Registration Application

Complete if you have a permanenet residence

Questions?
Email: info@redecan.ca

Mail or Courier Completed Documents To:
Redecan P.O. Box 138
Ridgeville, Ontario, L0S 1M0

APPLICANT INFORMATION

Full Name: ____________ Given First Name(s) ____________ Surname (Last Name)

Date of Birth: ____________ Day / Month / Year

Gender: ☐ Male ☐ Female

Is this registration for interim supply? ☐ No ☐ Yes

CONTACT INFORMATION - Primary Residence (Must be in Canada and cannot be post office box).

Primary Residence: Unit # | Street Address 1 | Street Address 2 (If Applicable)

City | Province | Postal Code

Residence Type: ☐ Private home ☐ Nursing home ☐ Shelter ☐ Hostel ☐ Group Home ☐ Other

If Other, Please Specify | Name of Establishment (if not a private residence)

Contact: Phone Number | Fax Number

Email Address

MAILING ADDRESS

☐ Same as primary residence above

Where you receive correspondence. Complete if your mailing address is different than your primary residential address.

Mailing Address: Unit # | Street Address 1 | Street Address 2 (if applicable)

City | Province | Postal Code

SHIPPING ADDRESS (required)

☐ Same as primary residence above (where you want product shipped). Must be a residence.

Mailing Address: Unit # | Street Address 1 | Street Address 2 (If Applicable)

City | Province | Postal Code

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CAREGIVER / INDIVIDUAL RESPONSIBLE FOR APPLICANT

Caregiver Name: ______________ ______________
Given First Name(s) Surname (Last Name)

Caregiver Date of Birth: ______________
Day / Month / Year

Gender: ☐ Male ☐ Female

____
Caregiver Phone Number

Caregiver / Person Responsible Declaration:

I ______________ am responsible for ______________
Caregiver / Person Responsible Full Name Applicant's Full Name

Caregiver Signature: ______________

____
DATE: Day / Month / Year

OTHER INDIVIDUAL(S) RESPONSIBLE FOR THE APPLICANT - (IF YOU HAVE MORE THAN ONE CAREGIVER)

Caregiver Name: ______________ ______________
Given First Name(s) Surname (Last Name)

Caregiver Date of Birth: ______________
Day / Month / Year

Gender: ☐ Male ☐ Female

____
Caregiver Phone Number

Caregiver / Person Responsible Declaration:

I ______________ am responsible for ______________
Caregiver / Person Responsible Full Name Applicant's Full Name

Caregiver Signature: ______________

____
DATE: Day / Month / Year

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HEALTH CARE PRACTITIONER INFORMATION

Complete only if your health care practitioner is consenting to receive dried marihuana and/or cannabis oil on your behalf.

Name: Title | Given First Name(s) | Surname (Last Name)

Contact: Practitioner Phone Number | Practitioner Fax Number | Practitioner Email

Clinic Name:

Primary Residence: Unit # | Street Address 1 | Street Address 2 (If Applicable)

City | Province | Postal Code

Consent to receive dried marihuana and/or cannabis oil on behalf of applicant

☐ Ship dried marihuana and/or cannabis oil to my office

☐ Send dried marihuana and/or cannabis oil to the shipping address above

I ____________ consent to receive marihuana and/or cannabis oil on behalf of ____________

Name of Health Care Practitioner | Applicant's Full Name

Health Care Practitioner's Signature: ______________________________

DATE: Day / Month / Year

IMPORTANT - PLEASE READ AND SIGN BELOW

The undersigned applicant or person responsible hereby agrees and warrants that:

- Applicant ordinarily resides in Canada.
- The original Medical Document accompanies this Application.
- The applicant understands and acknowledges that any Medical Documents sent with this form cannot be returned once registration is complete.
- The medical document/registration certificate is not being used to seek or obtain fresh or dried marijuana and/or cannabis oil from another source.
- The information in the original application and medical document/registration certificate is correct and complete.
- The Applicant will use fresh or dried marihuana and/or cannabis oil only for his or her own medical purposes.
- The Applicant understands and acknowledges that medicinal marihuana is not currently approved for use as a drug in Canada and that its safety and risks have not been fully studied and the appropriate dosage is unclear.
- The Applicant acknowledges and agrees that he or she is using any medicinal marihuana product obtained from Redecan at his or her own risk, and releases Redecan (and its partners, providers, officers, directors and staff) from any and all actions, claims, complaints and demands for damages, loss or injury whatsoever arising directly or indirectly from the use of medicinal marihuana obtained from Redecan.
- The Applicant consents to the health care practitioner named in this document disclosing required personal health information to Redecan for the purposes of complying with the requirements of the Access to Cannabis for Medical Purposes Regulations (ACMPR). The Applicant understands and agrees that a copy of this consent & registration application may be provided to the health care practitioner named herein.

Applicant/Individual Responsible Signature: ______________________________

DATE: Day / Month / Year