

# MEDICAL CANNABIS REQUEST VERIFICATION FORM

**AccessAbility Services** - University of Waterloo  
1401 Needles Hall, 200 University Avenue West,  
Waterloo, ON N2L 3G1  
P. 519.888.4567 ext. 35082 F. 519.746.2401  
Web: [uwaterloo.ca/accessability-services](http://uwaterloo.ca/accessability-services)  
E-mail: [access@uwaterloo.ca](mailto:access@uwaterloo.ca)

**Occupational Health** – University of Waterloo  
Commissary Building COM 115, 200 University Avenue West  
Waterloo, ON N2L 3G1  
P. 519.888.4567 ext. 40538 F. 519.888.4373  
Web: <https://uwaterloo.ca/occupational-health>  
Email: [occupationalhealth@uwaterloo.ca](mailto:occupationalhealth@uwaterloo.ca)

## TO BE COMPLETED BY APPLICANT

### SECTION 1: APPLICANT INFORMATION

Applicant information (please print)	
Last name:	
First name:	
Waterloo ID number: <i>(Student or Employee ID)</i>	
Phone number (home/cell/work ext.)	
Waterloo e-mail address:	@uwaterloo.ca

### SECTION 2: PURPOSE OF THE MEDICAL CANNABIS REQUEST VERIFICATION FORM

The University of Waterloo Policy 29 indicates that *the University prohibits the smoking or vaporizing of cannabis on University property, except for the purposes of medicinal use which may occur only with appropriate documentation provided to the University (AccessAbility Services for students and Occupational Health for employees)*. The purpose of this form is to provide information to the University which verifies a medical need to smoke or vaporize cannabis while the applicant is on University of Waterloo property.

**Please note:** if there are any **accommodation needs** (academic or employment) beyond smoking or vaporizing medical cannabis on campus property, please complete a disability verification form that aligns with the applicant’s underlying disability or disabling condition and associated functional limitations. Applicants should contact [AccessAbility Services](#) (students) or [Occupational Health](#) (employees) for the documentation that applies to their situation. Cannabis impairment will be addressed as a student or employee conduct matter, following the University’s expectations as outlined in [Policy 71: Student Discipline](#) (students) and [Fit for Work Guidelines](#) (employees).

### SECTION 3: APPLICANT INFORMED CONSENT AND AUTHORIZATION

Completion of all sections listed below is voluntary. Applicant may also withdraw consent pertaining to any of the below at any time. NOTE: Should you elect not to provide your consent, you may forfeit your access to support services you require during your admission to /employment with the University of Waterloo.

#### **AUTHORIZATION TO MY ATTENDING HEALTH CARE PROFESSIONAL TO COMPLETE THIS FORM:**

By submitting this form, I authorize the attending health care professional named in this form to complete the Medical Cannabis Verification Request Form and disclose information concerning myself to AccessAbility Services (students) or Occupational Health (employees), University of Waterloo.



**CONTACT WITH MY ATTENDING HEALTH CARE PRACTITIONER:**

By signing below, I give consent for the University of Waterloo (AccessAbility Services or Occupational Health) to contact the service provider who completed this form to discuss information provided in this document, if necessary, to clarify information regarding functional limitations or if there are questions related to my application.

Applicant's signature:	Date completed (DD/MM/YYYY):
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Applicant's informed authorization for disclosure of information is obtained 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.

**TO BE COMPLETED BY ATTENDING HEALTH CARE PRACTITIONER**

This form should be completed by one of the following appropriately licensed and trained professionals, **qualified to prescribe medical cannabis** and provide an assessment of the associated functional limitations: Psychiatrist, Family Physician, etc.

**SECTION 4: PURPOSE OF THE MEDICAL CANNABIS REQUEST VERIFICATION FORM**

The University of Waterloo requires your verification that above-named applicant (student or employee of the University of Waterloo) has a medical need to smoke or vaporize cannabis while the applicant is on University of Waterloo property. Currently, University of Waterloo Policy 29 indicates that *the University prohibits the smoking or vaporizing of cannabis on University property, except for the purposes of medicinal use which may occur only with appropriate documentation provided to the University (AccessAbility Services for students and Occupational Health for employees).*

**SECTION 5: VERIFICATION OF DISABILITY**

Does your patient have a disability-related need to consume medical cannabis while on campus at the University of Waterloo during their academic studies or during the course of their employment?

- Yes
- No

**SECTION 6: CURRENT TREATMENT**

Are you the prescribing physician of the applicant's medical cannabis?  Yes  No

Is the applicant currently prescribed medical cannabis for their disability, or disabling condition symptoms?  Yes  No

Prescription Expiry Date (DD/MM/YYYY): \_\_\_\_\_

Will the applicant smoke or vape the medical cannabis?  Yes  No

Is the applicant's medical cannabis required at certain times of the day?  Morning  Afternoon  Evening

## SECTION 7: FUNCTIONAL LIMITATIONS

If an applicant is eligible for a medical cannabis accommodation plan to smoke or vape on campus, the applicant is expected to smoke or vape only in those areas where the smoking of tobacco is permitted, and is expected to comply with all rules in accordance with UW Policy 29. Specifically, the **University prohibits smoking** (tobacco, or medical cannabis):

- *in any building, bus shelter or other enclosed area;*
- *in University owned or operated vehicles;*
- *within 10 meters of any building;*
- *on or within 20 meters of sports playing fields, surfaces and spectator areas;*
- *on or within 20 meters of children’s playgrounds;*
- *on restaurant and bar patios.*

*Individuals engaging in smoking on University Property must dispose of all disposable components of a smoking device safely and in designated receptacles.*

*The sale, promotion, distribution or display of tobacco and cannabis products is strictly banned on University Property. Cultivation of tobacco or cannabis is prohibited on University Property except for research purposes and then, only with the proper approvals in place.*

Are you aware of any disability-related functional limitations (physical, cognitive or otherwise) that would *prevent* the applicant from complying with the above parameters?

- No
- Yes (Please explain and outline all relevant functional limitations)

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Are you aware of any effects of the medical cannabis (physical, cognitive or otherwise) that would result in cannabis impairment, or impact the applicant’s fitness for work (which may include safety-sensitive or safety-critical work)?

- No
- Yes (Please explain and outline all relevant functional limitations)

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**Additional information** (Please use this space to provide any other information about the applicant’s disability/disabling condition and their functional limitations that the University of Waterloo should consider):

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### CERTIFICATE OF ATTENDING HEALTH CARE PRACTITIONER

*Documentation completed by a relative of the applicant will not be accepted due to professional and ethical considerations even when the relative is otherwise qualified to do so. The provider signing this form must be the same person answering the questions on the form above.*

<b>Practitioner Name (Please print):</b>	<b>Specialty:</b> <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Family Physician <input type="checkbox"/> Other: _____
<b>Practitioner Signature:</b>	<b>Address/Clinic Name:</b>
<b>Practitioner License/Registration #:</b>	<b>Phone #:</b> (     )     -
<u>Affix card here or office stamp</u>	<b>Fax #:</b> (     )     -
	<b>Date Completed:</b>  _____/_____/____ (DD/MM/YYYY)

