

**Complete this form if your Health Care Practitioner is consenting to receive your product for you**

Health Care Practitioner information can be filled in on page 2 of this form. He/she must sign the declaration at the bottom of that page  
If you are a person responsible for the applicant, please complete page 3 of this form and include it in the application package

## Applicant information

First name  Last name   
Date of birth  Gender  Male  Female Preferred language  English  French  
MM/DD/YYYY

## Optional information

Veterans Blue Cross #  CARP member #

## Contact information

**Physical address** - Primary Physical Residence must be in Canada. If providing a box # you must also include your physical residence.

Address line 1  Address line 2   
City  Province  Postal code   
Phone #  Ext.  Cell #   
E-mail address  Fax #   
An email address is required if you choose to order online

**Mailing address** - Address where you receive your usual mail correspondence. If different than above.

Address line 1  Address line 2   
City  Province  Postal code

## Declaration of the Applicant or the Person Responsible For the Applicant

**Important, please read and sign below:**

- The applicant acknowledges that medical cannabis is not approved for the use as a drug in Canada, that its indications, safety and risks have not been adequately studied and the appropriate dosage is unclear. The applicant acknowledges and agrees that he or she is using any medical cannabis product obtained from CanniMed Ltd. at his or her own risk, and releases CanniMed Ltd. (and its production partners, including Prairie Plant Systems Inc.) from any and all actions, claims, complaints and demands for damages, loss or injury whatsoever arising directly or indirectly as a consequence of the use of medical cannabis obtained from CanniMed Ltd.
- The applicant is ordinarily a resident in Canada.
- The information in the application and Medical Document or Registration Certificate is correct and complete.
- The Medical Document or Registration Certificate is not being used to seek or obtain fresh or dried cannabis, or cannabis oil from another source.
- The original Medical Document or copy of Registration Certificate (to provide interim supply) is provided in support of this application or has/will be sent separately.
- The applicant will use fresh or dried cannabis, or cannabis oil, only for their own medical purposes.
- The applicant gives consent to CanniMed Ltd. to forward the necessary personal information to our production licensed producer, the applicant's health care practitioner and service providers for purchasing, shipping, verification and distribution purposes only. Note: this consent is required to receive our products.
- The applicant gives consent to his or her health care practitioner to forward the necessary personal information to CanniMed Ltd. in order to register the applicant and fulfill his or her orders.

**SIGNATURE** \_\_\_\_\_

Applicant/Person responsible for Applicant

Date

MM/DD/YYYY

## Health Care Practitioner information

First name  Last name   
Profession  Medical licence number   
Identify licensing province if different than that of your clinic

Clinic/Business name

### Address

Address line 1  Address line 2   
City  Province  Postal code   
Phone #  Ext.  Fax #   
E-mail address

### Shipping address - Address where product will be shipped. If different than above.

Address line 1  Address line 2   
City  Province  Postal code

I,  consent to receive dried marijuana on behalf of   
Health Care Practitioner's name Applicant's name  
Health Care Practitioner's signature \_\_\_\_\_ Date   
MM/DD/YYYY

## Notice to the Health Care Practitioner

If the Health Care Practitioner no longer wants to receive dried cannabis on behalf of a patient, he or she must send a written notice to CanniMed as well as the patient. Notice can be sent to Canned at:

**#1 Plant Technology Road** Fax #: 1-844-231-8929  
**Box 19A, RR#5** Email: info@cannimed.com  
**Saskatoon, SK S7K 3J8**

Complete this page and include it in the application package only if you are a person responsible for the applicant  
Space is provided for up to three persons responsible for the applicant

### First person responsible for the Applicant

Caregiver name    
Given name(s) Surname

Date of birth  Gender  Male  Female  
MM/DD/YYYY

E-mail address  Phone #  Ext.

Declaration of person responsible for the applicant:  
I,  am responsible for   
Person responsible for Applicant Applicant

Person responsible for Applicant signature \_\_\_\_\_ Date   
MM/DD/YYYY

### Second person responsible for the Applicant

Caregiver name    
Given name(s) Surname

Date of birth  Gender  Male  Female  
MM/DD/YYYY

E-mail address  Phone #  Ext.

Declaration of person responsible for the applicant:  
I,  am responsible for   
Person responsible for Applicant Applicant

Person responsible for Applicant signature \_\_\_\_\_ Date   
MM/DD/YYYY

### Third person responsible for the Applicant

Caregiver name    
Given name(s) Surname

Date of birth  Gender  Male  Female  
MM/DD/YYYY

E-mail address  Phone #  Ext.

Declaration of person responsible for the applicant:  
I,  am responsible for   
Person responsible for Applicant Applicant

Person responsible for Applicant signature \_\_\_\_\_ Date   
MM/DD/YYYY