



REGISTRATION APPLICATION

This information must match your Medical Document

Acreage Pharms Ltd.

PO Box 51, Peers, AB. T0E 1W0

clientcare@acragepharms.ca

Phone: 1-888-386-0149

Fax: 1-780-693-0167

Please Note: All fields with an asterisk * are mandatory. Incomplete forms may cause a delay in registration. Please contact Acreage Pharms Client Care if you have any questions or require assistance.

Your completed Registration Application may be submitted by mail, email, or fax.

This application will be processed once the original medical document is received by mail or fax by your Practitioners office.

APPLICANT INFORMATION

NEW CLIENT

RETURNING CLIENT

***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?**

Yes

No

Business Name (If Yes, State Business name and type of business)

Preferred Method of Contact:

Phone

Email

*SHIPPING ADDRESS (if different than above)

SHIP TO PRIMARY ADDRESS

SHIP TO HEALTH CARE PRACTITIONER (if applicable)

SHIP TO SHIPPING ADDRESS

SHIPPING ADDRESS:

Street Address

Unit #

City

Province

Postal Code

HEALTH CARE PRACTITIONER DELIVERY (if applicable)

Your Health Care Practitioner is required to complete this section if they have agreed to receive medical marijuana 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 marijuana or cannabis oil on behalf of the Applicant.

Health Care Practitioner Signature

Print Health Care Practitioner Name

Date: Month / Day / Year



REGISTRATION APPLICATION

This information must match your Medical Documentation form

Acreage Pharms Ltd.

PO Box 51, Peers, AB. T0E 1W0

clientcare@acreagepharms.ca

Phone: 1-888-386-0149

Fax: 1-780-693-0167

CAREGIVER INFORMATION *(if applicable)*

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

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 Access to Cannabis for Medical Purposes Regulations (ACMPR).
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.