

Client Registration Form.

1

Applicant Information

Applicant's Name:

surname	given name
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Date of Birth:
(mm/dd/yyyy)

Gender:

female male other

Address Line 1:

street	postal
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Address Line 2:

city	province	fax #
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Email Address*:

telephone #

Mailing Address Line 1:
(if different from residence)

street	postal
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Address Line 2:

city	province	fax #
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telephone #

Shipping Address Line 1:
(if different from mailing address)

street	postal
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Address Line 2:

city	province	fax #
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telephone #

2

Individual(s) Responsible
for the Applicant
(If you have caregiver(s),
please complete this section)

Person 1 Name:

surname	given name
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Date of Birth:
(mm/dd/yyyy)

Gender:

female male other

Email Address*:

telephone #

I, name of caregiver

am responsible for applicant name

Individual Responsible for Applicant:

signature	date
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Person 2 Name:

surname	given name
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Date of Birth:
(mm/dd/yyyy)

Gender:

female male other

Email Address*:

telephone #

I, name of caregiver

am responsible for applicant name

Individual Responsible for Applicant:

signature	date
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HEALTH CARE PRACTITIONER INFORMATION (Please complete this section)

Name:	surname	given name	
Title/Profession:			
Clinic Business Name:			
Address Line 1:	street	postal	
Address Line 2:	city	province	fax #
Email Address*:			telephone #

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ADDITIONAL INFORMATION (optional)

Is there anything else you would like us to know?

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ACKNOWLEDGMENT

The Applicant and/or the Person Responsible for the Applicant Must Read and Acknowledge the Following:

- * The applicant is ordinarily a resident of Canada.
- * The individual signing the statement, in the case that an adult who is responsible for the applicant is signing the application, is responsible for the applicant.
- * The information in the application and medical document is correct and complete.
- * The medical document is not being used to seek or obtain fresh or dried cannabis, or cannabis oil from another source.
- * The original medical document accompanies this application.
- * The original medical document used to form the basis of this application has not, to the knowledge of the individual signing the statement, been altered.
- * The applicant will use fresh or dried cannabis or cannabis oil only for their own medical purposes.

Applicant/Individual Responsible Signature:

signature	date
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IMPORTANT NOTE: When returning this application please include the original medical document signed & dated by your health care practitioner. The original copy of the medical document is required to complete your registration.