United Greeneries Ltd.
PO Box 21090
Duncan, BC V9L 0C2
Phone: 1-236-889-8271
Fax: 1-250-984-0769
www.unitedgreeneries.ca

PATIENT REGISTRATION FORM

To be completed by a patient without a permanent residence

1. PATIENT INFORMATION

Preferred Language: ☐ English ☐ Français

Primary Condition (Optional)

Primary Symptom (Optional)

☐ I am a new patient with United Greeneries

☐ I am a renewing patient with United Greeneries

☐ Female ☐ Male ☐ Other ☐ Undisclosed

Given First Name | Last Name | D.O.B. (MM/DD/YYYY)

Primary Phone Number | Secondary Phone Number | Email | Fax

Are you a Canadian Veteran? (Optional) ☐ Yes ☐ No

If your benefit plan includes medical cannabis, please indicate your Policy Number OR K Number

Policy Number OR K Number: | Name of Policy Provider:

By indicating your Policy Number OR K Number, you give permission to United Greeneries to share your details with Veterans Affairs Canada and/or your insurance provider.

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2. ESTABLISHMENT INFORMATION

Address | Unit # | City | Province | Postal Code

Name of Establishment | Type of Establishment | Phone Number

Declaration of the Manager of the Establishment:

I, _____ , attest that I am a Manager of the Establishment listed above, which provides food,

Full Name of Manager

lodging or other social services to the Applicant.

Manager Signature: | Date (MM/DD/YYYY):

- PLEASE SEE REVERSE FOR REMAINDER OF FORM -

Please fax this complete document to 1-250-984-0769 OR mail original document to:
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3. MAILING ADDRESS *Please fill out if different from establishment address identified above*

Address | Unit # | City | Province | Postal Code

4. HEALTH CARE PRACTITIONER INFORMATION *To be completed by Health Care Practitioner,if you wish to have medical product shipped to your Health Care Practitioner*

Title | Given First Name | Last Name | Profession

Professional License No. | Province of Issue of Medical License # | Phone | Fax

Business Address | Unit # | City | Province | Postal Code

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

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

5. SIGNATURE

Patient Signature: Date (MM/DD/YYYY):

*- PLEASE SEE NEXT PAGE FOR **PATIENT CONSENT FORM** -*

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CONSENT FORM *To be completed by the patient*

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

1. You ordinarily reside in Canada.
2. The information in this application and the accompanying Medical Document or Registration Certificate is correct and complete.
3. The Medical Document or Registration Certificate is not being used to seek or obtain dried marijuana or cannabis oil from another source.
4. The use of dried marijuana and cannabis oils are for your own medical purposes ONLY.
5. The original of the Medical Document is provided in support of the application.
6. Medical marijuana is not currently approved for use as a pharmaceutical drug in Canada. You acknowledge and agree that you are using the medical product obtained from United Greeneries at your own risk. You hereby release United Greeneries 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 marijuana obtained from United Greeneries.

☐ I would like to receive email communication (order receipts, prescription reminders, and monthly promotions) from United Greeneries through the contact information I have provided in this registration package.

☐ By initialing this box, I acknowledge that the faxed document shall constitute the original document.

By signing this Consent Form you consent to United Greeneries' collection, use and disclosure of the personal information contained in it, in accordance with United Greeneries' External Privacy Policy available at: www.UnitedGreeneries.ca. This includes, without limitation, disclosure of this Consent Form 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. Consent may be withdrawn at any time but such withdrawal will not have retroactive effect.

Patient Signature:

Date (MM/DD/YYYY):

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