	Potanicals Green Growers Inc. APPLICATION on basis of medical document Please contact our care team at 778-479-2458 if you have any questions.	**Potanicals Green Growers Inc.** 4715 Paradise Valley Drive Peachland, BC, V0H 1X3 Phone: +1-855-702-5647 Fax: +1-604-373-8198 Email: med@potanicals.ca

Section 1: Applicant Information – THIS SECTION IS MANDATORY

First Name(s)									Middle Name(s)	Last Name
Date Of Birth	Y	Y	Y	Y	M	M	D	D	Gender	Phone
VAC Health Care Identification Card ID No. (K number) (if applicable)										
Email										Fax

Primary Residence Address (if this is not a private residence please complete the name and type of establishment in Section 3)

Unit No.	Street No.	Street Address	
City		Province	Postal Code

Shipping / Mailing Address (where you would like to receive your medication) ☐ check box if same as Primary Residence Address

Unit No.	Street No.	Street Address	
City		Province	Postal Code

The Applicant and/or the Caregiver must agree to the following: (1) The Applicant ordinarily resides in Canada; (2) The information in the Application for Medical Cannabis is correct and complete; (3) the medical document that forms the basis for the application has not, to the knowledge of the individual signing the statement, been altered; (4) The medical document is not being used to seek or obtain cannabis products from another source; (4) An original Medical Document accompanies this application; (5) 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; (6) The Applicant acknowledges that dried cannabis are not approved drugs in Canada and thus the indications and safety risks of its use have not been adequately studied nor an appropriate dosage determined; (7) The Applicant acknowledges and agrees that he/she is using products obtained from Potanicals Green Growers Inc. (Potanicals) at their own risk, and releases Potanicals (and its production partners) from any and all actions, claims, and demands for damages, loss or injury whatsoever arising directly or indirectly as a consequence of the use of dried cannabis obtained from Potanicals.

Consent to Release Health Information: By signing below, the Applicant or the Caregiver responsible for the Applicant, consents to the disclosure of the Applicant's information to the Health Care Practitioner who has signed their medical document. By signing below, the Applicant or Caregiver responsible for the Applicant understands that they may have chosen to refuse to sign the consent form and chosen not to submit their application.

Signature	Today's Date	Y	Y	Y	Y	M	M	D	D

Section 2: Caregiver Information - If you would like to authorize someone to talk with Potanicals on your behalf please provide their information below

If you wouldn't like to authorize anyone to communicate with Potanicals on your behalf you can leave this section blank.

By signing below, the Caregiver agrees that they are responsible for the Applicant listed in Section 1.

First Name(s)									Middle Name(s)	Last Name
Date Of Birth	Y	Y	Y	Y	M	M	D	D	Gender	Phone

Caregiver Signature	Date	Y	Y	Y	Y	M	M	D	D

Section 3: Residents of care homes, shelters, hostels or similar institutions that provide social services to applicant

If you don't live in a care home, shelter, hostel or similar institution you can leave this section blank.

Name of Establishment		Type of Establishment
Phone	Fax	Email

By signing below, the manager of the establishment confirms that the institution provides food, lodging or other social services to the applicant.

Name of Residence Manager	Signature of Residence Manager	Date	Y	Y	Y	Y	M	M	D	D

Section 4: Ship to your Healthcare Practitioner - If you would like to authorize your health care practitioner to receive your medication on your behalf

By signing below, the Healthcare Practitioner consents to receive cannabis products, other than cannabis plants and cannabis plant seeds, on the applicant's behalf.

Name of Healthcare Practitioner	Signature of Healthcare Practitioner	Date	Y	Y	Y	Y	M	M	D	D