CLIENT REGISTRATION APPLICATION

1) Applicant Information

Applicant Name | *(First name)* | *(Middle name)* | *(last name)*

Date of Birth *YYYY* *MM* *DD* **Gender** *Male* *Female*

Contact *Phone with area code* *Email* *Fax*

1.1) Optional *(If the applicant is under 18 please have a responsible individual to fill the below information)*

Name of Resonsible *(First name)* *(Middle name)* *(last name)*

Relationship: Date of Birth

Contact of Responsible person (Phone/Email):

Are you enrolled in the Veterans Affairs Canada Program ? *YES* *NO*

If YES, provide following information K number

Residential Address *Unit/Apt number* *Street name* *City*

Nova Scotia *Province* *Postal Code*

2) Mailing Address

Provide the mailing address if it is different from residential address given above

Mailing Address *Unit/Apt number* *Street name* *City*

Nova Scotia *Province* *Postal Code*

3) Shipping Address

We will ship product to this address

(Applicants without a residential address can receive their product shipped to the Healthcare Practitioner who completed the Medical Document)

- ☐ Same as residential address
- ☐ Same as mailing address
- ☐ Healthcare practitioner's business address as specified in the Medical Documene

3.1) Non Private Residence (If Applicable)

Residence Type *Example: Care Home* *Name of Establishment*

Contact *Phone with area code* *Email* *Fax*

Manager Name

I hereby certify that I am a manager of the given establishment and that we provide food, lodging, other social services to the Applicant

Manager Signature **Date**

3.3) Healthcare Practitioner Delivery (If Applicable)

To be filled by Healthcare Practitioner on your behalf if they agreed to receive products on your behalf

Practitioner Name			
	Title	*Given Name*	*Surname*

I, _____ *(Name of Healthcare Practitioner)* agree to receive the medical cannabis product(s) on behalf of _____ *(Name of Applicant)*

Signature of Healthcare Practitioner **Date**

4) Acknowledgements of Applicant or Responsible Individual

I, hereby declare the following

1) The information provided in the Application and Medical Document is correct and complete

2) The Medical Document is not being misused just to get the cannabis products from another source

3) The applicant will use the cannabis products only for his/her own purposes

4) The appliacnt should be hold accountable for any misrepresentaitons as well as associated legal actions

Applicant Signature **Date** *(YYYY-MM-DD)*

Responsible person signature *(if applicable)*

Submit the form to LP once it is filled and signed

RP or designate has reviewed and approved the form ☐ Initial/Date