



**CannTrust™**

Online registration is now available at [www.canntrust.ca](http://www.canntrust.ca)

Application can also be mailed or faxed to:

P.O. Box 92068-9200 Weston Road

Vaughan, Ontario, L4H 3J3

**Fax:** 1-844-295-6641 or 647-872-4808

1-855-RX4-CANN (794-2266) | 1-844-295-6641 | [www.canntrust.ca](http://www.canntrust.ca)

**New Client Registration PAGE 1 | Form A: For applicants with a residence**

Version 3.0 June 2016

**IMPORTANT NOTE:**

The original copy of the Medical Document is required to complete your registration.

**Applicant Information**

**Applicant's Name:**    
First Name Last Name

**Date of Birth:** Month  Day  Year

**Gender:** Male ☐ Female ☐ **Veteran:** Yes ☐ VAC#

**Residential Address**

Ship product here ☐

Address Line 1

City  Province  Postal Code

Best Telephone No.  Fax No.

Email Address

Not a Private Residence ☐

☐ **Please sign me up to receive information about CannTrust™**  
Email address is required.

Type and Name of Establishment

**Mailing Address** (if different from residential address)

Where you receive correspondence from CannTrust™

Ship product here ☐

Address Line 1

Address Line 2

City  Province  Postal Code



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## New Client Registration PAGE 2 | Form A: For applicants with a residence

Version 3.0 June 2016

Individual(s) responsible for the applicant (if you have caregiver(s), please complete this section)

**Person 1:**

Given Name

Surname

**Date of Birth:**

Month

Day

Year

**Gender:**

Male

☐

Female

☐

Email Address

I,

Individual Responsible / Caregiver

am responsible for

Applicant's Name

**Individual Responsible for Applicant Signature** \_\_\_\_\_

**Date**

**Person 2:**

Given Name

Surname

**Date of Birth:**

Month

Day

Year

**Gender:**

Male

☐

Female

☐

Email Address

I,

Individual Responsible / Caregiver

am responsible for

Applicant's Name

**Individual Responsible for Applicant Signature** \_\_\_\_\_

**Date**

### Health Care Practitioner Information

**Name:**

Given Name

Surname

**Clinic/Business Name:**

**Address Line 1**

**City**

**Province**

**Postal Code**

**Telephone No.**

**Fax No.**



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## New Client Registration PAGE 3 | Form A: For applicants with a residence

Version 3.0 June 2016

### Additional Information (Optional)

Please feel free to provide us with information regarding your medical condition(s), ailment(s) and symptom(s).

Please feel free to provide us with information regarding your Medicinal Marijuana preferences (if applicable).

*Ex. strain preferences and/or potency preferences.*

Is there anything else you would like us to know?

Are you interested in participating in clinical trials?

☐

Yes

☐

No

The applicant and/or the person responsible for the applicant must read and acknowledge the following.

- The applicant is ordinarily a resident of Canada.
- The information in the application and Medical Document is correct and complete.
- The Medical Document is not being used to seek or obtain dried marijuana from another source.
- The original Medical Document accompanies this application
- The applicant will use dried marijuana only for their own medical purposes.
- The applicant acknowledges and agrees that he or she is using medical marijuana obtained from CannTrust™ at his or her own risk, and releases CannTrust™ (and its partners, officers, providers, directors and staff) from any and all claims, actions, complaints and demands for damages, loss or injury whatsoever arising directly or indirectly from the use of dried medical marijuana received from CannTrust™
- The applicant acknowledges and understands that the safety and risks associated with the use of dried marijuana have not been fully studied and that a standard dosage of medical marijuana has not yet been established.
- The applicant consents to the Health Care Practitioner named in this document disclosing to CannTrust™, personal health information for the purpose of complying with the requirements of the Access to Cannabis for Medical Purposes Regulation (ACMPR). The applicant understands and agrees that a copy of the consent & registration application may be provided to the Health Care Practitioner named in this registration.

Applicant / Individual Responsible Signature \_\_\_\_\_

Date