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   Referral Code (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)

Permanent 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 as the mailing address in section 1.

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

Shipping Address   Unit Number   City   Province   Postal Code

Is this a private residence?   Yes   No   If no, please provide the name and type of establishment below (example: nursing or care home)

Name of establishment   Type of establishment

Institution Information

The institution that provides you with food, lodging, or other services (shelter, hostel, etc.)

Name of institution   Type of institution

Institution manager's first name   Institution manager's last name

Address of institution   City   Province   Postal Code

Phone   Fax   Email

Attestation – to be completed by the manager of the institution

I attest that the institution above provides food, lodging, or other social services to the applocant.

Institution manager's signature   Date (dd/mm/yy)

For More Information
223 Riviera Drive, Markham, ON, Canada L3R 5J6
1-833-301-3812 | care@canntab.ca | www.canntab.ca
Secure Fax Line - 1 (833) 615-2855

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3. Product Shipped to Health Care Provider

Have your health care provider complete this section if they have agreed to receive product on your behalf. Product will be shipped to the business address specified on the Medical Document.

Health care provider first name

Health care provider last name

Profession type Doctor Nurse Practitioner

Name of clinic

The health care provider consents to receive fresh or dried marijuana or cannabis oil on behalf of the applicant.

Health care provider signature

Date (dd/mm/yy)

Not to the health care provider: If at any point in time you cease to consent to receive fresh or dried marijuana or cannabis oil on behalf of the client, you must send a written noticed to that effect to both the client and the licensed producer.

4. Caregiver Information

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

Male Female

Prefer not to disclose

Caregiver's first name

Caregiver's last name

Caregiver's date of birth

Primary phone number

Caregiver's email

Can we leave detailed voicemails? Yes No

I, ______________________ ______________________ , am the responsible

Caregiver for ______________________ .

Applicant Signature

Caregiver Signature

Date (dd/mm/yy)

As the applicant, you authorize the responsible Caregiver to act on your behalf with respect to anything you could do on your behalf with Canntab and you authorize Canntab to accept such authority.

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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
223 Riviera Drive,
Markham, ON, Canada L3R 5J6

Email
care@canntab.ca

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