Rosebud Productions Inc. 115-23000 Fraserwood Way Richmond, BC V6V 3C7	CLI-001 Form B.2 MEDICAL CLIENT REGISTRATION WITHOUT A RESIDENCE			
	Revision Number	V1.1	Effective Date	Aug 23 2023
	Name	**Signature**	**Date**	
Author:	Enas Jewaid	*EJ*	Aug 23, 2021	
Reviewed by:	Madeleine Gwynne	*MG*	August 23 2021	
Approved by QAP	Cindy Chow	*CC*	Aug 23 2021	

☐ **New Client** ☐ **Renewal (Current Client ID # _____)**

Part 1: Applicant Information

Applicant's Name (surname, given name):
Gender: ☐ Male ☐ Female ☐ Undisclosed
Date of Birth (MM/DD/YYYY):
Would you like to sign up for online shopping? ☐ Yes ☐ No
Email Address (Required for online shopping):

Part 2: Establishment Information

Establishment Name: **Establishment Type:**
Manager Name:
Address Line 1: City:
Address Line 2: Province:
Telephone #: Postal Code:
Fax #: Email Address:

Shipping Address (If different from establishment address)
Address Line 1: City:
Address Line 2: Province:
Telephone #: Postal Code:
Fax #:

I, _____, attest that _____ provides
(Name of Manager) (Establishment's Name)
food, lodging or other social services to the Applicant.

Manager's Signature: _____ Date: _____

Part 3: Individual(s) Responsible for the Applicant (If you have caregiver[s], please complete this section)

Person 1
Name (surname, given name):
Gender: ☐ Male ☐ Female ☐ Undisclosed
Date of Birth (MM/DD/YYYY):
Telephone #:
Email Address:

I, _____, willingly assume responsibility for the Applicant.
(Name of caregiver)

Responsible Individual's Signature: _____ Date: _____

IMPORTANT: When returning this application 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.

Person 2

Name (surname, given name):
Gender: ☐ Male ☐ Female ☐ Undisclosed
Date of Birth (MM/DD/YYYY):
Telephone #:
Email Address:

I, _____, willingly assume responsibility for the Applicant.
(Name of caregiver)

Responsible Individual's Signature: _____ Date: _____

Part 4: Health Care Practitioner Information (Please complete this section)

Title/Profession:
Name:
Clinic Business Name:
Address Line 1: City:
Address Line 2: Province:
Telephone # Postal Code:
Fax #:

Part 5: Additional Information (Optional)

Is there anything else you would like us to know?

Part 6: Acknowledgement

The Applicant and/or the person responsible for the Applicant must read and acknowledge the following:

- The Applicant is ordinarily a resident of Canada.
- The information in the application and medical document is correct and unaltered.
- The medical document is not being used to seek or obtain cannabis products from another source.
- The original medical document accompanies this application.
- The Applicant will use cannabis products only for their own medical purposes.

Applicants Signature: _____ Date: _____

Responsible Individual's Signature: _____ Date: _____

IMPORTANT: When returning this application 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.