★ STARSEED Medicinal Inc.

MEDICAL DOCUMENT - To be completed by a Health Care Practitioner

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SECTION 1: Patient Information

Information must match information on patient registration form.

First Name:

Last Name:

Date of Birth (MMM/DD/YYYY):

Email:

Phone #:

Male: ☐ Female: ☐ Other: ☐

Caregiver required?* Yes ☐ No ☐

* A caregiver is a responsible individual for the applicant who is able to complete documents on their behalf. If yes, please complete 'Section 7: Caregiver Information' on the Registration Application.

SECTION 2: Health Care Practitioner Information

Please print clearly in full (no abbreviations).

Title:

First Name:

Last Name:

Profession:

License #:

License Province:

Health Care Practitioner's business address

or

Full business address of the location at which the patient consulted the health care practitoner (if different)

NOTE: STAMP OR STICKER IS ACCEPTABLE HERE

Phone #:

Extension:

Email:

SECTION 3: Prescription

Quantity (grams per day):

Duration - # of days, weeks, and/or months (365 days max):

Diagnosis:

THC limitation (% or mg/mL):

Additional notes:

Dried Cannabis: ☐

Product	Description	THC %	CBD %
Green Star 1	High CBD	< 2.0	≥ 7.0
Green Star 2	1 to 1 CBD/THC	≥ 2.0 - ≤ 12.0	≥ 2.0 - ≤ 20.0
Green Star 3	Moderate THC	≥ 9.0 - ≤ 16.0	< 2.0
Green Star 4	High THC	> 16.0 - ≤ 28.0	< 2.0

Cannabis Extract – Inhalation: ☐

Product	Description	THC mg/g	CBD mg/g
Aurum 1	High CBD	< 30	700 - 900
Aurum 2	Balanced	300 - 500	300 - 500
Aurum 3	Moderate THC	> 550 - < 800	< 10
Aurum 4	High THC	700 - 900	< 10

Cannabis Extract – Ingestion: ☐

Product	Description	THC mg/mL	CBD mg/mL
Blue Star 1	High CBD	≤ 2.8	≥ 17.0
Blue Star 2	1 to 1 CBD/THC	≥ 8.0 - ≤ 17.0	≥ 8.0 - ≤ 17.0
Blue Star 3	High THC	> 17.0 - ≤ 28.0	≤ 2.0
Prime 1	High CBD	≤ 2.8	≥ 34.0
Prime 2	1 to 1 CBD/THC	≥ 20.0 - ≤ 28.0	≥ 20.0 - ≤ 28.0
Prime 3	High THC	> 28.0 - ≤ 30.0	≤ 4.0

Health Care Practitioner Signature:

Date Signed (MMM/DD/YYYY):

Attest that the information contained herein is correct & complete

PLEASE INITIAL HERE IF SUBMITTING THIS DOCUMENT TO STARSEED BY FAX

I have chosen to submit the original Medical Document to Starseed via Starseed's secure fax. I acknowledge that the faxed medical document is now the original medical document and that I have retained a copy of this document for my records.