Paul Menton Centre for Students with Disabilities
500 University Centre, 1125 Colonel By Drive
Ottawa, ON, Canada K1S 5B6
Tel: (613) 520-6608 Fax: (613) 520-3995
Web: carleton.ca/pmc Email: pmc@carleton.ca

DOCUMENTATION FOR MEDICAL CANNABIS

Patient's Name: ___________________________________ **Date of Birth** (YYYY-MM-DD) ______________

PART A: INFORMED CONSENT (To be completed by the student)

I authorize Dr.________________________________ (full name) to release this form and provide other information relevant for provision of disability supports and services at the Paul Menton Centre for Students with Disabilities.

Date (YYYY-MM-DD) ____________ Student Signature : ____

Patient's Informed Release is done in accordance with the following sections of the Freedom of Information and Protection of Privacy Act. Sections 41.(1)(a), 41.(1)(b), and 41.(1)(c) allowing for the use of personal information and sections 42.(1)(b), s.42(1)(c), and s.42(1)(d) allowing for the disclosure of personal information

PART B: To be completed by a regulated health care professional

Who can complete this form?

- An authorized health care practitioner as defined in the Access to Cannabis for Medical Purposes Regulations (ACMPR).includes physicians and nurse practitioners in all provinces and territories where prescribing cannabis or medical purposes is permitted under their scope of practice.
- Must be completed by the authorized health care practitioner who is treating the patient..

Patient requires the consumption of medical cannabis to treat a medical condition. Yes ___ No ___

Consumption of medical cannabis is medically necessary to assist the patient's participation in post-secondary studies.

Yes __ No __

Medical condition(s) or functional impairment(s) being treated:

Note: The period of use cannot exceed one year and will begin on the day that this document is signed by the health care practitioner

Number of grams per day ___ for ___ days ___ weeks ___ months ___

Special Instructions:

Please note any side effects from medical cannabis consumption that may impact participation in academic studies.

Certificate of Attending Registered/Certified Health Professional

I hereby certify that I provided health care services to, ____, a student at Carleton University. I am providing the above information for use by the University in assessing what academic accommodations, if any, should be offered to the student. I understand I may be contacted by the student's PMC coordinator to verify this information, but will not be requested to provide further information without the consent of the student.

Area of expertise/ Type of practitioner: ____

Name: ____ Registration Number: ____________________

Signature:____________________________________ Date (YYYY-MM-DD) _______________

Address: ____

Telephone:______________________ Fax:___________________ Email:__________________________________

Stamp or business card here

The personal information requested on this form is collected in accordance with the Freedom of Information and Protection of Privacy Act (FIPPA), R.S.O. 1990, c.F.31 and the Personal Health Information Protection Act (PHIPA), 2004 SO 2004,c.3 as amended. The information provided will not be used for any purposes other than those stated upon this form unless the applicant provides express written consent. Should you have any questions concerning your personal information please contact the Privacy Office at phone: (613) 520-2600 ext. 2047, e-mail University.Privacy.Office@carleton.ca or mail: 607 Robertson Hall Carleton University 1125 Colonel By Drive, Ottawa Ontario K1S 5B6. Carleton University is fully compliant with FIPPA and PHIPA and endeavors at all times to treat your personal information in accordance with the law.