SERIOUS ADVERSE EVENT REPORT FORM
(GTI Products Only)

SECTION 1. AFFECTED INDIVIDUAL INFORMATION	
Person Completing Form - Name:	
Store Location:	
Phone Number:	**Email:**
Date of Complaint:	**Date of Incident:**
Product Information (Please include Product Name and Manufacturer's Product ID#:	
Person Providing the Affected Individual's Information and Details of the Event: ☐Affected Individual ☐Medical Professional ☐Other:_____	
Affected Individual Name:	
Affected Individual Address:	
Affected Individual Phone Number:	
Affected Individual Email:	
If a registered medical cannabis patient, ID#:	
If Medical Professional or Other Individual Providing Affected Individual's Information and Details of Event, complete below:	
Name:	**Phone Number:**
Email:	

SECTION 2. SERIOUS ADVERSE EVENT QUESTIONS			
Type of serious adverse event (check all that apply): ☐ Required medical attention or emergency room visit ☐ Required hospitalization ☐ Resulted in disability ☐ Caused other serious medical issues ☐ Considered life threatening by medical professional ☐ Caused death			
Name and Contact Information of Doctor	**Name:**		
	Phone:		
What time of day was the product used?			
What dosing amount was used? (How much, how many doses?)			
How often was the product used over a 24-hour period?			
How soon after taking the product did the Affected Individual contact the doctor or go to the hospital?	_____Minutes _____Hours _____Days _____Weeks		
How long did the event last?	_____Minutes _____Hours _____Days _____Weeks		
Has the Affected Individual stopped using the product?	Yes ☐ No ☐	If yes, when?	If no, why not?
Did the serious adverse event disappear after discontinuing use of the product?	Yes ☐ No ☐	How long after discontinuing use? _____Minutes _____Hours _____Days _____Weeks	
Are/were prescription or over the counter medications or supplements being used?	Yes ☐ No ☐ If yes, please list, add additional pages, if necessary:		
Describe the Event and its Outcome, add additional pages, if necessary:			