HYBRID PHARM™

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Patient Registration Form

Patient Information

First Name(s): ____________________ **Last Name:** ____________________

Birth Date: M ________ D ________ Y ________ **Gender:** ◯ Male ◯ Female ◯ N/A

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:** ____________ **Postcode:** ____________ **Province:** ________

Shipping Address (if different from above)

Address: ____________________ **City:** ____________ **Postcode:** ____________ **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 ◯ N/A

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: ______________________