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

RESPONSIBLE INDIVIDUAL FORM

To be completed by the Client and the Responsible Individual

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. The Medical Document will only be accepted in ORIGINAL FORM only.

RESPONSIBLE INDIVIDUAL INFORMATION

☐ Male ☐ Female ☐ Other

Responsible Individual's Given First Name

☐ / ☐ / ☐

Responsible Individual's D.O.B. (DD/MM/YYYY)

Responsible Individual's Surname

Responsible Individual's Phone

Responsible Individual's Email

May we leave detailed messages regarding the client? ☐ Yes ☐ No

Client's ID No.

SIGNATURE

I, RESPONSIBLE INDIVIDUAL'S FULL NAME, am the responsible individual for

CLIENT'S FULL NAME.

By signing this Responsible Individual 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 Client Registration and related documents to the health care practitioner named in the client's Medical Document and to any clinic or employer with which the health care practitioner works. Hard copies of the External Privacy Policy are available upon request. If the personal information in the Client Registration pertains to someone other than you, you represent and warrant that you have obtained their consent and/or have authority to consent on their behalf. Consent may be withdrawn at any time but such withdrawal will: not have retroactive effect; may have implications to you and/or the subject individual and will not affect the collection, use and disclosure of personal information where such collection, use and disclosure is permitted or required by law without consent.

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

Client Signature | Date (DD/MM/YYYY) | Responsible Individual Signature | Date (DD/MM/YYYY)

Your Responsible Individual Form may be submitted to us by mailing or by faxing a copy of the original. It may be sent to the address or fax number below depending on your preferred method.

Please fax or email a copy of your document to:
Secure fax line: 1-833-818-9025
Email: info@fvpharma.com

Mail a copy of your document to:
Client Care
P.O. Box 696, Cobourg, ON K9A 4R5