



THE ALWAYS GROWING GREEN SOCIETY  
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<http://www.taggsdispensary.ca>

## PRACTITIONER'S STATEMENT

For validation this form must be filled in by an MD, ND, or DR. TCM, and faxed from the practitioner's office to T.A.G.G.S. Dispensary.

Patient's name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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 specify
- Legal: Please explain
- Other: please explain

This patient is in a critical stage of their illness or treatment and requires immediate attention.

PRACTITIONER'S SIGNATURE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

DATE SIGNED: \_\_\_\_\_

PRACTITIONER'S PHONE: \_\_\_\_\_

PRACTITIONER'S ADDRESS: \_\_\_\_\_

PRACTITIONER'S STAMP/LICENSE