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 B: For applicants with no residence

Version 3.0 June 2016

(shelter, hostel or similar institution)

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#

Email Address

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

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 up 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 up 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 2 | Form B: For applicants with no residence

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Establishment Information

Establishment Name:

Establishment Type:

Manager's Name:

First Name | Last Name

Establishment Address

Ship product here

Address Line 1

City | Province | Postal Code

Best Telephone No. | Fax No.

Email Address

Mailing Address (if different from mailing address)

Ship product here

Address Line 1

City | Province | Postal Code

Shipping Address (if different from mailing address)

Ship product here

Address Line 1

City | Province | Postal Code

I, ______ attest that ______

Manager's Name | Establishment Name

provides food, lodging or other social services to ______

Applicant's Name

Manager's Signature ______ **Date**

Health Care Practitioner Information

Name:

Title | First Name | Last Name

Clinic/Business Name:

Address Line 1

City | Province | Postal Code

Telephone No. | Fax No.

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New Client Registration PAGE 3 | Form B: For applicants with no residence

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 Access to Cannabis for Medical Purposes Regulation (ACMPR). 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** ____________