

# Application to Amend Registration

Language Selection:  English  French

Fields marked with  are required.

Current Client Details:

						
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First name

Last name

Date of birth (mm/dd/yyyy)

Gender


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Medical Cannabis by Shoppers Client ID

What would you like to amend?  Name  Date of birth  Gender  Address  Contact information  Caregiver

## Section 1:

If you are changing information in Section 1, please include proof of change such as government-issued ID and/or marriage certificate. Subsequent sections to be completed as applicable.

Please make your changes below

						
------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------

First name

Last name

Date of birth (mm/dd/yyyy)

Gender

## Section 2:

### Residential address

			
------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------

Street address

Unit #

City

Province

			
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Postal code

Primary phone

Secondary phone







Email

Residence Type  Private residence  Shelter/hostel  Nursing home  Other

\*Attestation of residence required if shelter/hostel selected. Establishment manager must complete this section.

I, (Manager's name) \_\_\_\_\_ confirm that (Name of establishment) \_\_\_\_\_

provides food, lodging, or other social services to (Patient's name) \_\_\_\_\_

					
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Signature of manager

Contact email

Date (mm/dd/yyyy)

**Mailing address**

Complete the following information only if mailing address differs from residence address

Address

Unit #

City

Province

Postal code

I have requested that medical cannabis products be delivered to my healthcare practitioners' address, with their consent as noted on my medical document.

**Section 3:**

**Caregiver Information (only complete if applicable)**

Add a caregiver     Remove a caregiver

Caregiver's first name

Caregiver's last name

Date of birth (mm/dd/yyyy)

Gender

Primary phone

Secondary phone

Email

Relationship to patient

I, (*Print caregiver name*) \_\_\_\_\_ acknowledge that I am the caregiver for (*Print patient name*) \_\_\_\_\_

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

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Signature of caregiver

Date (mm/dd/yyyy)

# Consent

The patient and caregiver, or the individual responsible for the patient, if applicable, acknowledges and agrees to the following:

1. Medical Cannabis by Shoppers Drug Mart Inc. (“Shoppers”) may collect, use and disclose personal information contained in this application, and any related medical document that is provided to Shoppers (the “Medical Document”), in accordance with Shoppers Drug Mart Inc.’s Privacy Policy (the “Privacy Policy”) and applicable laws. The purposes for which Shoppers 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 Shoppers to communicate with the patient via telephone or email regarding registration or order status, product availability, and additional matters in accordance with Shoppers’ 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 Shoppers.
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 Shoppers is done at their own risk. The patient releases Shoppers, 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 Shoppers.
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.
9. Shoppers may collect, use and disclose personal information contained in this application. This includes disclosure of any and all patient personal information collected by Shoppers to the patient’s caregiver and disclosure of any and all caregiver personal information to the patient. In the case where the individual who is signing the statement is neither the client nor a named responsible adult, you represent and warrant that you have obtained their consent and/or have authority to consent on their behalf. Consent may be withdrawn at any time but such withdrawal will not have a retroactive effect.
10. As the patient, you authorize the responsible individual/caregiver to act on your behalf with respect to anything you could do on your behalf with Shoppers and you authorize Shoppers to accept such authority.

<hr/> Signature of patient	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table> Date (mm/dd/yyyy)			

<hr/> Signature of caregiver/individual responsible for patient (if applicable)	<table border="1"><tr><td> </td><td> </td><td> </td></tr></table> Date (mm/dd/yyyy)			

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

Please drop off this completed document at your local Shoppers Drug Mart OR fax this completed document to 1-866-220-2627  
OR mail this document to Medical Cannabis by Shoppers™, 6941 Kennedy Road, Unit 100, Mississauga, ON L5T 2R6