99 NORTH
MEDICAL CANNABIS DISPENSARY

37768 2nd Ave. BOX 1312 Squamish BC V8B 0A9
Membership enquiries: info@99northdispensary.com
Tel:604.892.9699 Fax: 604.892.0399
99northdispensary.com

Dear Veterinary Physician,

Your patient's owner is requesting to receive services with 99 North Dispensary for their pet.

Restrictions are in place to allow animals, safe legitimate access to tinctures only, unless under the advice of the Veterinary Physician. The 'tincture only' restriction for animals addresses dosing as well as administering concerns.

In order to maintain the level of legitimacy expected from our organization, 99 North requires a confirmation of diagnosis and/or recommendation from a Veterinary Physician, faxed directly from their office, as a condition of membership.

Please fill in the attached Veterinary Physician Statement and fax it to our office. If you feel uncomfortable recommending cannabis due to medical, legal, or other concerns, please indicate this in the space provided.

For more information, please contact us at 604-892-9699, or by email at info@99northdispensary.com

Respectfully,

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FOR VALIDATION THIS FORM MUST BE FILLED IN BY A VETERINARY PHYSICIAN, AND FAXED FROM THE VETERINARY PHYSICIANS OFFICE TO 99 NORTH AT 604-892-9699

DATE OF BIRTH (d/m/y)

Animal name: _____/_____/_____

Has been diagnosed with_____
Eligible Diagnosis List (unless otherwise recommended by Veterinary Physician) Arthritis, Cancer, Chronic Pain, Seizure disorder, Tumour(s).
And is presenting symptoms of_____

Date of Diagnosis_____ Species: _____ Breed_____

[ ] I recommend cannabis to help my patient with their symptoms.

[ ] Patient's owner(s) have reported that they wish to try cannabis for their pet and therefore, on the basis of my knowledge, should have access to it.

[ ] I agree to work with my patient's owner(s) and 99 North to ensure appropriate dosing is administered.

[ ] 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: _____
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PRACTITIONER'S STAMP/LICENSE#

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APPLICATION FOR REGISTRATION

To be completed by the Pet Owner

Animal Name_____ Date of Birth_____

Caregiver's Name_____

Address: _____City:_____Prov:_____ ____
Postal code: _____ Phone number(s) _____
Email_____

[ ] I agree to keep the Veterinary physician informed and I will inform 99 North in the event of my Pet's death.

[ ] I understand that as a caregiver I am not entitled to consume any medicine purchased for my pet.

[ ] I understand that medicine only in the form of tincture will be available for my pet.

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