this form must be filled in by a MD, ND, DTCM, or DMD, and faxed from the Practitioner's Office.

Patient's Name: First _____ Last _____ D.O.B _____ G _____

I am writing to confirm that Mr./Mrs./Ms. _____

at ph. number (_____) _____ has been diagnosed with _____

and is presenting symptoms of _____

I recommend cannabis to help my patient with her/his symptoms.

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

This patient has reported that his/her symptoms are helped by 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 #

