



VETERANS AFFAIRS CANADA ATTESTATION FORM

AGMEDICA BIOSCIENCE INC.
229 St. Clair Street, Suite 208 | Chatham, ON N7L 3J4
t. 1-844-5MY-CARE f. 1-866-927-8847
e. clientcare@agmedica.ca www.agmedica.ca

PART A

Complete Part A, as well as any section that applies to your current arrangements of receiving medical cannabis.

Client's Name

Given Name

Middle Name

Surname

Date of Birth (MM/DD/YYYY)

Veterans Affairs Canada Health Benefit #: _____

- New to AgMedica Bioscience Inc. (see Part B)
- Splitting Prescription between two Licensed Producers (see Part C)
- Switching from a different Licensed Producer to AgMedica Bioscience Inc. (see Part D)
- Switching from one Licensed Producer to multiple Licensed Producers (see Part E)
- Switching from multiple Licensed Producers to alternate multiple Licensed Producers (see Part F)

Before submitting this document please verify all information is correct and accurate to the best of your knowledge, and then sign and date Part G.

PART B: NEW TO AGMEDICA BIOSCIENCE INC.

Complete this section ONLY if you are a new medical cannabis client and have NOT been registered with any other licensed producer previously.

I, _____, certify that:
Given Name / Surname

- I do not have a medical cannabis prescription with any other Licensed Producer in Canada other than AgMedica Bioscience Inc.
- I am not registered with another Licensed Producer in Canada other than AgMedica Bioscience Inc.

PART C: SPLITTING PRESCRIPTIONS BETWEEN TWO LICENCED PRODUCERS

Complete this section ONLY if your total medical cannabis prescription is split between two Licensed Producers.

I, _____, certify that effective today, I wish to split my medical cannabis prescription.
Given Name / Surname

My medical cannabis prescription is split between:

1. _____ For _____ grams per 30-day period
2. _____ For _____ grams per 30-day period

Please make the necessary notation in my profile.

CONFIDENTIAL

The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

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PART D: SWITCHING FROM A DIFFERENT LICENSED PRODUCER TO AGMEDICA BIOSCIENCE INC.

Complete this section ONLY if you are switching from another Licensed Producer to AgMedica.

I, _____, certify that effective today, I wish to change my licensed producer of choice.
Given Name / Surname

My medical cannabis prescription from:

_____ for _____ grams per 30-day period will
now be changed to: _____ grams per 30-day period with AgMedica.

Please make the necessary adjustments to my file.

My last order of medical cannabis from _____ was for _____ grams
on _____.
(MM/DD/YYYY)

PART E: SWITCHING FROM ONE LICENSED PRODUCER TO MULTIPLE LICENSED PRODUCERS

Complete this section ONLY if you are switching from ONE Licensed Producer to multiple Licensed Producers.

I, _____, certify that effective today, I wish to change my medical cannabis prescription of:
Given Name / Surname

_____ Grams per 30-day period with _____ to:
_____ Grams per 30-day period with _____ and
_____ Grams per 30-day period with _____.

Please make the necessary notations and adjustments to my file.

PART F: SWITCHING FROM MULTIPLE LICENSED PRODUCERS TO ALTERNATE MULTIPLE LICENSED PRODUCERS

Complete this section ONLY if you are switching from multiple Licensed Producers to different Licensed Producers.

I, _____, certify that effective today, I wish to change my medical cannabis
Given Name / Surname

prescription of:

_____ Grams per 30-day period with _____ and
_____ Grams per 30-day period with _____ to:
_____ Grams per 30-day period with _____ and
_____ Grams per 30-day period with _____.

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PART F cont.

Complete this section ONLY if you are switching from another Licensed Producer to AgMedica.

My last order with _____ was for _____ grams on _____.
(MM/DD/YYYY)

My last order with _____ was for _____ grams on _____.
(MM/DD/YYYY)

Please make the necessary notations and adjustments to my file.

PART G

ATTESTATION:

I attest that the information provided is true and accurate to the best of my knowledge. I understand that if any of the above statements are false or misleading I may be held liable for the cost of any medical cannabis, including applicable shipping and taxes, purchased from AgMedica Bioscience Inc. of which are not covered by my insurance because of the falsified statements in this document.

Client Signature

Date (MM/DD/YYYY)

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