GRAND RIVER
+DISPENSARY

info@cggrc.org

PHYSICIAN STATEMENT

IMPORTANT: This form must be completed by an MD, ND, NP, TCM or Traditional Healer and emailed from the practitioner's office to Grand River "Medicinal Cannabis" Dispensary at info@cggrc.org or brought in to Grand River Dispensary by the patient.

Patient Name: ____

Date of Birth: ______________________________ (M/D/Y)

I am willing to confirm that

Mr. /Mrs. /Ms. ____

At phone number (____) ____________________ is presenting the symptoms listed below:

____
____
____
____

Please choose from the options below:

☐ The above has reported that his/her symptoms are helped by cannabis; I recommend cannabis to help this patient with his/her symptoms.
Recommended Dosage:__________________________ Length of Time:_____________________

☐ I do not recommend the use of cannabis for this patient for the reason stated below:
Medical: ____
Legal: ____
Other: ____

COMMENTS:

_______________________________________ STAMP/LICENCE#_____________________________
Physician/Healer Signature

____
Print name

Date Signed ____________________________ (M/D/Y)
Phone (____) __________________

Address: ____