

### PATIENT INFORMATION

First Name(s): \_\_\_\_\_ Last Name: \_\_\_\_\_

Birth Date: [M]\_\_\_\_\_ [D]\_\_\_\_\_ [Y]\_\_\_\_\_ Gender:  Male  Female  Unspecified

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Do you currently have an active medical cannabis prescription?  Yes  No

Veterans please enter K#: \_\_\_\_\_

### ADDRESS

Address type:  Private  Establishment (nursing home, hospice, hospital) Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Province: \_\_\_\_\_

Shipping address (if different then above)

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Province: \_\_\_\_\_

Would you like to have your cannabis delivered to your healthcare practitioner at Hybrid Pharm?  Yes  No

### CAREGIVER INFORMATION (IF APPLICABLE)

First Name(s): \_\_\_\_\_ Last Name: \_\_\_\_\_

Birth Date: [M]\_\_\_\_\_ [D]\_\_\_\_\_ [Y]\_\_\_\_\_ Gender:  Male  Female  Other: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

### PATIENT / CAREGIVER CONSENT

1. The patient acknowledges that medical cannabis is not approved for the use as a drug in Canada, that its indications, safety and risks have not been adequately studied and the appropriate dosage is unclear. The patient acknowledges and agrees that they are using any medical cannabis product at their own risk, and releases hybridpharm inc. (and all its members) from any and all actions, claims, complaints and demands for damages, loss or injury whatsoever arising directly or indirectly as a consequence of the use of medical cannabis obtained from hybridpharm inc. or any related sources. In order to receive products and services, the patient/caregiver authorizes consent to hybridpharm inc. to disclose necessary information to related parties, including licensed producers, health care practitioners and related healthcare members to be transmitted via phone, physical means, digital means or other, for the purposes of processing, patient registration and patient care.
2. The applicant ordinarily resides in Canada.

3. The information in the application is correct and complete.
4. The medical document is not being used to seek or obtain cannabis products from another source.
5. The applicant intends to use any cannabis product that is supplied to them on the basis of the application only for their own medical purposes.
6. In the case where the applicant has named a responsible person, they are attesting to being responsible for the applicant.

I have read the above statement and consent

## SIGNATURES:

### PATIENT:

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date Signed (M/D/Y): \_\_\_\_\_

### CAREGIVER (if applicable):

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date Signed (M/D/Y): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_