Cannabis Permissions/Registration - Patient Information

Patient Information

First and Last Name	Veteran ID # *(if applicable)*	
Health Card # *(include version code)*	Date of Birth *(YYYY/MM/DD)*	Gender ☐ Male ☐ Female
Address	Telephone *(Home)* *(Mobile)* ☐ Send my appointment details by text message	
City/Province/Postal Code	Email ☐ Send my appointment details by email	

Health Information

Retirement/Nursing Home Name & Telephone	
Current Medications/Treatment	Allergies
Have you ever attended a substance abuse program? ☐ Yes ☐ No	**Any history of schizophrenia, bipolar, psychosis disorder?** ☐ Yes ☐ No

Care Giver & POA - List all Current Providers

Full Name	Full Name	Full Name
Address	Address	Address
Phone#	Phone#	Phone#
Email	Email	Email
☐ Additional Documents Attached	☐ Additional Documents Attached	☐ Additional Documents Attached

You acknowledge you will be a registered customer of the chosen Licensed Producer under the Cannabis Act and its accompanying regulations (the Act). You also acknowledge that you have read the terms of service on the Licensed Producer website. You further acknowledge that medical cannabis is not approved for use as a drug in Canada, that it's indications, safety, and risks have not been adequately studied and the appropriate dosage is unclear. You acknowledge and agree that you are using any medical cannabis product obtained at your own risk, and release all involved from any actions,claims complaints and demands for damages,loss,liability,or injury whatsoever arising directly or indirectly as a consequence of the use of medical cannabis. All parties involved make no representations and give no warranties or conditions, whether express,implied,statutory, or otherwise, including without limitation, any warranties or conditions of merchantability, merchantable quality. durability,or fitness for a particular purpose,all of which hereby disclaimed. That said,we take product quality very seriously, as well as its obligations under the Cannabis Act to investigate all customer complaints.If at any time you have an issue with your order of cannabis medicine we encourage you to get in touch with Ajja Medical Clinic.

We need you to sign here certifying that:
a) the applicant ordinarily resides in Canada.
b) the information in the application is correct and complete.
c) the medical document that forms the basis for the application has not, to the knowledge of the individual signing the statement, been altered.
d) the medical document is not being used to seek or obtain cannabis products from another source
e) in the case where the applicant is signing the statement, they intend to use any cannabis product that is supplied to them on the basis of the application only for their own medical purpose
f) in the case where an adult is named under section 4 is signing the statement, they are responsible for the applicant.

I _____ understand by signing this registration form, I give permission to send medical cannabis and all registration information to the shipping address provided. I give permission to communicate at my email address so all related information can be provided. It is understood all information is to be kept confidential unless otherwise stated by myself. by signing, I am agreeing to medical cannabis services.

Signature of Permission _____**Name**_____**Date**_____

I _____ understand by signing this registration form, I am responsible for providing health care, food, lodging and other social services to the applicant. It is understood all information is to be kept confidential unless otherwise stated by myself. by signing, I am agreeing to medical cannabis services.

Signature of Permission Director of Care/Manager Name_____**Date**_____

info@argentomedical.ca Fax- 1-866-483-1880 **clientcare@ajjaclinic.com**