REGISTRATION APPLICATION

This information must match your Medical Document

Acreage Pharms Ltd.
PO Box 51, Peers, AB. T0E 1W0 **clientcare@acreagepharms.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:** _____ **GENDER:** ☐Male ☐Female OR
Month / Day / Year ☐ 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?** **Business Name** *(If Yes, State Business name and type of business)*

☐ **Yes** ☐ **No** _____

Preferred Method of Contact: ☐ Phone ☐ Email

How did you hear about us? _____

*SHIPPING ADDRESS *(if different than above)*

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

SHIPPING _____
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 marihuana 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

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CAREGIVER INFORMATION *(if applicable)*

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

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

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.