#1-518-304 ST Kimberley, BC V1A 3H5
BUS: 778.481.5297 FAX: 778.481.5293
Membership inquiries:
membership@tamarackdispensaries.ca
Canada-wide delivery

FOR VALIDATION THIS FORM MUST BE FILLED IN BY AN MD, ND, OR DR. TCM, AND FAXED FROM THE PRACTITIONER'S OFFICE TO TAMARACK DISPENSARIES at 778.481.5293.

Patient's name:____ Birthdate _________________
I am willing to confirm that Mr./Mrs./Ms.____
at phone number (______)____________________ has been diagnosed with _______________________________
and is presenting symptoms of____
____

- ☐ I recommend cannabis to help my patient with her/his symptoms.
- ☐ This patient has reported that her/his symptoms are helped by cannabis and therefore, on the basis of my knowledge, s/he should have access to it.
- ☐ This patient has reported that her/his symptoms are helped by cannabis.
- ☐ I do not recommend the use of cannabis for the reasons stated below:
  Medical: Please explain____
  Legal: Please explain ____
  Other: please explain ____

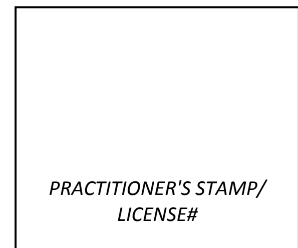
PRACTITIONER'S SIGNATURE:____

PRINTED NAME:____

DATE SIGNED:____

PRACTITIONER'S PHONE:____

PRACTITIONER'S ADDRESS:____



Documents submitted to Tamarack Dispensaries are the property of Tamarack Dispensaries and in accordance with privacy laws are held in the strictest confidence.