AGMEDICA BIOSCIENCE INC.
111 Heritage Road, Suite 200 | Chatham, ON N7M 5W7
tf. 1-844-5MY-CARE (1-844-569-2273) f. 1-866-927-8847
e. clientcare@agmedica.ca www.agmedica.ca

REGISTRATION APPLICATION

*Thank you for selecting **AgMedica Bioscience Inc.** as your licensed producer of choice! At **AgMedica Bioscience Inc.** our medical cannabis is produced in compliance with industry standards. All of our products are laboratory tested to ensure patients have access to safe and consistent products.*

Confidential Health Information Enclosed. Health care information is personal and sensitive. It is being submitted to you after appropriate authorization from the individual or under circumstances that do not require individual authorization. You, the recipient, are obligated to maintain this information in a safe, secure and confidential manner. Re-disclosure without additional consent or authorization of the individual or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain the confidentiality of this information could subject you to penalties under Federal and/or Provincial law.

INSTRUCTIONS:

To become an ***AgMedica Bioscience Inc.*** client, you must complete and sign this Registration Application and send it to our Client Care Team via secure fax, email or mail to:

MAIL: ATTN: AgMedica Bioscience Inc. Client Care Team
111 Heritage Road, Suite 200 | Chatham, ON N7M 5W7
EMAIL: clientcare@agmedica.ca
FAX: 1-866-927-8847

Our ***AgMedica*** team is available to answer any questions; we are here to assist you each step of the way.

To expedite the registration process, we advise registering online at: **www.agmedica.ca/register**

You must also have your physician or nurse practitioner complete and sign your Medical Document. Our Client Care Team **only accepts this document by secure fax** sent directly from your physician or nurse practitioner's office. If not, the original paper version of your Medical Document must be mailed by either you, your physician or your nurse practitioner.

If you need any assistance, our Client Care Team is happy to help you each step of the way.

Yours on this incredible journey,

The AgMedica Team

REGISTRATION APPLICATION

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CLIENT'S UNIQUE IDENTIFIER: _____

CLIENT'S INFORMATION

☐ NEW ☐ RENEWAL ☐ AMENDED

Proof of Client's information change under this section must be provided

Client's Name

Given Name | Middle Name | Surname

Date of Birth (MM/DD/YYYY)

☐ Male ☐ Female ☐ Other ☐ Undisclosed

☐ Veteran K #: _____

PART A: CLIENT'S RESIDENCE

AMENDED ☐ If checked, provide new information for this section below

***RESIDENCE* (must be in Canada and cannot be Post Office Box)**

The address of the place in Canada where the Client ordinarily resides. If the Client ordinarily resides in Canada but has no dwelling place (e.g. shelter or hostel) complete this section below, providing the address information for a shelter, hostel or similar institution, located in Canada, that provides food, lodging or other social services to the Client.

Address | Unit # / Buzzer Code | City

Province | Postal Code | Email

Primary Contact #
☐Cell ☐Home ☐Fax
☐OK to leave voicemail
☐Morning ☐Afternoon ☐Evening

Secondary Contact #
☐Cell ☐Home ☐Fax
☐OK to leave voicemail
☐Morning ☐Afternoon ☐Evening

The above address is one of the following:

☐ a private residence (e.g. house or apartment)

☐ an establishment that is not a private residence (e.g. hospice, hospital, nursing home, etc.)
If checked, complete details for the establishment.

Name of Establishment | Type of Establishment

☐ an institution that provides food, lodging or other social services to the Client (e.g. shelter, hostel, etc.)
If checked, complete details for the institution and attestation of residence.

Name of Institution | Type of Institution

ATTESTATION OF RESIDENCE: To be completed by a manager of the specified above Institution (shelter, hostel, etc.)

I, _____ attest and confirm that institution specified above, located at the address referred to in the "Residence" section of this application, provides food, lodging or other social services to the following Client: _____

Institution Manager's Name | Client's Name

Signature of Manager | Date (MM/DD/YYYY)

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PART B: CLIENT'S MAILING AND SHIPPING ADDRESS

To be completed by the Client or by an individual who is responsible for the Client and referred to in Part C of this application.

AMENDED ☐ If checked, provide new information for this section below

***MAILING ADDRESS* (must be in Canada)**

The mailing address of the place referred to in section "Residence" above, if different from the address provided under that section.

☐ SAME AS RESIDENCE

Address

City | Province | Postal Code

AMENDED ☐ If checked, provide new information for this section below

***SHIPPING ADDRESS* (must be in Canada)**

Indicate which one of the following is to be the shipping address:

☐ SAME AS RESIDENCE; OR

☐ SAME AS MAILING ADDRESS; OR

☐ THE BUSINESS ADDRESS OF THE PHYSICIAN OR NURSE PRACTITIONER WHO PROVIDED THE MEDICAL DOCUMENT TO THE CLIENT(1)

(1) If the shipping address is the address of the Healthcare Practitioner who provided the Medical Document to the client, the consent statement in Part D of this application must be signed and dated by that Healthcare Practitioner.

PART C: INDIVIDUAL(S) RESPONSIBLE FOR THE CLIENT (complete if applicable)

This Part C of the application must be completed if the Client has changed information regarding a person (Caregiver) who is responsible for the Client.

AMENDED ☐ If checked, provide new information for this section below

RESPONSIBLE INDIVIDUAL:

The mailing address of the place referred to in section "Residence" above, if different from the address provided under that section.

Given Name | Middle Name | Surname

Date of Birth (MM/DD/YYYY)

☐ Male ☐ Female ☐ Other ☐ Undisclosed

Phone | Email | Fax

I, _____ attest that I am an individual who is responsible for the Client: _____

Name of Responsible Individual | Name of Client

Signature of Responsible Individual | Date (MM/DD/YYYY)

PART D: PHYSICIAN OR NURSE PRACTITIONER WHO PROVIDED MEDICAL DOCUMENT TO THE CLIENT

To be completed by the Client or by an individual who is responsible for the Client and referred to in Part C of this application.

AMENDED ☐ If checked, provide new information for this section below

***HEALTHCARE PRACTITIONER'S CONSENT TO RECEIVE DRIED CANNABIS ON BEHALF OF CLIENT:* (complete if applicable)**

To be completed by a Healthcare Practitioner who provided Medical Document to the Client, if they have consented to receive medical cannabis on behalf of the Client (please refer to Part B (shipping address) of this application form):

I, _____ do hereby attest and confirm my consent to receive medical cannabis on behalf of the Client

Print Healthcare Practitioner's Name

_____ at my business address specified in this section below, which is the same as my business address specified on the Medical Document that I provided to the Client.

Name of Client

Name of Business	Address

City	Province	Postal Code

Phone	Email	Fax

Signature of Healthcare Practitioner	Date (MM/DD/YYYY)

PART E: STATEMENTS AND SIGNATURE BY CLIENT OR RESPONSIBLE INDIVIDUAL

To be completed by the Client or by an individual who is responsible for the Client and referred to in Part C of this application.
IMPORTANT: Carefully read the Consent Form before signing the application.

Signature of Client or Responsible Individual	Date (MM/DD/YYYY)

Print Name

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PART F: YOUR CONSENT

By signing this document, you state that you understand, agree, and consent to each of the following statements:

1. You ordinarily reside in Canada.
2. The information in this application and the accompanying Medical Document is correct and complete.
3. The Medical Document, being submitted, is not being used to seek or obtain dried cannabis from another source.
4. The use of dried cannabis is for your medical purposes ONLY.
5. The original of the Medical Document is provided in support of the application.
6. Medical cannabis is not currently approved for use as a pharmaceutical drug in Canada. You are using medical product obtained from AgMedica at your own risk. You hereby release AgMedica and its related entities from and all actions, claims, complaints, demands for damages, personal losses, and/or injuries arising directly or indirectly from the use of medical cannabis obtained from AgMedica.
7. You understand that this consent is valid for the duration of the Registration Application/Medical Document submitted by the Client, unless you withdraw your consent earlier by sending a written request to AgMedica at: ***ClientCare@AgMedica.ca*** or by sending my request to: ***AgMedica Bioscience Inc., 229 St. Clair Street, Suite 208, Chatham, ON., N7L 3J4***

Please initial the box if:

☐ You would like to receive email communication (promotions, newsletters, etc.) from AgMedica through the contact information you have provided in your registration application.

**If you wish to leave the box blank and not include your email within your registration application, you may request communication to be conducted via mail to your mailing address within in your registration application.*

By signing this Consent Form, you consent to AgMedica's collection, use and disclosure of the personal information contained in it, in accordance with AgMedica's Privacy Policy available at: ***www.AgMedica.ca.*** This includes, without limitation, disclosure of this Consent Form and related documents to the Healthcare Practitioner named in the clients' Medical Document and the clinic or employee with which the Healthcare Practitioner works. Hard copies of the External Privacy Policy are available upon request. If the personal information in the Client Registration Application pertains to someone other than you, you represent and warrant that you have obtained their consent and/or have authority to consent on their behalf. Consent may be withdrawn at any time, but such withdrawal will not have retroactive effect. This withdrawal may have implications to you and/or the subject individual and will not affect the collection, use and disclosure of the personal information where such collection, use and disclosure is permitted or required by law without consent.

Client Signature	Date (MM/DD/YYYY)
Responsible Individual Signature	Date (MM/DD/YYYY)