Client Registration Form B: Applicants without a Residence

WAYNE PATRICK CONSUMER PRODUCTS LTD

1 Applicant Information

Applicant's Name: surname | given name

Date of Birth: (mm/dd/yyyy)

Gender: female | male | other

Email Address: | telephone #

2 Establishment Information

Establishment Name:

Type:

Manager Name:

Address Line 1: street | postal

Address Line 2: city | province | fax #

Email Address: | telephone #

Mailing Address Line 1: (if different from establishment address) street | postal

Address Line 2: city | province | fax #

telephone #

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

Address Line 2: city | province | fax #

telephone #

I, name of manager

attest that establishment's name provides lodging or other social services to applicant, applicant's name

Manager Signature:

Date:

3 Individual (s) Responsible for the Applicant

Person 1 Name: surname | given name

Date of Birth: (mm/dd/yyyy)

Gender: female | male | other

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

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

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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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 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

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.