

Welcome to Toronto's newest Medical Compassion Clinic located at 66 Wellesley Street East, 2<sup>nd</sup> Fl. Located East of Yonge Street on Wellesley Street Toronto, Ontario, Canada.

Over the past few years many Medical studies have confirmed what people have known for over 5000 years, that marihuana has practical therapeutic value. Many gravely ill patients have found relief from marihuana that they cannot get from chemical pharmaceutical products. Health Canada decided to include an exemption to the Canadian narcotics law which would allow medical patients to consume marihuana to help relieve serious ailments for which medical marihuana has been shown to be beneficial. The Medical Compassion Clinic is here to help seriously ill medical patients relieve their suffering through the use of medical marihuana as medicine. In Canada medical marihuana can be legally prescribed by Medical Practitioner's. Under the Marihuana Medical Access Regulations, a "medical practitioner" is a person who is authorized under the laws of a province to practice medicine in that province **and** who is not named in a notice given under sections 8 or 59 of the Narcotic Control Regulations.

**Our mission at the Medical Compassion Clinic is to help seriously ill medical patients relieve their suffering through the use of medical marihuana as medicine.**

**The Medical Compassion Clinic is run by medical patients for medical patients thus ensuring that professional medical standards are always met and exceeded since 2005.**

If you have any questions please feel free to contact us by

Email: [info@medicalcompassionclinic.com](mailto:info@medicalcompassionclinic.com) or Tel 647-291-0420 or visit our office at

66 Wellesley Street East 2<sup>nd</sup> Fl Toronto, Ontario, Canada, M4Y 1G2

**Please download and print our Medical Compassion Clinic Application and take it to your Medical Practitioner to be filled out if you require medical marihuana as medicine.**

**[www.medicalcompassionclinic.com](http://www.medicalcompassionclinic.com)**

## **STEPS TO BECOMING A MEDICAL COMPASSION CLINIC PATIENT**

### **HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?**

- AIDS, HIV Infection
- Spinal Cord Injury
- Multiple Sclerosis
- Epilepsy
- Glaucoma
- Irritable Bowel Syndrome (IBS)
- Fibromyalgia
- Intractable Pain
- Mental Disorders
- Cancer
- Spinal Cord Disease
- Severe Arthritis
- Hepatitis
- Crohn's Disease
- Chronic Fatigue Syndrome
- Muscular Dystrophy
- Premenstrual Syndrome
- Tourettes Syndrome

### **Medical Compassion Clinic Health Canada Card Holder Form**

If you are presently a holder of a valid Health Canada Marihuana Exemption card holder, go to the back page and fill out the Medical Compassion Clinic Health Canada Card Holder Form.

### **Have Your Medical Practitioner fill out the forms**

Two forms of valid I.D. are required, one must be photo I.D. otherwise two passport size photo's that are signed and dated on the back of each photo by your Medical Practitioner and submitted with the application forms.

Mail or bring your Medical Compassion Clinic Application to  
66 Wellesley Street East, 2<sup>nd</sup> Fl, Toronto, Ontario, Canada, M4Y 1G2

If you have any questions please contact us at [info@medicalcompassionclinic.com](mailto:info@medicalcompassionclinic.com) Tel.  
647-291-0420

Your application should be processed within two weeks.

You will be called into the office for orientation where you will sign a medical patient form with Medical Compassion Clinic and have your patient I.D. Card picture taken. You will be required to bring two pieces of valid I.D. One must have your photo on it.

**THEN YOU ARE A REGISTERED MEDICAL PATIENT WITH**

# MEDICAL COMPASSION CLINIC

## Medical Compassion Clinic Application

page1/4

### Medical Practitioner's Form for Applicants

**This form is to be completed for by the applicant's medical practitioner.**

Under the Marihuana Medical Access Regulations, a "medical practitioner" is a person who is authorized under the laws of a province to practice medicine in that province **and** who is not named in a notice given under sections 8 or 59 of the Narcotic Control Regulations.

#### Important

1. It is important to understand that all information requested must be provided to avoid unnecessary delays.
2. We cannot process the application until *all* appropriate forms are received.
3. Please retain a photocopy of this form for your files.
4. Your Office will be contacted by our staff to confirm the authenticity of this patient's information.

**If you have any questions regarding this form, please contact us:**

**66 Wellesley Street East, 2<sup>nd</sup> Fl, Toronto, Ontario, Canada, M4Y 1G2**

[info@medicalcompassionclinic.com](mailto:info@medicalcompassionclinic.com) Tel. 647-291-0420

#### The Proposed Daily Amount

a. The proposed daily amount of dried marihuana is less than or equal to _____grams; and	
b. The following method and form of administration (please check appropriate box):	
<input type="checkbox"/>	Inhalation
<input type="checkbox"/>	Oral

**Details on medical condition(s) and symptom(s)**

**Please check (X) in the table below the medical condition(s) and the symptom(s) that are the basis for the application (if applicable).**

	SEVERE PAIN	PERSISTENT MUSCLE SPASMS	CACHEXIA	ANOREXIA	WEIGHT LOSS	SEVERE NAUSEA	SEIZURES
MULTIPLE SCLEROSIS							
SPINAL CORD INJURY							
SPINAL CORD DISEASE							
CANCER							
AIDS, HIV INFECTION							
SEVERE ARTHRITIS							
EPILEPSY							

**OR**

	If the applicant is treated within the context of compassionate end-of-life care, please specify the medical condition(s) and the symptom(s):
	Medical Condition(s) and Symptom(s): <hr/> <hr/> <hr/>

<b>OR other Medical Condition(s) not listed above:</b> <hr/> <hr/> <hr/>
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# Information on Medical Practitioner

page3/4

Medical practitioner's full name:

Provincial medical license number:

STAMP (if available)

Business Address:

Suite Number:

City/Town:

Province:

Postal Code:

Telephone:

Fax:

E-mail:

I declare that all the information contained in this form is correct and complete. I acknowledge that my office will be contacted by staff from the Medical Compassion Clinic by telephone to confirm the authenticity of this patient's information. (When applicable: I declare that the two passport size photo's are my patient and I have signed and dated the back of each photo.)

Medical Practitioner's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Notes:


# Information on Medical Patient

Medical Patients full name:

Home Address:

Suite Number:

City/Town:

Province:

Postal Code:

Telephone:

Fax:

E-mail:

Date of Birth:

Male \_\_\_\_\_ Female \_\_\_\_\_

I declare that all the information contained in this form is correct and complete and that I am nineteen years of age or older.

## Release of Confidential Medical Information

I, \_\_\_\_\_, do hereby grant permission for the release of my confidential medical information to the Medical Compassion Clinic. I give permission for the medical practitioner noted below to verify my medical status with a staff member of Medical Compassion Clinic by telephone. The Medical Compassion Clinic agrees to use this information for the sole purpose of determining eligibility and also agrees to keep this information strictly confidential.

Medical Patient's Signature: \_\_\_\_\_ Print Name \_\_\_\_\_

Medical Practitioner's Name: \_\_\_\_\_

Medical Practitioner's Signature: \_\_\_\_\_

Date: \_\_\_\_\_
