



REGISTRATION APPLICATION

FOR APPLICANTS WITH A NON-PERMANENT ADDRESS
(you currently reside in a shelter, hostel or similar institution)

Please Note: All fields are mandatory unless specified with an asterisk * and relative notes.

This information must match the Medical Documentation form.

Incomplete forms will cause a delay in registration. Please contact APL Client Care for assistance.

Acreage Pharms Ltd.

PO Box 51, Peers, AB. T0E 1W0

clientcare@acreagepharms.ca

Phone: 1-888-386-0149

Fax: 780-693-0167

*HEALTH CARE PRACTITIONER DELIVERY

Your Health Care Practitioner is required to complete this section to receive medical marihuana or cannabis oil on your behalf.

Product will ship to the business address specified on the Medical Document.

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

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

CAREGIVER INFORMATION (if applicable)

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

DATE OF BIRTH: _____ **GENDER:** Male Female OR
Month / Day / Year Other (please specify) _____

CONTACT INFO: _____
Phone # Email Address

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

Responsible Individual Signature Date: Month / Day / Year

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 Medical Document that accompanies this Application must be the original, or faxed directly from the Practitioner office. Once registration is completed, the Medical Document cannot be returned to the Applicant for any reason.
3. The accompanying Medical Document is not being used to seek or obtain medical marihuana from another source.
4. The Applicant consents that the Health Care Practitioner named in the accompanying Medical Document may disclose to Acreage Pharms Ltd. the Applicant's personal health information for the purposes of processing this Registration Application to comply with the requirements of the Cannabis Act
5. The information in this Application and the accompanying Medical Document is correct and complete.
6. The Applicant acknowledges that some of the information provided in this document may be shared with our service providers for shipping purposes only.
7. The Applicant will use fresh or dried marihuana or cannabis oil only for their own medical purposes.
8. The Applicant acknowledges that dried marihuana and/or cannabis oil products are not approved for use as a drug in Canada, and that its risks and appropriate dosages have not been determined. The Applicant acknowledges that they are using these products at their own risk, and that Acreage Pharms Ltd. is not liable for any damages, loss, or injury that results, either directly or indirectly, from the use of medical marihuana.

*SIGNATURE OF APPLICANT

*DATE: Month / Day / Year

SIGNATURE OF CAREGIVER (if applicable)

DATE: Month / Day / Year

Your completed Registration Application may be submitted to Acreage Pharms Ltd. by mail, email, or fax.
Once we receive the original Medical Document, this application will be processed and you will be contacted.