MyMedi.ca
MEDICAL CANNABIS CARE

**MyMedi.ca**
c/o Northern Green Canada Inc.
275 Orenda Road
Brampton, ON L6T3T7

www.mymedi.ca
Fax: 1-844-500-4042
Tel: 1-844-500-2040

# Patient Registration Form

**Language Selection:** ☐ English ☐ French

*Note: If you are the patient's caregiver, please complete this form with the patient and sign the caregiver acknowledgement and confirmation.

**The patient's first and last names must be identical to what is written on the Medical Document.**

First Name | Last Name | Date of Birth *(mm/dd/yyyy)* | Gender

**Fields marked with ▸ are required.**

## Type of Registration

☐ New patient ☐ Transferring from a Licensed Producer _____

## Residential Address

Street Address | Unit # | City | Province

Postal Code | Primary Phone | Secondary Phone | Email

Preferred means of communication: ☐ Primary Phone ☐ Secondary Phone ☐ Email

## Mailing Address

*Complete this section only if it is different from above. Mailing address must be a residence, P.O. Box or healthcare professional's office.*

Street Address | City | Province | Postal Code

**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)* _____

Signature of manager | Contact email | Date *(mm/dd/yyyy)*

**THIS APPLICATION IS NOT COMPLETE UNTIL THE PATIENT CONSENT IS ALSO SIGNED BY THE PATIENT (AND CAREGIVER IF APPLICABLE)**

## Insurance Information (if applicable)

Are you a Canadian veteran?

☐ Yes ☐ No

If so, please provide Blue Cross number:

*Please provide a copy of your Blue Cross card with your completed Registration form.*

Do you have private coverage for medications?

☐ Yes ☐ No

If so, please provide insurer name:

Policy number:

## Caregiver Information (if applicable)

A caregiver is a designated adult who is responsible for the patient.

Caregiver First Name

Caregiver Last Name

Date of Birth *(mm/dd/yyyy)*

Gender

Primary Phone

Secondary Phone

Email

Relationship to Patient

## Caregiver Acknowledgement and Confirmation

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

Date *(mm/dd/yyyy)*

## Consent

**The patient (and caregiver 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. If the patient has specified a K number or insurance policy number on the application, the patient consents to MyMedi.ca's sharing of personal details and information contained in this application with Veterans Affairs Canada or the patient's insurance provider.

4. 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

5. The information in this application and the Medical Document is correct and complete.

6. The patient ordinarily resides in Canada.

7. The Medical Document is original and has not been modified.

8. The Medical Document is not being used to obtain medical cannabis from another source.

9. The use of medical cannabis is for the patient's own medical purposes.

| | |
|---|---|
| Signature of patient | Date *(mm/dd/yyyy)* |
| Signature of caregiver/individual responsible for patient (if applicable) | Date *(mm/dd/yyyy)* |

**For Healthcare Providers consenting on the patient's behalf:**
Consent must be obtained from your patient for the collection, use and disclosure of their personal information as described above.
***Yes, the consent statement above has been explained to the patient and I have obtained verbal consent for registration.*** ☐ Yes

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

Please fax this completed document to 1-844-500-4042 OR mail this document to **MyMedi.ca** c/o Northern Green Canada Inc., 275 Orenda Road, Brampton, ON, L6T3T7