THE GREEN ORGANIC DUTCHMAN
PO BOX 219, LYNDEN, ON L0R 1T0
PHONE: 1-888-603-TGOD | FAX: 1-800-526-2821
EMAIL: CARE@TGOD.CA

Patient Registration Form

Section 1 INFORMATION

FIRST NAME(S)		LAST NAME	
DATE OF BIRTH (YYYY/MM/DD)		GENDER (CIRCLE ONE)	FEMALE / MALE / OTHER
PHONE		EMAIL	
PRIMARY RESIDENCE ADDRESS IF THIS IS NOT A PRIVATE RESIDENCE PLEASE COMPLETE THE ALTERATIVE RESIDENCE OR PHYSICIAN SHIPMENT FORM			
UNIT NO.	STREET NO.	STREET	
CITY		PROVINCE	POSTAL CODE
SHIPPING / MAILING ADDRESS CHECK BOX IF SAME AS PRIMARY RESIDENCE ADDRESS ☐			
UNIT NO.	STREET NO.	STREET	
CITY		PROVINCE	POSTAL CODE

Section 2 CAREGIVER INFORMATION

IF YOU WOULD LIKE TO AUTHORIZE SOMEONE TO TALK WITH TGOD ON YOUR BEHALF, PLEASE PROVIDE THEIR INFORMATION BELOW. IF YOU WOULDN'T LIKE TO AUTHORIZE ANYONE TO COMMUNICATE WITH TGOD ON YOUR BEHALF, YOU CAN LEAVE THIS SECTION BLANK.

FIRST NAME(S)		LAST NAME	
DATE OF BIRTH (YYYY/MM/DD)		GENDER (CIRCLE ONE)	FEMALE / MALE / OTHER
PHONE			

Who is your drug plan provider? _____

Would you like to be subscribed to our newsletter ☐ Y ☐ N Are you interest in participating in future clinical trials or studies? ☐ Y ☐ N

THE APPLICANT AND/OR THE CAREGIVER MUST AGREE TO THE FOLLOWING

(1) The Applicant is ordinarily a resident of Canada; (2) The information in the Application for Medical Cannabis and Medical Document is correct and complete and has not to the knowledge of the individual signing the statement, been altered; (3) The Medical Document accompanying this application is not being used to seek or obtain cannabis products from another source; (4) An original Medical Document accompanies this application; (5) The Applicant will use cannabis products for their own medical purposes only; (6) The Applicant acknowledges that cannabis products are not approved drugs in Canada and thus the indications and safety risks of their 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 The Green Organic Dutchman Holdings Ltd. (TGOD) at their own risk, and releases TGOD from any and all actions, claims, complaints and demands for damages, loss or injury whatsoever arising directly or indirectly as a consequence of the use of cannabis products obtained from TGOD.

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.

I am the (check one) ☒ patient or ☐ caregiver completing this form

FIRST & LAST NAME (PLEASE PRINT)	SIGNATURE OF APPLICANT/CAREGIVER	DATE (YYYY/MM/DD)

If you or your patient is a resident of a care home, shelter, or institution that provides social services, or if you would like your medical cannabis shipped to a physician's office, please contact TGOD and ask for the Alternative Residence or Physician Shipment Form.

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Medical Document

THIS FORM IS TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Section 1

APPLICANT INFORMATION

FIRST NAME(S)	LAST NAME
DATE OF BIRTH (YYYY/MM/DD)	GENDER (CIRCLE ONE) FEMALE / MALE / OTHER
EMAIL	PHONE

Section 2

HEALTH CARE PRACTITIONER INFORMATION

FIRST NAME(S)	LAST NAME	
PROFESSION		
LICENSE/REGISTRATION NUMBER		
PROVINCE OF LICENSE/REGISTRATION		
BUSINESS ADDRESS		
STREET ADDRESS		
CITY	PROVINCE	POSTAL CODE
EMAIL	PHONE	FAX
LOCATION OF CONSULTATION (IF DIFFERENT THAN BUSINESS ADDRESS)		
CITY	PROVINCE	POSTAL CODE

Section 3

PRESCRIPTION INFORMATION

NOTE - The maximum quantity of dried Cannabis a client may possess at any time cannot exceed the lesser of 150 g or 30 times the daily maximum amount prescribed below, as per the Cannabis Act. The prescription period cannot exceed one year and will begin on the day this document is signed by the Health Care Practitioner.	
DAILY PRESCRIBED MAXIMUM QUANTITY OF DRIED CANNABIS (G/DAY)	
PRESCRIPTION PERIOD (MAXIMUM 12 MONTHS)	
I HEREBY CERTIFY THAT THE INFORMATION IN THIS DOCUMENT IS CORRECT AND COMPLETE.	
SIGNATURE OF HEALTH CARE PRACTITIONER	DATE (YYYY/MM/DD)

Please FAX completed, signed form to 1-800-526-2821