AMENDMENT FORM

All fields with an asterisk (*) are mandatory.

Acreage Pharms Ltd.
PO Box 51, Peers, AB. T0E 1W0
clientcare@acreagepharms.ca
Phone: 1-866-386-0149
Fax: 780-693-0167

An Application to amend a registration must be made if any of the information provided under subsection 130(1) has changed. This includes;
1. Name change (i.e. name change of client or caregiver for the client). Proof of name change must be submitted.
2. Address Change (shipping address change, primary address change)
3. Contact Information Change (telephone number change, cell phone number change, fax number change, email address change)
4. Gender Change (doctor verification required)

- ☐ Patient Name Change
- ☐ Phone, Fax or Email Change
- ☐ Health Care Practitioner Address Change
- ☐ Shipping Address Change
- ☐ Caregiver Name Change
- ☐ Gender Change
- ☐ Primary Address Change
- ☐ Change in Caregiver
- ☐ Other _____

CHANGE TO CLIENT INFORMATION

***NAME:** _____ _____
Given Name(s) *(First Name)* Surname *(Last Name)*

***DATE OF BIRTH:** _____
Month / Day / Year

GENDER: ☐ Male ☐ Female OR
☐ Other (please specify) _____

***CONTACT INFO:** _____ _____
Phone # Email Address *(required for online purchasing)*

***PRIMARY ADDRESS:** _____ _____ _____
Street Address Unit # City

_____ _____
Province Postal Code

***Is the address above a business?** *(If Yes, State the name and type of business)*

Yes ☐ **No** ☐ _____

***Client Registration Number** _____

*SHIPPING ADDRESS

☐ **SHIP TO PRIMARY ADDRESS** ☐ **SHIP TO HEALTH CARE PRACTITIONER** *(if applicable)*
☐ **SHIP TO SHIPPING ADDRESS**

SHIPPING ADDRESS: _____
Street Address Unit

_____
City Province Postal Code

AMENDMENT FORM

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CHANGE TO HEALTHCARE PRACTITIONER ADDRESS

Title: ☐ **Dr** ☐ **Nurse Practitioner**

Given Name(s) *(First Name)* _____ Surname *(Last Name)* _____

Street Address _____ Unit _____ City _____

Province _____ Postal Code _____ Licence Number _____

Phone Number _____ Fax Number _____ Email *(if applicable)* _____

I hereby attest that I consent to receive dried marihuana or cannabis oil on behalf of the Applicant.

Health Care Practitioner Signature _____ Print Health Care Practitioner Name _____ Date: Month / Day / Year _____

CHANGE TO CAREGIVER INFORMATION

NAME: Given Name(s) *(First Name)* _____ Surname *(Last Name)* _____

DATE OF BIRTH: Month / Day / Year _____

GENDER: ☐ Male ☐ Female OR ☐ Other (please specify) _____

CONTACT INFO: Phone # _____ Email Address _____

ACKNOWLEDGEMENT OF APPLICANT OR CAREGIVER

The undersigned Applicant or Caregiver hereby acknowledges, understands and agrees that:

1. The Applicant ordinarily resides in Canada.

2. The information in this application is correct and complete.

***SIGNATURE OF APPLICANT** _____ ***DATE:** Month / Day / Year _____

I, Name of Responsible Person _____ *attest that I am responsible for* Name of Applicant _____

Responsible Individual Signature _____ Date: Month / Day / Year _____

Your completed Amendment form may be submitted to Acreage Pharms Ltd. By mail, email, or fax.