ZYUS™

Medical Document Form

Phone: 1-833-713-CARE (2273)
Secure Fax: 1-877-226-5909
Email: care@zyus.com
www.zyus.ca

Section 1 – Healthcare Practitioner Information

First Name		Last Name			
Profession		Medical Licence Number			
Clinic/Business Name					
Business Address					
City		Province		Postal Code	
Telephone		Ext.			
Email		Fax			
Address of Consultation (Only applicable if different from above)					
Street Address					
City		Province		Postal Code	

Section 2 – Patient Information

First Name		Last Name	
Date of Birth MM/DD/YYYY		Telephone	
Email			

Section 3 – Authorization

Medical Condition (Optional, except for patients seeking coverage through Veteran Affairs)				
The patient may access the following	Daily Quantity (Grams/Day)		Duration (May not exceed 12 months)	
The applicant can possess a maximum of 150 grams or 30 times their daily amount, whichever is less for their own medical purposes.				

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Section 4 – Healthcare Practitioner Additional Dosing Directions (Optional)

Section 5 – Signature of Healthcare Practitioner

I (the Healthcare Practitioner) attest that the information in this document is correct and complete.

Initial Here (Required)	I (the Healthcare Practitioner) acknowledge that the faxed/electronic document shall now be treated as the original medical document. I further acknowledge that I will retain a copy of the medical document for my records only.		
Signature		**Date** MM/DD/YYYY	

Section 6 – How to Submit Medical Document

Option 1: Email	**Option 2: Secure Fax**
care@zyus.com	1-877-226-5909

Section 7 – This Section is Optional

☐ I (Healthcare Practitioner) consent to receive cannabinoid products at my business address.

Section 8 – This Section is Optional

☐ I consent to receiving updates from ZYUS regarding clinical trials, news and educational material. I understand that I may withdraw my consent at any time.

This Section is for Internal Use Only

Verified by (Employee Name)	
Date (Include Time if by Phone)	