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

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

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

at phone number (___)_____has been diagnosed with_____

and is presenting symptoms of _____

☐ This form allows this patient to access services & products from Green Era Medicinal Society only.

☐ I recommend cannabis to help my patient with their symptoms.

☐ This patient has reported that their symptoms are helped by cannabis and therefore, on the basis of my knowledge, they should have access to it.

☐ This patient has reported that their 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 #

Green Era Medicinal Society
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