SMALL BATCH HIGH GRADE
BROKEN COAST CANNABIS LTD

REGISTRATION AMENDMENT

CHANGE OF THE ADDRESS AT WHICH YOUR HEALTH CARE PRACTITIONER HAS AGREED TO RECEIVE FRESH OR DRIED CANNABIS OR CANNABIS OIL ON YOUR BEHALF

CLIENT INFORMATION *All fields marked * are mandatory.*

FIRST NAME*

LAST NAME*

CLIENT ID

HEALTH CARE PRACTITIONER INFORMATION *All fields marked with * are mandatory.*

FIRST NAME*

LAST NAME*

PROFESSION*

NAME OF OFFICE/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

NAME OF HEALTH CARE PRACTITIONER

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oil on behalf of _____
NAME OF CLIENT

SIGNATURE OF HEALTH CARE PRACTITIONER*

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.*

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*

DATE (MM/DD/YEAR)*

OR

SIGNATURE OF RESPONSIBLE INDIVIDUAL(S)

DATE (MM/DD/YEAR)*

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