TEMAGAMI FIRST NATION
BEAR ISLAND,
LAKE TEMAGAMI, ONTARIO P0H 1C0
TEL 1.888.737.9884 | 705-237-8943
FAX 705.237.8959

# Appendix A
# Medical Marijuana (Cannabis) Authorization Form

| | |
|---|---|
| *Name:* | *Band Number* |
| *Mailing Address:* *City/Town, Prov.* *Postal Code.* | *Date of Birth:* |
| *Email:* | *Telephone:* |

Please have your Marijuana Physician fill out the below information and submit with your health claim:

| | |
|---|---|
| *Physician Prescribing:* | |
| *Mailing Address:* *City/Town, Prov:* *Postal Code:* | |
| *Telephone:* | *Specialty:* |

1. Is your Patient authorized to possess marijuana for medical purposes under the current legislation?
   Yes No
2. Prescription dosage form and regimen: _____
3. Diagnosis/Indication for use (including date of initial diagnosis) (MM/YYYY): _____

_____

- ☐ Spasticity or neuropathic pain associated with multiple sclerosis
- ☐ Chemotherapy-induced nausea and vomiting or neuropathic plan associated with cancer
- ☐ Anorexia or neuropathic pain associated with HIV/AIDS
- ☐ Symptoms associated with palliative care

4. What is the anticipated duration of treatment with medical cannabis? _____

_____

**I certify that the information provided is true, correct and complete.**

**Physician's Signature:** _____ **Date:** _____