CanniMed®
Toll-free: 1-855-787-1577
Fax: 1-844-231-8929
info@cannimed.com
www.cannimed.ca

Application Form C

Health Care Practitioner to receive Applicant's product

#1 Plant Technology Road
Box 19A, RR#5
Saskatoon, SK S7K 3J8

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 (MM/DD/YYYY) | Gender ◯ Male ◯ Female | Preferred language ◯ English ◯ French

Optional information

VAC Health ID # | CARP member #

Contact information - Primary Residence must be in Canada

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 accompanies 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.

Applicant/Person responsible for Applicant signature _____ Date (MM/DD/YYYY)

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Box 19A, RR#5
Saskatoon, SK S7K 3J8

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 Cannimed at:

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Saskatoon, SK S7K 3J8

Fax #: 1-844-231-8929
Email: info@cannimed.com

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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 _____ (MM/DD/YYYY) Gender ◯ Male ◯ Female

E-mail address _____ Phone # _____ Ext. _____

Declaration of person responsible for the applicant:

I, _____ (Person responsible for Applicant) am responsible for _____ (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 _____ (MM/DD/YYYY) Gender ◯ Male ◯ Female

E-mail address _____ Phone # _____ Ext. _____

Declaration of person responsible for the applicant:

I, _____ (Person responsible for Applicant) am responsible for _____ (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 _____ (MM/DD/YYYY) Gender ◯ Male ◯ Female

E-mail address _____ Phone # _____ Ext. _____

Declaration of person responsible for the applicant:

I, _____ (Person responsible for Applicant) am responsible for _____ (Applicant)

Person responsible for Applicant signature _____ Date _____ (MM/DD/YYYY)