BCPS Canada
Quality Medical Marijuana

www.bcpscanada.com

Please fax completed form to 604.608.9461

Medical practitioners consent to use marijuana

Patients Information

First Name: _____ Last Name: _____

Date of Birth: _____ /_____/_____
(Month) (Date) (Year)

Gender: Male ☐ Female ☐

Residential Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____

Medical Practitioners Information

Medical practitioner's full name: _____

Provincial medical licence number: _____

Medical specialization (if applicable): _____

Business Address: _____

Suite: _____ City: _____ Province: _____ Postal Code: _____

Telephone: _____ Fax: _____ E-mail: _____

STAMP (if available)

I conclude that marijuana for medical purposes is an appropriate option for the above patient.

Date: _____ Signature: _____

Misc. Information

All information on this form may be verified before BCPS Canada will issue the above patient a membership and ID card. This form will remain the property of BCPS Canada and may be shown to any member of the local law enforcement if requested.