



P.O. Box 47023, RPO 425
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Non-Standard Letter of Diagnosis

My patient, _____ D.O.B _____

Has been diagnosed with: _____

Symptoms include: _____

*I understand that my office will be contacted via phone to verify this information.
*I have discussed the use of cannabis with my patient and will continue to monitor their condition.

Patient Contact Information:

Address _____

Phone # _____ Email _____

To be completed by
M.D. ___ R.N. (E.C) ___ N.P. Doctor ___ Chiropractor ___

Medical Practitioner's Printed Name: _____ Reg.# _____

Medical Practitioner's Signature: _____

Medical Practitioners Address:

Phone # _____

Date signed: _____ / _____ / _____
(Month) (Day) (Year)

Please keep a copy of this form at your doctor's office *CALM reserves the right to refuse any member on a case by case basis*