

PATIENT REGISTRATION FORM



PLEASE NOTE: All fields on this form are mandatory. The information provided on this form must match the Medical Document. Incomplete forms will result in a delay of registration. Complete Patient Registration Forms may be submitted by mail, email, or fax.

New Client Returning Client Referring Clinic (if applicable): _____

1. Applicant Information

First name _____ Last name _____ Date of birth (dd/mm/yy) _____

Male Female Prefer not to disclose

Phone _____ Email (used to grant you access to the online store) _____

Mailing Address _____ Unit Number _____ City _____ Province _____ Postal Code _____

Additional Information (optional)

Do you wish to self-identify as an Aboriginal person in Canada? Yes No

Veteran K No. _____

By indicating you are a veteran, you give permission for Canntab to share your details with Veterans Affairs Canada. Please complete the [VAC Consent to Disclose \[link\]](#).

2. Shipping Address (check one)

Shipping address is the same mailing address in section 1.

Shipping address is different from the mailing address in section 1. Please fill out shipping address below.

Shipping Address _____ Unit Number _____ City _____ Province _____ Postal Code _____

3. Responsible Individual Information (if applicable)

Only complete this section if you are an Individual Responsible for the Applicant and applying on their behalf. A Responsible Individual may act on behalf of the registered client. They may make inquiries, changes, and orders on behalf of the client.

First name _____ Last name _____

Date of birth _____ Phone _____ Email _____

Male Female Prefer not to disclose

The undersigned attests that he/she is the Responsible Individual for the Applicant.

Responsible Individual Signature _____ Date (dd/mm/yy) _____



For More Information
[Address]
Markham, ON,
Canada 1A2 B3C

1-833-301-3812
care@canntab.com
www.canntab.com

Secure Fax Line
123-123-1234

PATIENT REGISTRATION FORM



4. Authorization of Applicant or Responsible Individual

Please sign below to certify that you understand and agree to the following:

1. You reside in Canada
2. The information in this Customer Registration Form and the accompanying Medical Document is correct and complete and to the knowledge of the individual signing, the information has not been altered.
3. The Medical Document is not being used to seek or obtain medical cannabis from another source.
4. In the case where the applicant is signing the statement, they intend to use any cannabis product that is supplied to them on the basis of the application only for their own medical purposes.
5. The original Medical Document is provided to support this Customer Registration Form.
6. Medical cannabis is not approved for use as a pharmaceutical drug in Canada. You are using medical cannabis obtained from Canntab at your own risk. You hereby release Canntab and its related entities from any, and all actions, claims, complaints, demands, for damages, personal losses, and/or injuries arising directly and indirectly from the use of medical cannabis obtained from Canntab.
7. In the case where an alternate adult who is named in the registration certificate is signing the statement, they are responsible for the applicant.
8. In the case where the individual who is signing the statement is not the client, they are responsible for the client, and
9. In the case where the individual who is signing the statement is neither the client nor a named responsible adult, the client and any named responsible adult have been notified of the application.

By signing this Consent Form you consent to Canntab's collection, use and disclosure of the personal information contained in it. This includes, without limitation, disclosure of this Consent Form and related documents to the health care practitioner named in the client's Medical Document and to any clinic or employer with which the health care practitioner works. If the personal information in the Customer Registration pertains to someone other than you, you represent and warrant that you have obtained their consent and/or have authority to consent on their behalf. Consent may be withdrawn at any time but such withdrawal will not have retroactive effect.

NOTE: This may have implications to you and/or the subject individual and will not affect the collection, use and disclosure of personal information where such collection, use and disclosure is permitted or required by law without consent.

By checking this box you agree that you have read, acknowledged, understood, and formally agree to the statements above and that the applicant information provided is accurate and complete.

Signature

Full Name

Date (dd/mm/yy)

Once completed, this Registration Form may be submitted to Canntab in one of the following ways:

Mailing Address

[Address]

Markham, ON, Canada 1A2 B3C

Email

care@canntab.com

Secure Fax Line

(123) 123-1234

This application can only be processed once we receive your original Medical Document from your Health Care Provider.



For More Information

[Address]

Markham, ON,
Canada 1A2 B3C

1-833-301-3812
care@canntab.com
www.canntab.com

Secure Fax Line

123-123-1234