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 / Mailing 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: (i) the applicant ordinarily resides in Canada, (ii) the information in the application is correct and complete, (iii) the medical document that forms the basis for the application has not, to the knowledge of the individual signing the statement, been altered, (iv) the medical document is not being used to seek or obtain cannabis products from another source, (v) in the case where the applicant is signing the statement, they intend to use any cannabis product that is supplied to them on the basis of the application only for their own medical purposes, and (vi) in the case where an adult who is named under section 2 is signing the statement, they are responsible for the applicant, (vii) in the case where the individual who is signing the statement is neither the client nor a named responsible adult, the client and any named responsible adults have been notified of the application.

If the applicant is applying based on a registration certificate: (viii) the copy of the registration certificate is an accurate reproduction of the original, (ix) if the application is being made to obtain cannabis products other than cannabis plants or cannabis plant seeds, the registration certificate is not being used to seek or obtain the cannabis products from another source. (x) in the case where an adult who is named in the registration certificate is signing the statement, they are responsible for the applicant.

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