Your Medical Documentation

Instructions for Patients

This Medical Document form is to be completed only by a licensed Health Care Practitioner such as a family physician, a specialist, or in some provinces and territories, a Nurse Practitioner.

Bonify will verify the information on this Medical Document form with your Health Care Practitioner to be able to complete your registration as an Approved Bonify Member.

Information for Health Care Practitioners

Thank you for taking the time to assess whether cannabis is appropriate for your patient. We recognize that, for many Health Care Practitioners, authorizing cannabis for medical purposes is new and we are committed to providing you with the resources you need to make an informed decision regarding what is right for your patient. We have worked together in consultation with members of our Scientific Advisory Board, which is made up of several of the world's foremost experts on the use of medical cannabis, to gather information especially for you. We invite you to visit the Health Canada website at http://www.hc-sc.gc.ca/dhp-mps/marihuana/med/infoprof-eng.php or the Health Care Practitioner section of our web site where we've aggregated information to assist you as you make decisions regarding medical cannabis for your patients.

Instructions for Health Care Practitioners

Bonify requires the original version of a Medical Document, completed and signed by you. You may choose to use the Health Canada sample Medical Document found here: http://www.hc-sc.gc.ca/dhp-mps/alt_formats/pdf/marihuana/info/med-eng.pdf

OR

Please fill in the attached Medical Document for your patient and have the original sent to us one of two ways:

1. **By Mail:**
   422 Jarvis Avenue
   Winnipeg, Manitoba
   R2W 3A6
   ATTN: Bonify Member Care
2. **By Secure Fax:** *(with the acknowledgement that the faxed Medical Document is the original Medical Document)*
   204.582.9630
   ATTN: Bonify Member Care

Need Help?

If you need any help completing this form, please feel free to contact our Customer Care Team at 1.844.586.3556.

Medical Document

A Health Care Practitioner must complete the following Medical Document for a person who is under their professional treatment and send the original to Bonify at:

by Mail:
422 Jarvis Avenue
Winnipeg, Manitoba
R2W 3A6
ATTN: Bonify Member Care

OR

by Secure Fax:
204.582.9630
ATTN: Bonify Member Care

Health Care Practitioner Information

Name: (please print) ______________________ ______________________
Last Name First Name

Profession: ______________________ Gender Male ☐ Female ☐

Email: ______________ Phone: ______________ Fax: ______________

Business Address: ______________________ Postal Code: ______________

City: ______________ Province: ______________ Country: ______________

Provincial Jurisdiction: ______________________ License Number: ______________

Consultation Address (If different from above)

Address of the location at which the patient consulted with the Health Care Practitioner:

Address: ______________________ Consultation Date: (YYYY/MM/DD): ______________

City: ______________ Province: ______________ Postal Code: ______________

Patient Information

Name: (please print) ______________________ ______________________
Last Name First Name

Date of Birth: (YYYY/MM/DD) ______________________ Gender Male ☐ Female ☐

Medical Diagnosis (optional) ____

Consent to Receive

Certification by Health Care Practitioner: I hereby consent to receive dried cannabis on behalf of the Patient listed above

Name: ______________ Signature: ______________ Date: (YYYY/MM/DD) ______________

Provincial Jurisdiction: ______________________ License Number: ______________

Medical Document

Medical Requirements

Daily quantity of dried cannabis to be used by the patient:

_______________ *grams/day for* __________________ Days ☐ Weeks ☐ Months ☐

(This Medical Document is valid up to one year from the date it is authorized by the Health Care Practitioner stated below and must not exceed 1 year. A Medical Document is valid for the period of use specified in it.)

Additional Comments (optional) ____

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If you wish to provide a recommendation on a cannabinoid profile (ex: Indica dominant strain, THC range) please do so here. Please note that if you require Bonify to enforce any restrictions, please have your office contact the Member Care Team at 1-844-586-3556 for assistance.

Authorization of Health Care Practitioner

I attest that the information in this Medical Document is accurate and complete. I understand that Bonify will use the information provided in this form for the purposes of complying with its obligations pursuant to the Access to Cannabis for Medical Purposes Regulations and I consent to such use and to the disclosure of the information contained in this form to Health Canada.

Health Care Practitioner's Signature: ________________________________ Date: (YYYY/MM/DD): __________

I have chosen to submit the original Medical Document to Bonify via facsimile. I acknowledge that the faxed Medical Document is now the original Medical Document and that I have retained a copy of this document for my records only.

Please keep a copy of this Medical Documentation for your records as Bonify is required to verify the accuracy of the document we receive from a client with your office.