

Registration Amendment Form

Change of a Residential, Mailing, or Shipping Address

Client information

Name: _____
Last Name *First Name*

Telephone Number: _____ Email Address: _____

Residential address

Address: _____

City: _____ Province _____ Postal Code: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Is the address above an establishment that is not a private residence? Yes No

If yes, please provide the type and name of the establishment below:

Type (example: nursing or care home) *Name of Establishment*

Mailing address of residence (if different from above)

Please provide the mailing address associated with the residence listed above.

Address: _____

City: _____ Province: _____ Postal Code: _____

Shipping address

This is the address we will ship your product to.

This address must be either the mailing address of the residence above, or the business address of your health care practitioner as specified in the Medical Document.

- Same as mailing address of residence
- Health care practitioner's address as specified in the Medical Document

Health care practitioner information

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

Title : _____ Name: _____
Last Name *First Name*

I, _____, agree to receive medical marijuana 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 dried marihuana on behalf of the client, you must send a written notice to that effect to both the client and the licensed producer.

Individual(s) responsible for client (if applicable)

To be completed by the individual(s) responsible for the client.

Name: _____
Last Name *First Name*

Date of Birth: _____ Gender: Male Female
Day/Month/Year

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

Signature: _____ Date: _____
Signature of Responsible Individual *Day/Month/Year*

Second responsible individual (if applicable)

Name: _____
Last Name *First Name*

Date of Birth: _____ Gender: Male Female
Day/Month/Year

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

Signature: _____ Date: _____
Signature of Responsible Individual *Day/Month/Year*

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(s) (if applicable): _____

Date: _____
Day/Month/Year