Application for Medical Marihuana Instructions

» Complete and sign the application form (Step 1 document)

» Speak to your doctor, and have them complete the Medical Document (Step 2 document)

» Mail both **original** documents to:

Emerald Health Botanicals Inc.
4420 West Saanich Road, PO Box 24076
Victoria BC Canada V8Z 7E7

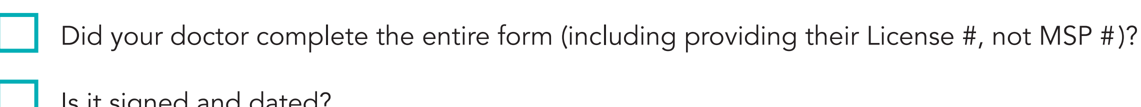
YOUR CHECKLIST

STEP 1 APPLICATION FORM:

- ☐ Did you complete Section 1 ?
- ☐ Did you read and complete Section 2 ?
- ☐ Section 3 only applies if your doctor will be accepting the dried marihuana on your behalf.
- ☐ Section 4 only applies if you have a caregiver (Individual Responsible).

IMPORTANT: Please fill out ALL the fields. If there are areas that do not pertain to you, please put "N/A" (not applicable). Health Canada will not allow us to accept incomplete applications.

STEP 2 MEDICAL DOCUMENT:



- ☐ Did your doctor complete the entire form (including providing their License #, not MSP #)?
- ☐ Is it signed and dated?

If you or your doctor have any questions or require further information, please refer to our website at **www.emerald.care**, contact us by email [patients@emerald.care] or call 1.800.757.3536

» Patient completes Application Form

» Doctor completes and signs Medical Document

» Mail completed, original forms to us

» We verify documents

» Registration Approval Notification sent to you

» Order online, or by phone

STEP 1: Application for Medical Marihuana

FORM MAY BE FILLED OUT IN ADOBE ACROBAT READER AND PRINTED FOR SIGNING AND COMPLETION.

SECTION 1: APPLICANT / PATIENT INFORMATION

IMPORTANT: FORM MUST BE COMPLETELY FILLED IN OR APPLICATION WILL BE REFUSED.

GIVEN NAME ▼ SURNAME ▼

BIRTHDATE ▼ YEAR MONTH DAY

GENDER ▼ ☐ MALE ☐ FEMALE

CONTACT INFORMATION *(PRIMARY RESIDENCE MUST BE IN CANADA)*

UNIT # ▼ BUZZER CODE ▼ STREET ADDRESS ▼

CITY / TOWN ▼ PROVINCE ▼ POSTAL CODE ▼

PHONE NUMBER ▼ FAX NUMBER ▼ EMAIL ADDRESS ▼

IS THE ADDRESS ABOVE A BUSINESS? BUSINESS NAME *(IF YES, STATE BUSINESS NAME AND TYPE OF BUSINESS)* ▼ BUSINESS TYPE ▼

☐ NO ☐ YES

MAILING ADDRESS

☐ **CHECK BOX** *IF SAME AS RESIDENTIAL*

(where you will receive mailed correspondence)

UNIT # ▼ STREET ADDRESS ▼

CITY / TOWN ▼ PROVINCE ▼ POSTAL CODE ▼

SHIPPING ADDRESS *(where you will receive Emerald Health Botanicals Inc. Products)*

CHECK APPROPRIATE BOX BELOW

☐ **SAME AS RESIDENTIAL** ☐ **SAME AS MAILING** ☐ **SHIP TO DOCTOR**

» ***(IF YES FILL OUT SECTION 3 ON PAGE 2)***

☐ **CHECK BOX ONLY IF AN INDIVIDUAL RESPONSIBLE (OR FAMILY MEMBER) WILL BE MAKING DECISIONS / PLACING OR ASSISTING WITH ORDERS ON YOUR BEHALF**

IMPORTANT » ***(IF YES FILL OUT SECTION 4 PAGE 2)***

SECTION 2: CERTIFICATION INFORMATION

Whether you are the Applicant or the Individual Responsible for the Applicant, you need to sign this application form certifying that:

» The Applicant is ordinarily a resident in Canada. » The information in this application and the accompanying Medical Document is correct and complete.
» The Medical Document is not being used to seek or obtain dried marihuana from another source. » The **original** of the Medical Document accompanies this application.
» The Applicant will use dried marihuana only for their own medical purposes. » The Applicant consents to the healthcare practitioner named in the accompanying Medical Document disclosing required personal health information to Emerald Health Botanicals Inc. for the purposes of complying with the requirements of the Marihuana for Medical Purposes Regulations. » The Applicant (or Individual responsible) acknowledges that he / she has read and agrees to Emerald Health Botanicals Inc.'s Terms & Conditions and Privacy Policy, available at www.emerald.care. The Applicant (or Individual Responsible) further acknowledges that medical marihuana is not approved for use as a drug in Canada, and that its indications, safety and risks have not been adequately studied and the appropriate dosage is not clear. The Applicant (or Individual responsible) acknowledges and agrees that he / she is using any medical marihuana obtained from Emerald Health Botanicals Inc. at his / her own risk and releases Emerald Health Botanicals Inc. from any and all actions, claims, complaints and demands for damages, loss or injury whatsoever arising directly or indirectly as a consequence of the use of medical marihuana obtained from Emerald Health Botanicals Inc. » The Applicant authorizes Emerald Health Botanicals Inc. to send emails as part of the relationship (note: this is required to order online).
» Emerald Health Botanicals Inc. makes no representations and gives no warranties or conditions, whether express, implied, statutory, or otherwise, including, without limitation, any warranties or conditions of merchantability, merchantable quality, durability, or fitness for a particular purpose, all of which are hereby disclaimed. Emerald Health Botanicals Inc. takes its product very seriously, as well as its obligations under the MMPR to investigate all customer complaints. If at any time you have an issue with your Emerald Health Botanicals Inc. medical marihuana, we encourage you to contact us.

IMPORTANT: APPLICANT OR INDIVIDUAL RESPONSIBLE FOR APPLICANT MUST SIGN, PRINT NAME AND DATE BELOW.

APPLICANT OR INDIVIDUAL WHO IS RESPONSIBLE FOR APPLICANT » **SIGNATURE** ▼ PRINT NAME BELOW **DATE** YEAR MONTH DAY

X

MAIL THIS DOCUMENT TO: EMERALD HEALTH BOTANICALS INC.
4420 West Saanich Road, PO Box 24076, Victoria BC Canada V8Z 7E7

www.emerald.care | clients@emerald.care
toll free: 1.800.757.3536 | fax: 1.800.757.3536

FORM MAY BE FILLED OUT IN ADOBE ACROBAT READER AND PRINTED FOR SIGNING AND COMPLETION.

COMPLETE SECTION 3 ONLY IF:

THE DOCTOR WHO SIGNED THE MEDICAL DOCUMENT WILL BE RECEIVING THE DRIED MARIHUANA OR CANNABIS OIL ON BEHALF OF THE APPLICANT

☐ **SECTION 3 NOT APPLICABLE**

SECTION 3: DOCTOR INFORMATION TO RECEIVE DRIED MARIHUANA OR CANNABIS OIL FOR CLIENT

HEALTHCARE PRACTITIONER TITLE ☐ DOCTOR ☐ NURSE PRACTITIONER

GIVEN NAME ▼

SURNAME ▼

UNIT # ▼

BUZZER CODE ▼

STREET ADDRESS ▼

CITY / TOWN ▼

PROVINCE ▼

POSTAL CODE ▼

PHONE NUMBER ▼

FAX NUMBER ▼

EMAIL ADDRESS ▼

PROFESSION ▼

LICENSE # ▼

CLINIC / BUSINESS NAME ▼

I hereby attest that I consent to receive dried marihuana on behalf of the Applicant (sign, print name and date below).

HEALTHCARE PRACTITIONER SIGNATURE TO RECEIVE DRIED MARIHUANA

X

▼ PRINT NAME BELOW

DATE

YEAR | MONTH | DAY

COMPLETE SECTION 4 ONLY IF:

YOU ARE THE INDIVIDUAL RESPONSIBLE (OR FAMILY MEMBER) WHO WILL BE MAKING DECISIONS / PLACING OR ASSISTING WITH ORDERS ON BEHALF OF APPLICANT

☐ **SECTION 4 NOT APPLICABLE**

SECTION 4: INDIVIDUAL RESPONSIBLE FOR THE APPLICANT (CAREGIVER INFO)

GIVEN NAME ▼

SURNAME ▼

BIRTHDATE ▼

YEAR | MONTH | DAY

GENDER ▼

☐ MALE ☐ FEMALE

PHONE NUMBER ▼

EMAIL ADDRESS ▼

I AM RESPONSIBLE FOR: *(PRINT NAME OF APPLICANT)* ▼

RELATIONSHIP TO APPLICANT ▼

Individual Responsible: I hereby attest that I am responsible for the Applicant listed above *(sign, print name and date).*

X

▼ PRINT NAME BELOW

DATE

YEAR | MONTH | DAY

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