CUSTOMER REGISTRATION FORM

To be completed by the client

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

CLIENT INFORMATION

I am a NEW client   I am a RETURNING client

Given First Name

Surname

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

Other

Primary Phone Number   Secondary Phone Number

Email (this email address will be use to grant you access to the online store to purchase your medication. If no email address is provided, orders will only be possible over the phone.)

Primary Condition (optional)   Primary Symptom (optional)

Are you a Canadian Veteran?   Yes   No

Veteran K No.

RESPONSIBLE INDIVIDUAL

Responsible Individual's Given First Name

Responsible Individual's Surname

Responsible Individual's Email

Primary Phone Number   Secondary Phone Number

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

Other

MAILING ADDRESS

Address

Unit No. (if applicable)   Buzzer Code (if applicable)

City   Province

Postal Code

SHIPPING ADDRESS (PRIMARY RESIDENCE)

Shipping address is the same as mailing address

Address

Unit No. (if applicable)   Buzzer Code (if applicable)

City   Province

Postal Code

Residence Type

Private Residence   Nursing Home

Shelter   Group Home/Other

Ship to Health Care Practitioner's business address

HEALTH CARE PRACTITIONER: Sign if you agree to receive the client's medical cannabis to your business address listed on the Medical Document. I, the client's Health Care Practitioner, agree to have the client's medical cannabis shipped to the business address specified on the client's Medical Document.

Signature of Health Care Practitioner   Date (DD/MM/YYYY)

Your Customer Registration 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 number: 1-833-818-9025
Email: info@fvpharma.com

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

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PLEASE READ CAREFULLY

By signing this Customer Registration Form you state that you understand, agree, and consent to each of the following statements:

1. You reside in Canada
2. The information in this Customer Registration Form and the accompanying Medical Document is correct and complete and to the knowledge of the individual signing, the information has not been altered.
3. The Medical Document is not being used to seek or obtain medical cannabis from another source.
4. 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.
5. The original Medical Document is provided to support this Customer Registration Form.
6. Medical cannabis is not approved for use as a pharmaceutical drug in Canada. You are using medical cannabis obtained from FV Pharma at your own risk. You hereby release FV Pharma and its related entities from any, and all actions, claims, complaints, demands, for damages, personal losses, and/or injuries arising directly and indirectly from the use of medical cannabis obtained from FV Pharma.
7. In the case where an alternate adult who is named in the registration certificate is signing the statement, they are responsible for the applicant.
8. In the case where the individual who is signing the statement is not the client, they are responsible for the client, and
9. 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 adult have been notified of the application.

By signing this Consent Form you consent to FV Pharma's collection, use and disclosure of the personal information contained in it. This includes, without limitation, disclosure of this Consent Form 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. If the personal information in the Customer 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.

NOTE: This 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)

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.

Responsible Individual Signature Date (DD/MM/YYYY)

Your Customer Change of Information 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 number: 1-833-818-9025
Email: info@fvpharma.com

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

This Application will be only processed once we receive your original Medical Document,.