





Application to Amend Registration

Language Selection: English French

Fields marked with  are required.

Current Client Details:



			<input type="text"/>	<input type="text"/>
First Name	Last Name	Date of Birth (mm/dd/yyyy)	Gender	


MyMedi.ca Client ID

What would you like to amend? Name Date of Birth Gender Address Contact information Caregiver


Section 1

If you are changing information in Section 1, please include proof of change such as government-issued ID and/or marriage certificate. Subsequent sections to be completed as applicable. Please make your changes below.

		<input type="text"/>	<input type="text"/>	<input type="text"/>
First Name	Last Name	Date of Birth (mm/dd/yyyy)		

Section 2

Residential address

	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street Address	Unit #	City	Province	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Postal Code	Primary Phone	Secondary Phone	Email	

Residence Type Private Residence Shelter/Hostel Nursing Home Other

*Attestation of residence required if shelter/hostel selected. Establishment manager must complete this section.

I, (Manager's name) _____ confirm that (Name of establishment) _____

provides food, lodging or other social services to (Patient's name) _____

		<input type="text"/>	<input type="text"/>	<input type="text"/>
Signature of manager	Contact email	Date (mm/dd/yyyy)		

Mailing address

Complete the following information only if mailing address differs from residence address.

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Address

Unit #

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City

Province

Postal Code

I have requested that medical cannabis products be delivered to my healthcare practitioners' address, with their consent as noted on my medical document.

Section 3

Caregiver Information (only complete if applicable)

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First Name

Last Name

Date of Birth (mm/dd/yyyy)

Gender

--	--	--

Primary Phone

Secondary Phone

Email

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Relationship to Patient

I, (*Print caregiver name*) _____ acknowledge that I am the caregiver for (*Print patient name*) _____ and take responsibility for the ordering, safe storage and administration of medical cannabis products.

Signature of caregiver	<table border="1"><tr><td style="width: 40px; height: 30px;"></td><td style="width: 40px; height: 30px;"></td><td style="width: 80px; height: 30px;"></td></tr></table> Date (mm/dd/yyyy)			

Consent

The patient and caregiver, or the individual responsible for the patient, if applicable, acknowledges and agrees to the following:

1. MyMedi.ca may collect, use and disclose personal information contained in this application, and any related medical document that is provided to MyMedi.ca (the "Medical Document"), in accordance with MyMedi.ca's Privacy Policy (the "Privacy Policy") and applicable laws. The purposes for which MyMedi.ca may collect, use and disclose personal information include: for shipment and fulfillment purposes, to complete the registration of the patient and to communicate with the patient's healthcare professionals, medical clinics, licensing authorities or suppliers that may be responsible for production of medical cannabis and service providers that are responsible for purchase fulfillment and verification purposes.
2. The patient permits MyMedi.ca to communicate with the patient via telephone or email regarding registration or order status, product availability and additional matters in accordance with MyMedi.ca's Privacy Policy. The patient understands that electronic communications are not secure and can be forwarded, intercepted, circulated, stored or even changed without their knowledge or permission and agrees to accept that risk. Electronic communication is at the patient's option and the option to communicate electronically may be withdrawn at any time by providing written notice to MyMedi.ca
3. The patient understands that the safety and risks associated with the use of medical cannabis have not been sufficiently studied and that using medical cannabis products obtained from MyMedi.ca is done at their own risk. The patient releases MyMedi.ca, its related entities, affiliates, subsidiaries, directors, officers, partners, providers and employees from any and all actions, claims, complaints and demands for damage, loss or injury arising as a consequence of the use of medical cannabis products obtained from MyMedi.ca
4. The information in this application and the Medical Document is correct and complete.
5. The patient ordinarily resides in Canada.
6. The Medical Document is original and has not been modified.
7. The Medical Document is not being used to obtain medical cannabis from another source.
8. The use of medical cannabis is for the patient's own medical purposes.
9. MyMedi.ca may collect, use and disclose personal information contained in this application. This includes disclosure of any and all patient personal information collected by MyMedi.ca to the patient's caregiver and disclosure of any and all caregiver personal information to the patient. In the case where the individual who is signing the statement is neither the client nor a named responsible adult, you represent and warrant that you have obtained their consent and/or have the authority to consent on their behalf. Consent may be withdrawn at any time but such withdrawal will not have a retroactive effect.
10. As the patient, you authorize the responsible individual/caregiver to act on your behalf with respect to anything you could do on your behalf with MyMedi.ca and you authorize MyMedi.ca to accept such authority.

_____	<input type="text"/> <input type="text"/> <input type="text"/>
Signature of patient	Date (mm/dd/yyyy)

_____	<input type="text"/> <input type="text"/> <input type="text"/>
Signature of caregiver/individual responsible for patient (if applicable)	Date (mm/dd/yyyy)

Please indicate if you consent to receiving email communications from MyMedi.ca containing offers and updates related to medical cannabis. You may unsubscribe at any time. Yes No