Treatment Agreement

Because we take our responsibilities to authorize and supervise the medical use of cannabis very seriously, we ask you to read, understand and sign this form

1. I request Dr. Kobetz, M.D., to sign a medical document for me under the Health Canada ACMPR legislation so that I may legally purchase medical cannabis from a Licensed Commercial Producer OR cultivate my own cannabis OR designate a cannabis grower to treat my medical condition
2. I agree to receive a medical document for cannabis from only one physician
3. I agree to consume no more than the dose authorized by Dr. Kobetz, M.D., I will not request a refill before the agreed upon date
4. I agree not to distribute my cannabis to any other person, for personal use or sale. I am aware that redistribution of any cannabis for sale is an illegal activity
5. I am aware that using cannabis may be associated with psychosis in person's still undergoing neurodevelopment (brain growth). Therefore, I will ensure that no person under the age of 25 years has access to my cannabis
6. I agree to safe storage of my cannabis
7. I am aware that using cannabis with any other substances, especially sedating substances, may cause harm. I will not use illegal drugs (eg. cocaine, heroin) or controlled substances (eg. narcotics, stimulants, anxiety pills) that were not prescribed for me.
8. I will not used controlled substances that were prescribed by another doctor unless Dr. Kobetz, M.D., is aware of this
9. I agree to drug testing (eg urine drug screening) when and as requested by my physician
10. I agree to have an office visit and medical assessment at least every ___ weeks or ___ months
11. I understand that Health Canada has provided my access to medical cannabis by a signed medical document from a physician for the treatment of certain medical conditions, but despite this, Health Canada has not approved cannabis as a registered medication in Canada
12. I understand that my physician may not be knowledgeable about all the risks associated with the use of a non-Health Canada-approved substance like cannabis
13. I agree to communicate to my physician, Dr. Kobetz, M.D., any experiences of altered mental status or possible medical side effects of the use of cannabis
14. I accept full responsibility for any and all risks associated with the use of cannabis, including theft, altered mental status, and side effects of the cannabis
15. I am aware that cannabis use is not advisable during pregnancy or breastfeeding. I agree to inform my physician, Dr. Kobetz, M.D., if I am pregnant
16. I am aware that smoking any substance can cause harm and medical complications to my breathing and respiratory status. I will avoid smoking cannabis. I will avoid mixing cannabis with tobacco. I agree to use my cannabis by vaporizer or as an edible product
17. I am aware that my physician may discontinue authorizing cannabis for my condition if he/she assesses that the medical or mental health risk side effects are too high
18. I agree to see specialists or therapists about my condition at my physicians request
19. I agree to avoid driving a vehicle or operation heavy machinery for at least 4 hours after the use of cannabis, and for longer if I feel any persistent negative effects on my ability to drive

20. As per the Health Canada ACMPR legislation, I acknowledge that the possession of cannabis from sources other than from a Licensed Commercial Producer or though self-production, is illegal
21. I am aware that any possible criminal activity related to my cannabis use may be investigated by legal authorities and criminal charges may be laid. During the course of an investigation, legal authorities have the right to access my medical information with a warrant
22. Following the terms of this contract is one of the conditions I must meet to access cannabis for medical treatment. I understand that if I violate any of the agreements terms, my physician may stop authorizing my use of medical cannabis
23. Dr. Kobetz, M.D., has the right to discuss my health care issues with other care professionals or family members if it is felt, on balance, that my safety outweighs my right to confidentiality

_____ _____

Patient's Printed Name Patient's Signature

_____ _____

Date Practitioner's Signature

I, _____ hereby authorize all third parties to release all information of my health records to Dr. L Kobetz

_____ _____

Patient's Signature Date

_____ _____

Witness's Printed Name Witness's Signature