Registration Application

Complete this form if you DO NOT have a residential address

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

Contact Information:
Phone Number | Email Address

Is this registration for interim supply? ☐ Bc ☐ MYg

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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ESTABLISHMENT INFORMATION

The facility where you currently reside

Establishment Name:

Name of the Establishment

Establishment Type:

Type of Establishment (Shelter, Hostel, Other – please describe)

Manager's Name:

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

Establishment Office Address:

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

City | Province | Postal Code

Contact Information:

Phone Number | Fax Number

Email Address

I ______ attest that ______

Establishment Manager Name | Establishment Name

provides food, lodging and other services to ______

Applicant Name

Manager's Signature: ______

DATE: Day / Month / Year

MAILING ADDRESS

Same as Establishment Address

(Where you receive correspondence — Complete if different from 'Establishment Office Address' listed above)

Mailing Address:

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

City | Postal Code

SHIPPING ADDRESS (Where you want product shipped)

Same as Mailing Address

Shipping Address:

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

City | Province | Postal Code

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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:

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

City | Postal Code

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

Ship dried marihuana and/or cannabis oil to my office

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

I ______ consent to receive marijuana on behalf of ______

Name of Health Care Practitioner | Applicant Name

Health Care Practitioner's Signature: ______

(required if you are consenting to receive dried marihuana and/or cannabis oil on behalf of applicant)

DATE: Day / Month / Year

IMPORTANT – PLEASE READ AND SIGN BELOW The Undersigned Applicant or Person Responsible Hereby Agrees and Warrants That:

- The 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 (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