

CALM

Phone: (416) 367-3459

Fax: (416) 367-4679

My patient, (legal name and DOB): _____.

Has been diagnosed with: _____.

Symptoms include: _____.

I have discussed the use of cannabis with my patient and will continue to monitor their condition. I understand that my office will be contacted via phone to verify this information.

Physician's Signature: _____.

Physician's Printed Name: _____.

Date signed: _____ / _____ / _____
(Month) (Day) (Year)

Physician's Address:

Applicants Contact Information:

Notes:

Please keep a copy of this form at your doctor's office

CALM reserves the right to refuse any member on a case by case basis