SMALL BATCH HIGH GRADE
BROKEN COAST CANNABIS LTD

Box 1150, 610 First Ave.
Ladysmith BC, V9G 1A8
Phone: 1-888-486-7579

Registration Amendment Form

Change of the address at which your health care practitioner has agreed to receive fresh or dried marijuana or cannabis oil on your behalf

Health care practitioner information

Name: _____ _____
Last Name *First Name*

Profession: _____ Name of Office or Clinic: _____

Address: _____
The address to which you consent to receive fresh or dried marijuana or cannabis oil on behalf of the client

City: _____ Province _____ Postal Code: _____

Telephone: _____ Fax: _____ Email: _____

Statement of agreement

The following agreement must be completed and signed by your health care practitioner

I , _____ , agree to receive fresh or dried marijuana or cannabis oil on behalf of
Name of Health Care Practitioner

_____
Name of Client

Signature: _____ **Date:** _____
Signature of Health Care Practitioner *Day/Month/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.

Statement of individual responsible for applicant (if applicable)

I , _____ , attest that I am responsible for _____
Name of Responsible Individual *Name of Client*

Acknowledgement of client or responsible individual(s)

- The client ordinarily resides in Canada.
- The information contained in this application is correct and complete.

Signature of client _____

OR

Signature of responsible individual (if applicable): _____

Date: _____
Day/Month/Year

Please mail this form to Broken Coast Cannabis, Box 1150 610 First Ave. Ladysmith, BC V9G 1A8.