

Client Registration Form A: Applicants with a Residence

1

Applicant Information

Applicant's Name: Surname given name

Date of Birth:
(mm/dd/yyyy)

Gender: female male other

Address Line 1: Street Postal

Address Line 2: City Province fax #

Email Address: telephone #

Mailing Address Line 1: Street postal
(if different from residence)

Address Line 2: City Province fax #

telephone #

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

Address Line 2: City Province fax #

telephone #

2

Individual (s)
Responsible for the
Applicant

(If you have caregiver(s),
please complete this section)

Person 1 Name: Surname given name

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

Person 2 Name: surname given name

Date of Birth:
(mm/dd/yyyy)

Gender: female male other

Email Address: telephone #

I, name of caregiver

am responsible for applicant name

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Individual Responsible for Applicant:

signature	date
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Health Care Practitioner Information
(Please complete this section)

Name:

surname	given name
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Title/ Profession:

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Clinic Business Name:

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Address Line 1:

street	postal
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Address Line 2:

city	province	fax #
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Email Address:

	telephone #
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4

Additional Information
(optional)

Is there anything else
You would like us to know?

5

Acknowledgement

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.