THE GREEN ORGANIC DUTCHMAN
6205 AIRPORT ROAD MISSISSAUGA, ONTARIO
CANADA L4V 1E3
PHONE: (905) 304-4201
FAX: (289) 919-2543

Welcome to The Green Organic Dutchman Community

The Green Organic Dutchman grows high quality organic cannabis using sustainable all-natural processes. Our company's products are laboratory tested to ensure patients have access to a standardized, safe and consistent product.

Registering with us is fast and easy

FORM 1 - APPLICATION FOR MEDICAL CANNABIS

To be filled out by the APPLICANT or the person responsible for the APPLICANT, referred to as the CAREGIVER.

FORM 2 - MEDICAL DOCUMENT

To be completed by a Health Care Practitioner such as a family physician, medical specialist or, in some provinces and territories, a nurse practitioner.

Submitting your registration package

ONCE YOU HAVE COMPLETED THE APPLICATION, PLEASE RETURN BOTH FORMS TO US BY MAIL OR SECURED FAX:

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Once we receive your completed registration package we will email you to notify you that it has arrived safely. Next, we will contact your Health Care Practitioner by phone to verify your Medical Document. **Once everything is confirmed**, we will e-mail you again and send out your Notification of Registration document which contains your personal **Client Identification Number**. **Once you have your number** you can begin placing orders immediately.

Please keep in mind that most importantly, we are here to help. If you have any questions or would like to know more about our current strains, feel free to give us a call at (905) 304-4201.

Kind regards,
The Team at The Green Organic Dutchman

Please note

It is **VERY IMPORTANT** that **ALL** mandatory sections are completed. If any of the fields in the mandatory sections are left blank, we won't be able to accept your application. If you require assistance, **contact our team at (905) 304-4201.**

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form 1

Application For Medical Cannabis

Section 1

INFORMATION

THIS SECTION IS MANDATORY

FIRST NAME(S)		LAST NAME
DATE OF BIRTH (YYYY/MM/DD)		GENDER
PHONE		EMAIL
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
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
CITY	PROVINCE	POSTAL CODE

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.

SIGNATURE

DATE (YYYY/MM/DD)

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IF YOU WOULD LIKE TO AUTHORIZE SOMEONE TO TALK WITH TGOD ON YOUR BEHALF, PLEASE PROVIDE THEIR INFORMATION BELOW

Section 2
CAREGIVER INFORMATION

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	PHONE

BY SIGNING BELOW, THE CAREGIVER AGREES THAT THEY ARE RESPONSIBLE FOR THE APPLICANT LISTED IN SECTION 1.

SIGNATURE

DATE (YYYY/MM/DD)

RESIDENTS OF CARE HOMES, SHELTERS, HOSTELS OR SIMILAR INSTITUTIONS THAT PROVIDE SOCIAL SERVICES TO THE APPLICANT.

Section 3
SOCIAL SERVICES

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
Please have the manager of the establishment sign below to confirm that the institution provides food, lodging or other social services to the applicant.		
NAME OF RESIDENCE MANAGER		

SIGNATURE OF RESIDENCE MANAGER

DATE (YYYY/MM/DD)

IF YOU WOULD LIKE TO AUTHORIZE YOUR HEALTH CARE PRACTITIONER TO RECEIVE YOUR MEDICATION ON YOUR BEHALF.

Section 4
SHIP TO YOUR HEALTH CARE PRACTITIONER

NAME OF HEALTH CARE PRACTITIONER

SIGNATURE OF HEALTH CARE PRACTITIONER

DATE (YYYY/MM/DD)

☐ I CONSENT TO RECEIVE CANNABIS PRODUCTS ON THE APPLICANT'S BEHALF.

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form 2

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

Section 2

HEALTH CARE PRACTITIONER INFORMATION

FIRST NAME(S)	LAST NAME	
PROFESSION		
LICENSE/REGISTRATION NUMBER		
PROVINCE OF LICENSE/REGISTRATION		
BUSINESS ADDRESS		
CITY	PROVINCE	POSTAL CODE
EMAIL	PHONE	FAX
LOCATION OF CONSULTATION (IF DIFFERENT THAN BUSINESS ADDRESS)		
CITY	PROVINCE	POSTAL CODE
PLEASE INDICATE PREFERRED METHOD OF CONTACT FOR MEDICAL DOCUMENT VERIFICATIONS **(PHONE, FAX, EMAIL)**		

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.

MEDICAL DIAGNOSIS		
DAILY PRESCRIBED MAXIMUM QUANTITY OF DRIED CANNABIS (G/DAY) AND/OR OIL (ML/DAY)		
PRESCRIPTION PERIOD (MAXIMUM 12 MONTHS)		
DAYS	WEEKS	MONTHS
I HEREBY CERTIFY THAT THE INFORMATION IN THIS DOCUMENT IS CORRECT AND COMPLETE.		
SIGNATURE OF HEALTH CARE PRACTITIONER		DATE (YYYY/MM/DD)

Please mail us the **original, completed and signed** version of the Medical Document and Application For Medical Cannabis.

PLEASE MAIL YOUR DOCUMENTS TO:
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