Medical Client Registration Form

Applicant Details:

Full Name _____ Date of Birth _____

Address _____ City _____ Province _____ Postal Code _____

Phone Number _____ Email Address _____

Health Canada License Information:

Health Canada License Expiration Date (MM-DD-YYYY) _____

Cannabis Plant Count Limit _____

Please check (√) each box to indicate agreement:	**YES**
I confirm that I ordinarily reside in Canada	☐
I have a valid Health Canada license	☐
I've attached a copy of my valid Health Canada license	☐
I've attached a copy of a valid government-issued photo ID	☐
The documentation provided is authentic and unaltered	☐
There are no restrictions on my license that could impact my purchase	☐
The information provided in this application is correct and complete	☐

By signing below, I confirm that all the information provided is accurate and complete to the best of my knowledge. I understand that providing false or misleading information may result in penalties under the Cannabis Act and Regulations.

Signature: _____ Date: _____

INTERNAL USE ONLY:

Approved By: _____ Date: _____

Client ID: _____