Questions?
We're here to help!
Email: AskUs@MedReleaf.com
Phone: 1.855.4.RELEAF (473.5323)

www.MedReleaf.com

MEDRELEAF®
THE MEDICAL GRADE STANDARD™

SECTION 1a - PATIENT INFORMATION

Patient's name

Given First Name(s) | Surname (Last Name) | DOB (DD/MM/YY)

Gender ◯ Male ◯ Female

Email Address

Are you a veteran? ◯ Yes If so, please provide your 'K' number

By indicating you are a veteran, you give permission for MedReleaf to share your details with VAC.

SECTION 1b - INTERIM SUPPLY

Are you submitting this registration application form to obtain interim supply of dried marihuana or cannabis oil?

◯ Yes ◯ No

If yes, please provide your Health Canada-issued Registration Certificate Number

Please submit copy of Registration Certificate with this application.

Are you currently receiving interim supply from another Licensed Producer? ◯ Yes ◯ No

SECTION 2 - CONTACT & SHIPPING INFORMATION

Primary Residence, must be In Canada ◯ Use primary address as my shipping address.

Primary Residence

Unit # | Street Address 1 | Street Address 2 (If Applicable)

City | Province | Postal Code

Residence Type ◯ Private Residence ◯ Nursing/Care Home ◯ Shelter ◯ Hostel ◯ Group Home ◯ Other

If Other, Please Specify | Name of Establishment (if not private residence)

Contact Info

Phone Number | Fax Number

More establishment info (if necessary)

Confirm Email Address

ALTERNATE ADDRESS

Applicable **ONLY** if your primary residence has no postal service.

Shipping Address:

Unit # | Street Address 1 | Street Address 2 (If Applicable)

City | Province | Postal Code

This form may be filled out electronically or printed and completed by hand.

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SECTION 3 - CAREGIVER INFORMATION

Not Applicable ☐

Caregiver Name

Given First Name(s) | Surname (Last Name) | DOB (DD/MM/YY)

Gender ☐ Male ☐ Female

Caregiver Phone #

Email Address | Confirm Email Address

Caregiver / Person Responsible Declaration:

I ____________ am responsible for ____________

Caregiver / Person responsible Full Name | Patient's Full Name

Date Signed (DD/MM/YY)

Caregiver Signature

Other Person(s) Responsible For the Applicant (multiple caregivers)

Not Applicable ☐

Caregiver Name

Given First Name(s) | Surname (Last Name) | DOB (DD/MM/YY)

Gender ☐ Male ☐ Female

Caregiver Phone #

Email Address | Confirm Email Address

Caregiver / Person Responsible Declaration:

I ____________ am responsible for ____________

Caregiver / Person responsible Full Name | Patient's Full Name

Date Signed (DD/MM/YY)

Caregiver Signature

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SECTION 4 - AUTHORIZATION OF APPLICANT

By signing below the applicant and/or caregiver responsible for the applicant acknowledges that they have read, understood and agree that:

- The Applicant ordinarily resides in Canada.
- The information in this application and the accompanying Medical Document or accompanying Registration Certificate is correct and complete.
- The Medical Document or Registration Certificate is not being used to seek or obtain dried cannabis from another source.
- The original Medical Document or one of the original Personal Use Production License (PUPL) or Designated Person Production License (DPPL) MUST be received by MedReleaf Corp. in order for MedReleaf Corp. to complete the patient registration. OR a copy of the Registration Certificate issued by Health Canada MUST be received by MedReleaf Corp. in order for MedReleaf Corp. to complete the patient registration for interim supply.
- The Applicant will use dried cannabis only for its own medical purposes.
- The Applicant understands and acknowledges that medical cannabis is not currently approved for use as a pharmaceutical drug in Canada
- The Applicant acknowledges and agrees that he or she is using any medical cannabis product obtained from MedReleaf Corp. at his or her own risk, and releases MedReleaf Corp. (and is partners, providers, officers, directs and staff) from any and all actions, claims, complaints and demands for damages, loss or injury whatsoever arising directly or indirectly from the use of medical cannabis obtained from MedReleaf Corp.
- The Applicant consents to MedReleaf Corp. collecting and disclosing necessary personal information in order to process this registration and to fulfill orders for medical cannabis in accordance with the MedReleaf Corp. privacy policy (www.MedReleaf.com/privacy.php)
- By signing below, the applicant acknowledges that they have read, understood, and agree that: MedReleaf may from time to time use personal health information (i.e. your condition(s), product selection) on an anonymous and aggregate basis for research and/or medical educational purposes. We may also ask you to complete surveys that we use for research purposes, although you do not have to respond to these.
- The Applicant acknowledges that if registering to obtain interim supply under Part 2 of the Access to Cannabis for Medical Purposes Regulations, the accompanying Registration Certificate has not been used to obtain an interim supply of fresh or dried marihuana or cannabis oil from another Licensed Producer.
- The Applicant consents to their health care practitioner named in the Medical Document disclosing required personal health information to MedReleaf Corp. for the purposes of complying with the requirements of the Access to Cannabis for Medical Purposes Regulations (ACMPR). The Applicant understsands and agrees that a copy of this consent & registration application may be provided to the health care practitioner.

Applicant's or Caregiver's Signature

Date Signed (DD/MM/YY)

How did you hear about MedReleaf? (optional)

Please send both this completed document AND your ORIGINAL Medical Document, or copy of Health Canada Registration Certificate, to us at:

MedReleaf
P.O. Box 3040
Markham Industrial Park
Markham ON, Canada
L3R 6G4

This form may be filled out electronically or printed and completed by hand.