AYURCANN

PATIENT APPLICATION FORM

Please note that the applicant information provided on this application must match the information that appears on the original Medical Document.

Date (MMM/DD/YYYY): ______/_______/________

☐ **NEW APPLICANT**

How did you hear about us?: Friend/Family ☐ Google/Social Media ☐ Clinic/Practitioner ☐

☐ **PATIENT RENEWAL** (Patient I.D. Number: ________)

PATIENT INFORMATION

Title	Legal First Name	Legal Surname Name	Preferred Name
Date of Birth (MMM/DD/YYYY)		Gender	
_______/________/________		☐ MALE ☐ FEMALE ☐ X	
Email Address	Phone Number	Alternative Phone Number	
Residential Address, Unit, City, Province, Postal Code (**Note**: we cannot ship to a P.O. box)			
Shipping Address, Unit, City, Province, Postal Code (**Note**: we cannot ship to a P.O. box)			

ADDITIONAL APPLICANT INFORMATION

**Please note that we will require proof for all options that apply below.*

Are you a Veteran?	No ☐	Yes ☐	K____________________
Do you hold a Certificate of Indian Status card?	No ☐	Yes ☐	Card #______________________________
Do you require Compassionate Pricing?	No ☐	Yes ☐	

PREFERRED METHOD OF COMMUNICATION

Phone	Email	Registered Mail
☐	☐	Residential ☐ Establishment ☐

ESTABLISHMENT INFORMATION *(Shelter, Hostel, Care Home)*

Establishment Name	Establishment Type
Establishment Address, City, Province, Postal Code (**Note**: we cannot ship to a P.O. box)	
Phone Number	Email Address
Manager First Name	Manager Last Name

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STATEMENT *(To be completed by the Manager of the above Establishment)*

☐ I attest that this Establishment/ Institution provides food, lodging and social services to the applicant.

Manager Signature		Date (MMM/DD/YYYY)	

INDIVIDUAL(S) RESPONSIBLE ***(IF APPLICABLE)***

∗To be completed by the individual responsible for the applicant. The Individual Responsible may act on behalf of the registered patient. They may make inquiries, changes, and orders on the part of the patient. ***Must be 19 years of age or older.***

Individual Responsible #1			
Title	Legal First Name	Legal Surname Name	Preferred Name
Date of Birth (MMM/DD/YYYY)	Phone Number		Gender
_______/________/________			☐ MALE ☐ FEMALE ☐ X
Email Address			
Individual Responsible #2			
Title	Legal First Name	Legal Surname Name	Preferred Name
Date of Birth (MMM/DD/YYYY)	Phone Number		Gender
_______/________/________			☐ MALE ☐ FEMALE ☐ X
Email Address			

ACKNOWLEDGMENT:

THE APPLICANT AND/OR INDIVIDUAL RESPONSIBLE ACKNOWLEDGES AND AGREES THAT:

- Some of the information provided in this document may be shared with Health Canada, our service providers, Veterans Affairs, and/or insurance providers, as applicable, solely for the purposes of providing service support.
- Some of the information provided in this document may be shared with licensing authorities to remain compliant with relevant laws and regulations, namely the Cannabis Regulations.
- They give Ayurcann Inc permission to share their ordering information with their prescribing health care practitioner and/or clinic through which they received their consultation.
- The information in the application and the Medical Document is correct and complete.
- The Medical Document is not being used to seek or obtain cannabis product from another source.
- The Medical Document has not, to the knowledge of the individual signing the statement, been altered.
- The applicant will use cannabis only for their own medical purposes.
- The applicant ordinarily resides in Canada.

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- The only acceptable supporting Medical Document accepted will be the **original** Medical Document signed and submitted by your health care practitioner/prescribing clinic and who is in good standing with the SPCO and CNO.
- Once registration is completed, no Medical Document may be returned to the applicant for any reason.
- The applicant is using dried marihuana and/or cannabis products obtained from Ayurcann Inc. at their own risk. The applicant also specifically releases Ayurcann Inc (and its service providers, officers, directors, and staff) from any and all actions, claims, complaints and demands for damages, loss, or injury whatsoever, whether arising directly or indirectly as a consequence of the use of Ayurcann Inc products or services.

Signature of Individual Responsible #1 *By signing this document you are acknowledging that you are responsible for the applicant*	**Date (MMM/DD/YYYY)**
Signature of Individual Responsible #2 *By signing this document you are acknowledging that you are responsible for the applicant*	**Date (MMM/DD/YYYY)**

Applicant Signature	**Date (MMM/DD/YYYY)**

☐ Applicant agrees to have Ayurcann Inc. communicate with them through email and send them exclusive offers & updates.