REGISTRATION APPLICATION

FOR APPLICANTS WITH A NON-PERMANENT ADDRESS

CANNA FARMS MEDICAL

Address: PO Box 1419, Hope, B.C., V0X 1L0 ***Phone:*** 1-855-882-0988 ***Fax:*** 1-855-244-9158 ***Email:*** info@cannafarms.ca

PLEASE NOTE: In order to complete the registration, all fields marked with an **asterisk (*)** must be completed. This information must match the Medical Documentation form. Incomplete forms will cause a delay in registration. Complete Registration Application forms may be submitted by **mail, email or fax**. The Medical Document will only be accepted in **ORIGINAL FORM** only.

◯ **NEW CLIENT** ◯ **RETURNING CLIENT**

Referring Clinic (If applicable)

APPLICANT INFORMATION*

Title	**Given Name***	**Surname***

Date of Birth* (MM/DD/YYYY)	**Gender*** ☐ MALE ☐ FEMALE ☐ I do NOT identify or associate with either gender

◯ **PRODUCT FOR THIS APPLICANT IS TO BE SHIPPED TO THE ADDRESS BELOW**

Type of Establishment* ☐ GROUP HOME ☐ SHELTER ☐ HOTEL ☐ INSTITUTION	**Name of Establishment***

Street Address*	**Buzzer #** (if applicable)

City*	**Province***	**Postal Code***

Manager's Name*	**Manager's Phone Number***

Establishment's Email Address

Please note: This email address will be used to grant you access to the online store to purchase your medication. If no email address is provided, orders will only be possible over the phone.

HEALTH CARE PRACTITIONER (HCP) INFORMATION*

If your physician has agreed to receive cannabis on your behalf, they must complete the information below. In this case, product will be shipped to the business address specified on the Medical Document.

Title	**Given Name***	**Surname***

I, _____ , hereby agree to receive medical marijuana on behalf of _____

Name of Health Care Practitioner *Name of Applicant*

RESPONSIBLE INDIVIDUAL INFORMATION *(IF APPLICABLE)*

To be completed by the individual responsible for the applicant (if applicable). The responsible individual may act on behalf of the registered client. They may make inquiries, changes and orders on the part of the client

Title	**Given Name***	**Surname***

Date of Birth* (MM/DD/YYYY)	**Gender*** ☐ MALE ☐ FEMALE ☐ I do NOT identify or associate with either gender

Phone Number*	**Email Address**

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AUTHORIZATION OF APPLICANT AND/OR RESPONSIBLE INDIVIDUAL

The undersigned Applicant and/or Responsible Individual hereby understands, agrees, and warrants that:

1. The Applicant ordinarily resides in Canada.
2. The Medical Document that accompanies this Application is ORIGINAL. An Authorization to Possess (ATP), Personal Use Production License (PUPL), or Designated Person Production License (DPPL) may not be used to register with an ACMPR Licensed Producer (LP), as all validity dates have now passed. Once registration is completed, no Medical Document may be returned to the Applicant for any reason.
3. Registration with a ACMPR Licensed Producer (LP) does NOT give the Applicant a license to possess cannabis. It permits the Applicant to purchase cannabis directly from that Licensed Producer for the duration outlined by the Health Care Practitioner (HCP) in the accompanying Medical Document.
4. The Applicant will only use dried marihuana and/or cannabis oil obtained from Canna Farms Ltd. for his or her own medical purposes.
5. The information in this Application and the accompanying Medical Document is correct and complete.
6. The accompanying Medical Document is not being used to seek or obtain dried marihuana from another source.
7. The Applicant acknowledges that neither dried marihuana and/or cannabis oil are approved therapeutic products, and that cannabis has not been authorized through the standard Health Canada drug approval process. This is because the current scientific evidence does not establish the safety and efficacy of cannabis to the extent required by the Food and Drug Regulations for marketed drugs in Canada.
8. The Applicant acknowledges that they are using dried marihuana and cannabis oil products obtained from Canna Farms Ltd. at their own risk. The applicant also specifically releases Canna Farms Ltd. (and it's service providers, officers, directors, and staff) from any and all actions, claims, complaints and demands for damages, loss or injury whatsoever, whether arising directly or indirectly as a consequence of the use of Canna Farms Ltd. products or services.
9. In order to receive our products and services, the Applicant and/or Responsible Individual gives consent to Canna Farms Ltd. to disclose the necessary personal information to Canna Farms Ltd.'s service providers, in accordance with Canna Farms Ltd.'s Privacy Policy.
10. The Applicant consents that the Health Care Practitioner (HCP) named in this Application and accompanying Medical Document may disclose to Canna Farms Ltd. the Applicant's personal health information for the purposes of processing this Registration Application complying with the requirements of the Access to Cannabis for Medical Purposes Regulations (ACMPR). The Applicant understands and agrees that a copy of this consent and Registration Application may be provided to the Health Care Practitioner named in this Application and accompanying Medical Document.

APPLICANT SIGNATURE*: _____ **Date***: _____
(MM/DD/YYYY)

RESPONSIBLE INDIVIDUAL: SIGNATURE ***(IF APPLICABLE)*** _____ **Date***: _____
(MM/DD/YYYY)

Once completed, this Registration Application may be submitted to Canna Farms Ltd. in one of the following ways:

Email: info@cannafarms.ca **Fax:** 1-855-244-9158 **Mail:** PO Box 1419, Hope, B.C., V0X 1L0

This application will be processed once we receive your original Medical Document, **mailed** to PO Box 1419, Hope, B.C., V0X 1L0.