Patient Application

Agro-Greens Natural Products Ltd.
5508 - 48 Street, Box 126
Macklin, Saskatchewan S0L 2C0
Phone: 1-844-922-2244
Fax: 1-639-398-2244 ext. 6
Email: info@agrogreens.ca

To Be Completed By Patient Or Caregiver

Section 1: Patient Information — *THIS SECTION IS MANDATORY*

First Name(s)	Middle Name(s)	Last Name
Date of Birth: M M D D Y Y Y Y	Gender	Phone
Email		Fax

Primary Residence Address (If this is not a private residence please complete the name and type of establishment in Section 3)

Unit No.	Street No.	Street Address
City	Province	Postal Code

Shipping / Mainling Address (where you would like to receive your medication) ☐ check box if same as **Primary Residence Address**

Unit No.	Street No.	Street Address
City	Province	Postal Code

The Patient and/or the Caregiver must agree to the following: (1) The Applicant is ordinarily a resident or Canada; (2) The information in the Application for Medical Cannabis and Medical Document is correct and complete; (3) The Medical Document accompanying this application is not being used to seek or obtain dried cannabis or cannabis oil from another source; (4) An original Medical Document accompanies this application; (5) The Patient will use dried cannabis or cannabis oil for their own medical purposes only; (6) The Patient acknowledges that dried cannabis and cannabis oil are not approved drugs in Canada and thus the indications and safety risks of its use have not been adequately studied nor an appropriate dosage determined; (7) The Patient acknowledges and agrees that he/she is using products obtained from Agro-Greens Natural Products Ltd. (Agro-Greens) at their own risk, and releases Agro-Greens (and its production partners) from any and all actions, claims, complaints and demands for damages, loss or injury whatsoever arising directly or indirectly as a consequence of the use of dried cannabis or cannabis oil obtained from Agro-Greens.

Consent to Release Health Information: By signing below, the Patient or the Caregiver responsible for the Patient, consents to the disclosure of the Patient's information to the Healthcare Provider who has signed their medical document. By signing below, the Patient or the Caregiver responsible for the Patient understands that they may have chosen to refuse to sign the consent form and chosen not to submit their application.

Signature	Today's Date: M M D D Y Y Y Y

Section 2: Caregiver Information - To authorize someone to talk with Agro-Greens on your behalf please provide their information below

If you wouldn't like to authorize anyone to communicate with Agro-Greens on your behalf, you can leave this section blank.

First Name(s)	Middle Name(s)	Last Name
Date of Birth: M M D D Y Y Y Y	Gender	Phone

By signing below, the Caregiver agrees that they are responsible for the Applicant listed in Section 1.

Caregiver Signature	Date: M M D D Y Y Y Y

Section 3: Residents of care homes, shelters, hostels or similar institutions that provide social services to patient

If you don't live in a care home, shelter, hostel or similar institution you can leave this section blank.

Name of Establishment		Type of Establishment
Phone	Fax	Email

Please have the manager of the establishment sign below to confirm that the institution provides food, lodging or other social services to the applicants.

Name of Residence Manager	Signature of Residence Manager	Date: M M D D Y Y Y Y

Section 4: Ship to your Healthcare Provider - Fill in below to authorize your Healthcare Provider to receive your medication on your behalf

If the shipping address you provided in Section I is your Healthcare Practitioners Office, please have them sign this section to consent to receiving the product on your behalf.

Name of Healthcare Provider	Signature of Healthcare Provider	Date: M M D D Y Y Y Y