GREEN RELIEF

REGISTRATION FORM

Thank you for choosing Green Relief as your provider of medical marijuana. To register as a client, this document must be completed in full by the applicant or the caregiver responsible for the applicant's care. The completed Medical Document must be submitted to Green Relief along with a completed original form of the Green Relief Medical Document.

Applicant Information

Please choose one:

☐ I am applying on my own behalf.

☐ I am a caregiver, completing the registration on behalf of the Applicant.

Applicant First Name _____ Applicant Last Name _____

Applicant Date of Birth [DD/MM/YY] _____ Gender ☐ Male ☐ Female ☐ N/A

Applicant Residence Address _____

City _____ Province _____ Postal Code _____

Applicant Telephone _____ Fax _____

Email _____

Applicant Mailing Address (if different than Residence Address) _____

City _____ Province _____ Postal Code _____

The above Residence Address is a ☐ Private Residence ☐ Establishment

Only complete this section if "Establishment" was selected.

Name of Establishment _____ Type of Establishment _____

Address _____

Phone _____ Fax _____

Email _____

To be completed by the manager of the specified Establishment. Please print.

I, _____ (NAME OF MANAGER - PLEASE PRINT), hereby confirm that _____ (NAME OF ESTABLISHMENT) provides, food, lodging or other social services to _____ (NAME OF APPLICANT).

Manager's Signature _____ Date _____

Caregiver Information

The "Applicant" is the person who the medical marijuana is for. The "Caregiver" is defined as the responsible decision-maker in the patient's care and is filling out this form on behalf of the applicant. The Caregiver must provide the applicant's information on the registration form.

Caregiver First Name (if applicable) _____ Caregiver Last Name _____

Caregiver Date of Birth [DD/MM/YY] _____ Telephone _____

I am responsible for the Applicant YES / NO Gender _____

Caregiver Signature _____ Date _____

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Where will Green Relief be shipping your Medical Marijuana:

☐ Residence Address ☐ Mailing Address ☐ Establishment Specified Above ☐ Health Care Practitioner

I, Manager of Establishment, hereby consent to receive dried marijuana on behalf of the Applicant

_____
(PLEASE SIGN)

I, Health Care Practitioner, hereby consent to receive dried marijuana on behalf of the Applicant

_____
(PLEASE SIGN)

Health Care Practitioner Information This information must match the Health Care Practitioner Information that has been provided on the Green Relief Medical Document. Your completed Medical Document must be submitted with this registration form.

First Name _____ Last Name _____

Profession _____

Office Address _____

City _____ Province _____ Postal Code _____

Telephone _____ Fax _____

Email Address _____

Authorization of Applicant As Applicant or caregiver responsible for the Applicant, you attest, agree and consent to the following:

(a) the applicant is permanent resident in Canada;
(b) the information in the application and the Medical Document is correct and complete;
(c) the Medical Document is not being used to seek or obtain fresh or dried marijuana or cannabis oil from another source;
(d) the original of the Medical Document accompanies the application; and
(e) the applicant will use fresh or dried marijuana or cannabis oil only for their own medical purposes

The applicant acknowledges that dried marijuana is not an approved therapeutic product and cannabis has not been authorized through the standard Health Canada drug approval process because the available scientific evidence does not establish the safety and efficacy of cannabis to the extent required by the Food and Drug Regulations for marketed drugs in Canada.

The applicant acknowledges that they are using any medical marijuana or related product obtained from Green Relief Inc. at their own risk. The applicant also specifically releases Green Relief Inc. (and its service providers, officers, directors and staff) from any and all actions, claims, complaints and demands for damages, loss or injury whatsoever, whether arising directly or indirectly as a consequence of the use of Green Relief Inc.'s products or services.

In order to receive our products and services, the applicant or authorized person gives consent to Green Relief Inc. to disclose the necessary personal information to Green Relief Inc.'s service providers, including the health care practitioner named in this registration.

The applicant and/or authorized person consents to the health care practitioner named in this registration form disclosing to Green Relief Inc. the applicant's personal health information by phone, physical means or digital means (including Green Relief Inc.'s online portal or SFax secure system) for the purposes of processing this registration (which may include the submission of my Medical Document by digital means), client service and complying with the requirements of the Access to Cannabis for Medical Purposes Regulations (ACMPR). The applicant understands and agrees that a copy of this consent and registration application may be provided to the health care practitioner named in this registration.

Applicant Signature _____ Date _____

☐ I hereby acknowledge that I am the Caregiver responsible for the care of the Applicant

Caregiver Signature (if applicable) _____ Date _____