


Caregiver Form

To be completed by the caregiver who is responsible for the patient.

Fields marked with  are required.

Caregiver Information

First Name

Last Name

Date of Birth (mm/dd/yyyy)

Gender

Primary Phone

Secondary Phone

Email

Relationship to Patient

Patient Information

Patient First Name

Patient Last Name

Date of Birth (mm/dd/yyyy)

MyMedi.ca Client Number

Caregiver Acknowledgment and Confirmation

I, (Caregiver name) _____ acknowledge that I am the caregiver for (Patient name) _____

and take responsibility for the order, safe storage and administration of medical cannabis products.

THIS APPLICATION IS NOT COMPLETE UNTIL THE CONSENT FORM IS SIGNED

Consent

The patient acknowledges and agrees to the following:

1. MyMedi.ca may collect, use and disclose personal information contained in this application, and any related medical document that is provided to MyMedi.ca (the "Medical Document"), in accordance with MyMedi.ca's Privacy Policy (the "Privacy Policy") and applicable laws. The purposes for which MyMedi.ca may collect, use and disclose personal information include: for shipment and fulfillment purposes, to complete the registration of the patient and to communicate with the patient's healthcare professionals, medical clinics, licensing authorities or suppliers that may be responsible for production of medical cannabis and service providers that are responsible for purchase fulfillment and verification purposes.
2. The patient permits MyMedi.ca to communicate with the patient via telephone or email regarding registration or order status, product availability and additional matters in accordance with MyMedi.ca's Privacy Policy. The patient understands that electronic communications are not secure and can be forwarded, intercepted, circulated, stored or even changed without their knowledge or permission and agrees to accept that risk. Electronic communication is at the patient's option and the option to communicate electronically may be withdrawn at any time by providing written notice to MyMedi.ca
3. The patient understands that the safety and risks associated with the use of medical cannabis have not been sufficiently studied and that using medical cannabis products obtained from MyMedi.ca is done at their own risk. The patient releases MyMedi.ca, its related entities, affiliates, subsidiaries, directors, officers, partners, providers and employees from any and all actions, claims, complaints and demands for damage, loss or injury arising as a consequence of the use of medical cannabis products obtained from MyMedi.ca
4. The information in this application and the Medical Document is correct and complete.
5. The patient ordinarily resides in Canada.
6. The Medical Document is original and has not been modified.
7. The Medical Document is not being used to obtain medical cannabis from another source.
8. The use of medical cannabis is for the patient's own medical purposes.

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Signature of patient	Date (mm/dd/yyyy)			

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Signature of caregiver/individual responsible for patient	Date (mm/dd/yyyy)			

Please indicate if you consent to receiving email communications from MyMedi.ca containing offers and updates related to medical cannabis. You may unsubscribe at any time. ☐ Yes ☐ No