P.O. Box 40,
Pickering Ontario,
L1V 2R2
Email: customerservice@abbamedix.com
Tel: 1-844-696-3349
Fax: 905-492-8420

Form 01: PATIENT REGISTRATION FORM

Important Notice

Please **include** the original Medical Document signed and dated by your Health care Practitioner.
The original copy of the Medical Document is required to complete your registration.

PATIENT INFORMATION				
Patient's last name: **First:** **Middle:**			❑ Mr. ❑ Mrs. ❑ Miss. ❑ Ms.	
Veteran (circle one): ☐ Yes / No ☐			**VAC No:**	
Is this your legal name? ❑ Yes ❑ No	**If not, what is your legalname?**	**(Former name):**	**Date of Birth:** mm /dd /yy / /	**Gender:** ❑ M ❑ F
Primary Residence:				
Street address:			**Home phone no.:** ( )	
P.O. box:	**City:**	**Province:**		**Postal Code:**
Email Address:			**Alternate phone no.:** ( )	
Mailing Address (If different from Primary Residence)				
Street address:				
P.O. box:	**City:**	**Province:**	**Postal Code:**	
Shipping Address (If different from Mailing Address)				
Street address:				
P.O. box:	**City:**	**Province:**	**Postal Code:**	

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INDIVIDUAL RESPONSIBLE FOR THE PATIENT (IF YOU HAVE CAREGIVER, PLEASE COMPLETE THIS SECTION)			
Responsible Person Or Caregiver	**LAST NAME**	**FIRST NAME**	**MIDDLE NAME**
Date of Birth: mm/dd/yy: / /		**Gender:** ❑ **M** ❑ **F**	
Phone Number: ( )		**Email (if applicable):**	
I .....(Individual Responsible / Caregiver) am responsible for .....(Patient name). **Signature:** **Date:**			

HEALTH CARE PRACTITIONER INFORMATION			
Last Name	**First Name**	**Middle Name**	
Clinic Name			
Clinic Address	**Street Name and Number:**	**City**	**Province** **Postal Code**
Phone number: ( )	**Fax Number: ( )**		

STATEMENTS AND SIGNATURE BY APPLICANT OR RESPONSIBLE INDIVIDUAL

To be completed by the applicant or by an individual who is responsible for the applicant and referred to in this application. IMPORTANT: Carefully read all statements below before signing the application.

By signing this document below the applicant and/or individual who is responsible for the applicant is attesting that:

(a) the applicant is ordinarily resident in Canada;
(b) the information in the application and the medical document is correct and complete;
(c) the medical document is not being used to seek or obtain cannabis flower, seeds, and clones from another source;
(d) the original of the medical document accompanies the application; and
(e) the applicant will use cannabis flower, seeds, and clones only for their own medical purposes.

The applicant and/or individual who is responsible for the applicant acknowledge that cannabis for medical purposes, or cannabis generally, is not approved for the use as a drug, natural health product or food in Canada, and that its use of any kind, indications, efficacy, safety, and risks have not been adequately identified or studied, and the appropriate dosage is unclear. The applicant and/or individual who is responsible for the applicant acknowledge and agree that they are using any cannabis for medical purposes product obtained from ABBA MEDIX CORP at their own risk, and releases ABBA MEDIX CORP including directors, officers, employees, contractors and affiliates of ABBA MEDIX CORP form 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 for Medical Purposes obtained from ABBA MEDIX CORP. Therefore, the applicant and/or individual who is responsible for the applicant acknowledge and agree that they voluntarily accept and assume the risks and dangers associated with the use of cannabis for medical purposes obtained from ABBA MEDIX CORP.

THE APPLICANT AND/OR INDIVIDUAL WHO IS RESPONSIBLE FOR THE APPLICANT GIVE THEIR CONSENT TO ABBA MEDIX CORP TO RECEIVE, RETAIN, USE AND DISCLOSE THEIR PERSONAL INFORMATION AS IT NECESSARY ABBA MEDIX CORP. TO (1) PROCESS THE APPLICATION, (2) PROVIDE SERVICES OR CANNABIS FOR MEDICAL PURPOSES UNDER THE APPLICATION TO A REGISTERED CLIENT, AS APPLICABLE, AND (3) TO COMPLY WITH THE CANNABIS ACT REGULATIONS.

Patient/Responsible person Signature:	Date: