ESTABLISHMENT SHIPMENT AUTHORIZATION FORM

Customer Care
Toll-free number: 1-833-290-8878

PLEASE NOTE: All fields on this form are mandatory. The information provided on this form must match the Medical Document form. Incomplete forms will result in a delay of registration. Complete registration forms may be submitted by mail, email, or fax.

CLIENT INFORMATION

☐ I am a NEW client ☐ I am a RETURNING client

☐ Male ☐ Female

Client ID No. (if returning patient)

Given First Name

Surname

/ / D.O.B. (DD/MM/YYYY)

Phone

Email

ESTABLISHMENT INFORMATION

Name of Establishement

Address

Unit No. (if applicable)

Buzzer Code (if applicable)

City

Province

Postal Code

Type of Establishment

Phone

Fax

Email

☐ Ship product to this address

Manager's First Name

Manager's Surname

Phone

Fax

Email

SIGNATURE

I, Manager's Name attest that

Establishment Name

provides food, lodging, and/or other social services to

Client's Name .

Manager Signature

Date (DD/MM/YYYY)

PATIENT SIGNATURE

The patient and/or the Responsible Individual for the client must acknowledge the following:

1. The Applicant ordinarily resides in Canada.
2. The information on the application and Medical Document is correct and complete.
3. The Medical Document is not being used to seek or obtain medical marijuana from another source.
4. The original Medical Document accompanies this application.
5. The applicant will use medical marijuana for their own medical purposes.
6. The applicant acknowledges and agrees that he/she is using medical marijuana obtained from FV Pharma Inc. at his/her own risk, and releases aor injury whatsoever arising directly or indirectly from the use of medical marijuana received from FV Pharma Inc..
7. The applicant acknowledges and understands that the safety and risks associated with the use of medical marijuana have not been fully studied and that a standard dosage of medical marijuana has not yet been established.

☐ By checking this box you agree that you have read, acknowledged, understood, and formally agree to the statements above and that the information provided is accurate and complete.

Client or Responsible Individual Signature

Date (DD/MM/YYYY)

By signing this Establishment Shipment Authorization form you consent to FV Pharma's collection, use and disclosure of the personal information contained in it and in all related documents, such as any Medical Document or registration certificate. This includes, without limitation, disclosure of the Patient Registration and related documents to the health care practitioner named in the patient's Medical Document and to any clinic or employer with which the health care practitioner works.

Send a copy of your completed document to:

Customer Care - P.O. Box 696, Cobourg, ON K9A 4R5
Secure fax number: 1-833-818-9025
Email: info@fvpharma.com