



Dear Health Care Practitioner,

Your patient is requesting membership with the B.C. Compassion Club Society (BCCCS). The BCCCS has created safe and supportive access to clean, high quality, affordable cannabis for those in medical need. We also provide the services of integrative health care practitioners at our Wellness Centre.

In order to maintain the level of legitimacy expected from our organization, the BCCCS requires a recommendation from a Physician or Nurse Practitioner as a condition of membership. Many practitioners recognize the effectiveness of cannabis in their patients' treatment and are referring their patients to us. We have a database of over 14,000 registered members who have reported benefits from the use of medical cannabis since we became established 23 years ago.

As part of our orientation to the BCCCS, members learn about the safe and effective use of cannabis and the variety of forms in which it can be taken. We also provide members with our Safe and Effective Use of Medical Cannabis pamphlet and access to ongoing education and information.

For more information on the use of cannabis for specific symptoms and conditions, and for current research information, we recommend the following websites: [projectcbd.org](http://projectcbd.org); [leafly.org](http://leafly.org); [thecompassionclub.org](http://thecompassionclub.org).

Please fill in the attached Practitioner's Statement and fax it to our office. We will call you to verify that the fax did indeed come from your office.

For more information, please contact us at 604-875-0437, or by email at [info@thecompassionclub.org](mailto:info@thecompassionclub.org).

Respectfully,

The B.C. Compassion Club Society

2995 Commercial Drive, Vancouver, BC, V5N 4C8

Phone# 604-875-0448 Fax# 604-875-6083 [www.thecompassionclub.org](http://www.thecompassionclub.org)

We are honoured to work & live on the unceded and traditional territory of the

x̱w̱məθḵw̱əy̱ əm̱ (Musqueam), seli7lw7̱ itulẖ (Tsleil Waututh) & s̱ḵwx̱w̱ u7̱mesẖ (Squamish) Coast Salish peoples.

# BCCCS Practitioner's Statement

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

Patient's Name: First \_\_\_\_\_ Last \_\_\_\_\_ D.O.B \_\_\_\_\_

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 assist this patient with their symptoms arising from the above diagnosis and hereby authorize him or her to obtain reasonable access to such services and to possess such products for this purpose.

Practitioner's Notes (dosage, cannabinoid/product, etc.):

- This patient is in a critical stage of their illness or treatment and requires immediate attention**

- I do not recommend the use of cannabis for the reasons stated below:

Medical: Please Specify \_\_\_\_\_

Legal: Please Explain \_\_\_\_\_

Practitioner's Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Practitioner's Phone: \_\_\_\_\_

Practitioner's Address: \_\_\_\_\_

Practitioner's Stamp/  
License #



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