



# Registration Form

Complete this form to register as a client for the purchase of medical cannabis.

## Section 1: Applicant Information

Client Name:

\_\_\_\_\_ Date of Birth: \_\_\_\_|\_\_|\_\_\_\_  
First Name Last Name Year MM DD

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Email: \_\_\_\_\_

## Section 2: Residing Address

Residing Address:

\_\_\_\_\_ Address

\_\_\_\_\_ City Province Postal Code

Is this address:  A private residence  An establishment (i.e. care facility, retirement home, shelter, etc.)

\*If you selected "an establishment" please complete the following section:

Establishment Name: \_\_\_\_\_

Type of Establishment: \_\_\_\_\_

Address of Establishment: \_\_\_\_\_

Establishment Manager Contact Information:

\_\_\_\_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Email Phone

Manager's Signature

*By signing I hereby certify that I am a Manager of the above listed establishment and that we provide food, lodging or other social services to the applicant listed above.*

\_\_\_\_\_ Signature  
Name (PRINTED)  
Date: \_\_\_\_\_

