CannTrust™

Online registration is now available at www.canntrust.ca
This application can also be mailed or faxed to:
P.O. Box 92068-9200 Weston Road
Vaughan, Ontario, L4H 3J3
Fax: 1-844-295-6641
1-855-RX4-CANN (794-2266) | www.canntrust.ca

New Client Registration PAGE 1 | Form C: Medicine delivery to your Health Care Practitioner

Version 3.0 June 2016

(only if your Health Care Practitioner is consenting to receive your order)

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.

Applicant Information

Applicant's Name: First Name | Last Name

Date of Birth: Month | Day | Year

Gender: Male ◯ Female ◯ **Veteran:** Yes ☐ VAC#

Primary Adress: ☐ *Ship product here*

Address Line 1

City | Province | Postal Code

Best Telephone No. | Fax No.

Alternate Phone No. (optional) | Preferred Time for Contact

Email Address ☐ **Please sign me up for online ordering and to receive information about CannTrust™**
Email address is required.

Mailing Address (if different from residence) ☐ *Ship product here*

Address Line 1

Address Line 2

City | Province | Postal Code

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New Client Registration PAGE 2 | Form C: Medicine delivery to your Health Care Practitioner

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

Person 1: First Name _____ Last Name _____

Date of Birth: Month _____ Day _____ Year _____

Gender: Male ◯ Female ◯

Email Address _____

☐ **Please sign me to receive information about CannTrust™**
Email address is required.

I, _____ (Individual Responsible / Caregiver) am responsible for _____ (Applicant's Name)

Individual Responsible for Applicant Signature _____ **Date** _____

Person 2: First Name _____ Last Name _____

Date of Birth: Month _____ Day _____ Year _____

Gender: Male ◯ Female ◯

Email Address _____

☐ **Please sign me to receive information about CannTrust™**
Email address is required.

I, _____ (Individual Responsible / Caregiver) am responsible for _____ (Applicant's Name)

Individual Responsible for Applicant Signature _____ **Date** _____

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New Client Registration PAGE 3 | Form C: Medicine delivery to your Health Care Practitioner

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Health Care Practitioner Information (to be filled out by the Health Care Practitioner)

Name: Title | First Name | Last Name

Medical License Number:

Clinic/Business Name:

Address Line 1

Address Line 2

City | Province | Postal Code

Telephone No. | Fax No.

Shipping Address (if different from mailing address) ☐ same as 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**

Notice to Health Care Practitioner

Withdrawal of consent by the Health Care Practitioner:

If the Health Care Practitioner ceases to consent to receive dried marijuana for the applicant, the practitioner must send a written notice to that effect to the client and to CannTrust™

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New Client Registration PAGE 4 | Form C: Medicine delivery to your Health Care Practitioner

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Version 3.0 June 2016

Additional Information (Optional)

Please feel free to provide us with information regarding your medical condition(s), ailment(s) and symptom(s).

Please feel free to provide us with information regarding your Medicinal Marijuana preferences (if applicable).
Ex. strain preferences and/or potency preferences.

Is there anything else you would like us to know?

Are you interested in participating in clinical trials? Yes ◯ No ◯

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 dried marijuana from another source.
- The original Medical Document accompanies this application
- The applicant will use dried marijuana only for their own medical purposes.
- The applicant acknowledges and agrees that he or she is using medical marijuana obtained from CannTrust™ at his or her own risk, and releases CannTrust™ (and its partners, officers, providers, directors and staff) from any and all claims, actions, complaints and demands for damages, loss or injury whatsoever arising directly or indirectly from the use of dried medical marijuana received from CannTrust™
- The applicant acknowledges and understands that the safety and risks associated with the use of dried marijuana have not been fully studied and that a standard dosage of medical marijuana has not yet been established.
- The applicant consents to the Health Care Practitioner named in this document disclosing to CannTrust™, personal health information for the purpose of complying with the requirements of the Marijuana for Medical Purpose Regulation (MMPR). The applicant understands and agrees that a copy of the consent & registration application may be provided to the Health Care Practitioner named in this registration.

Applicant / Individual Responsible Signature _____ **Date**