1809 UNDERGROUND

1809 Underground
Ridgeville, ON
Phone: 289 897-9015
E-mail: admin@1809underground.ca
www.1809underground.ca

PATIENT REGISTRATION FORM
To be completed by patient or caregiver

## APPLICANT INFORMATION

Full Name: ______________________ ______________________
Given First Name(s) Surname (Last Name)

Gender: Male Female

Date of Birth: ______________________
Day / Month / Year

## CONTACT INFORMATION - Primary Residence (Must Be In Canada & Cannot Be Post Office Box)

Primary Residence:
Unit # Street Address 1 Street Address 2 (If Applicable)

Province Postal Code

Residence Type: Private home Nursing Home Shelter Hostel Group Home Other

If Other, Please Specify Name of Establishment (if not a private residence)

Contact:
Phone Number Fax Number

Email Address

## MAILING ADDRESS

Same as Primary Residence above

Where you receive correspondence. Complete if your mailing address is different than your primary residential address.

Mailing Address:
Unit # Street Address 1 Street Address 2 (If Applicable)

City Province Postal Code

**SHIPPING ADDRESS (required)**

Same as Primary Residence above

Where you want product shipped. Must be a residence.

Shipping Address:
Unit # Street Address 1 Street Address 2 (If Applicable)

City Province Postal Code

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## CAREGIVER / INDIVIDUAL RESPONSIBLE FOR APPLICANT

Caregiver Name:

Given First Name(s) Surname (Last Name)

Caregiver Date of Birth: Day / Month / Year

Gender: Male Female

Caregiver Phone Number

**Caregiver / Person Responsible Declaration:**

I am responsible for

Caregiver / Person Responsible Full Name Applicant's Full Name

Caregiver Signature: ____________________

DATE: Day / Month / Year

## Other Individual(s) Responsible For The Applicant - (If You Have More than One Caregiver)

Caregiver Name:

Given First Name(s) Surname (Last Name)

Caregiver Date of Birth: Day / Month / Year

Gender: Male Female

Caregiver Phone Number

**Caregiver / Person Responsible Declaration:**

I am responsible for

Caregiver / Person Responsible Full Name Applicant's Full Name

Caregiver Signature: ____________________

DATE: Day / Month / Year

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## HEALTH CARE PRACTITIONER INFORMATION

Complete only if your health care practitioner is consenting to receive dried marihuana on your behalf.

Name:
Title | Given First Name(s) | Surname (Last Name)

Contact:
Practitioner Phone Number | Practitioner Fax Number | Practitioner Email

Clinic Name:

Office Address:
Unit # | Street Address 1 | Street Address 2 (If Applicable)

City | Postal Code

**Consent to Receive Dried Marijuana on Behalf of Applicant**

Ship Dried Marijuana to My Office

Send Dried Marihuana to Shipping Address above

I ______ consent to receive marijuana on behalf of ______

Name of Health Care Practitioner | Applicant Name

Health Care Practitioner's Signature: ______________________

(required if you are consenting to receive dried marihuana on behalf of Applicant)

DATE: Day / Month / Year

***IMPORTANT* – PLEASE READ AND SIGN BELOW The Undersigned Applicant or Person Responsible Hereby Agrees and Warrants That:**

•The Applicant ordinarily resides in Canada
•The original medical document accompanies this Application
•The applicant understands and acknowledges that any Medical Documents sent with this form cannot be returned once registration is complete.
•The medical document/registration certificate is not being used to seek or obtain fresh or dried marijuana and/or cannabis oil from another source.
•The information in the original application and medial document/registration certificate is correct and complete and has not been altered.
•The Applicant will use fresh or dried marijuana and/or cannabis oil only for his or her own medical purposes.
•The applicant understands and acknowledges that medical marijuana is not currently approved for use as a pharmaceutical drug in Canada and that its safety and risk have not been fully studied and the appropriate dosage is unclear.
•The Applicant acknowledges and agrees that he or she is using any medicinal marijuana product obtained by 1809 Underground at his or her own risk, and releases 1809 Underground (and it's providers, officers, directors and staff) from any and all actions, claims, complaints and demands for damages, loss of injury whatsoever arising directly or indirectly from the use of medicinal marijuana obtain from 1809 Underground.
•The Applicant consents to the health care practitioner named in this document disclosing required personal health information to 1809 Underground for the purposes of complying with the requirements of Cannabis Regulations. The Applicant understand and agrees that a copy of this consent and registration application may be provided to the health care practitioner named herein.

Marketing Emails and Promotional Materials Consent

•I agree to receive electronic communications, including emails from 1809 Underground

Applicant/Individual Responsible Signature: ______________________

DATE: Day / Month / Year