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 ______________________________

☐ This form allows this patient to access services & products from BCCCS 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: ______________________________

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Practitioner's Stamp/
License #

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