SMALL BATCH HIGH GRADE
BROKEN COAST
CANNABIS LTD

EXPANDED MEDICAL CLIENT REGISTRATION

IMPORTANT:
The personal information provided on this form **must** match the information that appears on your Supporting Document.

APPLICANT INFORMATION

*All fields marked with * are mandatory.*

FIRST NAME*

LAST NAME*

PHONE NUMBER

EMAIL ADDRESS

If no phone or email are provided, we will contact you via mail.

DATE OF BIRTH (MM/DD/YEAR)*

GENDER*

☐ MALE ☐ FEMALE ☐ X

DO YOU HAVE A PERMANENT ADDRESS? * *No permanent address means you reside in a shelter, hostel or similar Institution.*

☐ YES, SKIP TO PERMANENT ADDRESS INFORMATION SECTION

☐ NO, SKIP TO INSTITUTION INFORMATION SECTION

PERMANENT ADDRESS INFORMATION

ADDRESS* *Must be a physical address; no post office boxes allowed.*

CITY*

PROVINCE*

POSTAL CODE*

IS THIS A PRIVATE RESIDENCE? *

☐ YES ☐ NO *If no, please provide the name and type of the establishment below (example: nursing or care home)*

NAME OF ESTABLISHMENT

TYPE OF ESTABLISHMENT *Only fill out if you chose "no" above*

INSTITUTION INFORMATION

The Institution that provides you with food, lodging or other services. (shelter, hostel, etc)

NAME OF INSTITUTION*

TYPE OF INSTITUTION*

INSTITUTION MANAGER'S FIRST NAME*

INSTITUTION MANAGER'S LAST NAME*

ADDRESS OF INSTITUTION*

CITY*

PROVINCE*

POSTAL CODE*

PHONE

FAX

EMAIL

ATTESTATION *To be completed by the manager of the institution*

◯ I attest that the institution above provides food, lodging, or other social services to the applicant.

SIGNATURE OF INSTITUTION MANAGER*

DATE (MM/DD/YEAR)*

PRODUCT SHIPPED TO YOUR HEALTH CARE PRACTITIONER

Have your health care practitioner complete this section if they have a agreed to receive product on your behalf. Product will ship to the business address specified on the Medical Document.

PRACTITIONER FIRST NAME*

PRACTITIONER LAST NAME*

PROFESSION TYPE*

☐ DOCTOR ☐ NURSE PRACTITIONER

NAME OF CLINIC*

◯ Practitioner consents to receive fresh or dried marijuana or cannabis oil on behalf of the applicant.

PRACTITIONER SIGNATURE*

DATE (MM/DD/YEAR)*

Note to health care practitioners: If at any time you cease to consent to receive fresh or dried marijuana or cannabis oil on behalf of the client, you must send a written notice to that effect to both the client and the licensed producer.

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VETERANS AFFAIRS COVERAGE

ARE YOU ELIGIBLE THROUGH VETERANS AFFAIRS?

☐ NO ☐ YES

K NUMBER

☐ ☐ ☐ ☐ ☐ ☐ ☐

If yes, please provide your k number. Must be 7 digits.

INDIVIDUAL RESPONSIBLE

APPOINT AN INDIVIDUAL TO BE RESPONSIBLE FOR THE APPLICANT?

☐ NO ☐ YES *If yes, please Add Individual(s) Responsible for Applicant below.*

ADD INDIVIDUAL(S) RESPONSIBLE FOR APPLICANT

Only complete if you answered "yes" above.

RESPONSIBLE PERSON FIRST NAME*

RESPONSIBLE PERSON LAST NAME*

RESPONSIBLE PERSON DATE OF BIRTH (MM/DD/YEAR)*

RESPONSIBLE PERSON GENDER*

☐ MALE ☐ FEMALE ☐ X

ACKNOWLEDGEMENTS OF RESPONSIBLE PERSON

Supporting Document refers to either a signed Medical Document or a Registration Certificate issued by Health Canada.

- The signatory is responsible for the applicant.
- The signatory acknowledges that some of the information provided in this document may be shared with Health Canada, our service providers, Veterans Affairs, and/or insurance providers, as applicable, solely for the purposes of providing service support.
- The signatory gives Broken Coast permission to share the applicants ordering information with their prescribing physician and/or the clinic through which they received their consultation.
- The applicant ordinarily resides in Canada.
- The information in the application and the Supporting Document is correct and complete.
- The Supporting Document is not being used to seek or obtain dried or fresh marijuana or cannabis oil from another source.
- For applicants applying using a Registration Certificate: The application is for the purpose of obtaining an interim supply of fresh or dried marijuana or cannabis oil.
- For applicants applying using a Medical Document: The original of the Medical Document accompanies the application.
- The applicant will use dried marijuana or cannabis oil only for their own medical purposes.

RESPONSIBLE PERSON SIGNATURE*

DATE (MM/DD/YEAR)*

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ADDITIONAL PERSONS RESPONSIBLE

IS THERE MORE THAN ONE PERSON RESPONSIBLE FOR THE APPLICANT?

☐ NO ☐ YES *If yes, please Add Individual(s) Responsible for Applicant below.*

ADD INDIVIDUAL(S) RESPONSIBLE FOR APPLICANT *Only complete if you answered "yes" above.*

RESPONSIBLE PERSON FIRST NAME*

RESPONSIBLE PERSON LAST NAME*

RESPONSIBLE PERSON DATE OF BIRTH (MM/DD/YEAR)*

RESPONSIBLE PERSON GENDER*

☐ MALE ☐ FEMALE ☐ X

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RESPONSIBLE PERSON SIGNATURE*

DATE (MM/DD/YEAR)*

BROKEN COAST CANNABIS
BOX 1150, LADYSMITH BC
CANADA V9G 1A8

INFO@BROKENCOAST.CA
TEL 1-888-486-7579
FAX 1-888-486-6384