



CannTrust™

Online registration is now available at 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

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

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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, am responsible for

Individual Responsible / Caregiver 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, am responsible for

Individual Responsible / Caregiver 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

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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