REGISTRATION FORM C - DELIVERY TO HEALTH CARE PRACTITIONER

Note: To complete your application, an original medical document is also required.

PERSONAL INFORMATION

First Name ______________________ Last Name ______________________

Date of Birth ______________________ Gender ☐ Male ☐ Female ☐ Other

Native Status ☐ Yes ☐ No VAC Number ______________________

Street Address ______________________

City ______________________ Province ______________________

Postal Code ______________________ PO Box ______________________

Primary Phone ______________________ Alternate Phone ______________________

Email Address ______________________

HEALTH CARE PRACTITIONER INFORMATION

Title/Profession ______________________ Clinic Name ______________________

First Name ______________________ Last Name ______________________

Clinic Address ______________________

Phone ____________ Fax: ____________ Email Address ______________________

ACKNOWLEDGMENT

The applicant acknowledges the following:

- The applicant is ordinarily a resident of Canada.
- A valid, original medical document accompanies this application.
- The information in this application and in the medical document is correct and complete.
- The medical document is not being used to acquire fresh or dried marijuana or cannabis oil from another source.
- The applicant will use fresh or dried marijuana or cannabis only for their own medical purposes.

The Health Care Practitioner consents to:

- Receiving dried marijuana or cannabis oil on behalf of the applicant.
- Written notice to the client and LP is required to withdraw consent.

Applicant Signature ______________________

Date ______________________

Health Care Practitioner Signature ______________________

Date ______________________