medical cannabis
by SHOPPERS

Medical Cannabis by Shoppers™
6941 Kennedy Road, Unit 100
Mississauga, ON L5T 2R6

www.shoppersdrugmart.ca/cannabis
Fax: 1-866-220-2627
Tel: 1-844-633-2627

Compassionate Pricing Application Form

Medical Cannabis by Shoppers Drug Mart Inc. offers a 20% discount on all cannabis products for eligible patients with an annual income below $30,000*

*Restrictions apply. Refer to Terms of service for more information: https://cannabis.shoppersdrugmart.ca/en_CA/terms-of-service

Instructions

To be eligible for consideration of our Compassionate Pricing Program, applicants must submit:

1. A completed Compassionate Pricing Application Form, attesting total annual income is below $30,000; and
2. Upon request and as proof of eligibility, a copy of the Notice of Assessment issued by the Canada Revenue Agency during the previous tax year (indicating name, address, taxation year, date issued and summary of line 150 only, with all other information masked) **OR** proof of receipt of financial assistance from a federal or provincial program, indicating that your income falls below $30,000

Applicant Information

Please ensure your name and address are exactly as indicated on your medical document

First name

Last name

Date of birth *(mm/dd/yyyy)*

Name of caregiver (if applicable)

- I hereby attest that my total annual income is under $30,000
- I understand that if I falsely represent financial or supporting information, my application for Compassionate Pricing with Medical Cannabis by Shoppers™ will be rejected
- I must reapply for approval annually
- I understand that I will be contacted by Medical Cannabis by Shoppers™ to verify eligibility

Signature

Date *(mm/dd/yyyy)*

Submit documents in person to your local Shoppers Drug Mart pharmacy or by mail to:
Medical Cannabis by Shoppers™ 6941 Kennedy Road Unit 100, Mississauga, ON L5T 2R6

For Medical Cannabis by Shoppers™ use only: Please fax this form to **Shoppers cannabis care at 1-866-220-2627** and return all original documents to patient

Approved by:

Name and position: ______________________ Signature: ______________________________

Date of approval: ______________________

Patient/caregiver notified by ____________________ on (date)______________________

Patient/caregiver directed to place all orders by telephone to redeem this discount

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