Medical Document

Mail/Fax this form to: **Pure Life Cannabis**
190043 Township Road 544
Lamont County, AB
T0B 0W0
Telephone: 1-780-298-2395
Fax: 780.669.3709

To be completed by a Health Care Practitioner. All fields required under regulation unless otherwise noted.

PATIENT INFORMATION Information must match information on patient registration.

Caregiver Required? ☐ Yes ☐ No *If yes, please complete in full the Caregiver form attached to this medical document.

Patient Name: First Name | Last Name

Date of Birth: Year / Month / Day **Telephone:**

Period of Use: Months(s) **Daily Usage:** g/day
Note: Duration Cannot Exceed One Year

Usage Purpose:
Note: Duration Cannot Exceed One Year
Primary Symptom (Optional)

☐ Dried Only ☐ Extract Only If neither option is selected, the patient will be able to order any combination of extracts or dried cannabis products

Additional Potency Guidance:
% THC max (for flower)
mg/mL THC max (for extracts)

HEALTH CARE PRACTITIONER INFORMATION Please print clearly in full (no abbreviations).

Title / Name: Title | Given Name | Surname

Profession:

Business / Clinic Name:

Business Address: Address
City | Province | Postal Code

Consultation Address: Address
City | Province | Postal Code

Phone / Fax / Email: Telephone (Required) | Fax (If Applicable) | Email (If Applicable)

Province of Practice: Province in which Practitioner is Authorized to Practice

Licence Number: Licence number issued by Provincial College
Note: Do not enter billing number (e.g. MSP no.)

Signature: By signing, the Practitioner attests that the information in this document is correct and complete

Date: Year / Month / Day

Practitioner Initials: (Use only when faxing document)
By initialling, Practitioner acknowledges that the Medical Document faxed to Pure Life Cannabis constitutes the original Medical Document and that he/she has retained a copy of the Medical Document for his/her records. Practitioner also attests that the Medical Document will not be faxed or provided to any party other than Pure Life Cannabis.

Application to be a Pure Life Cannabis Patient

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PATIENT INFORMATION Information must match information on patient registration.

All fields required unless otherwise noted. This form must be filled out by the patient (if patient is applying on his/her own behalf) or a caregiver (i.e. an individual responsible for the patient) applying on behalf of the patient. Caregivers must also complete the Caregiver Information form.

Patient Name:
First Name | Last Name

Date of Birth:
Year / Month / Day

Email:
Required for Online Shopping with Pure Life Cannabis

Residence Address*:
Address
City | Province | Postal Code

*If the residence address above is not for a private residence, please indicate the following:

Name of Establishment | Type of Establishment

Phone / Fax / Email:
Telephone (Required) | Fax (If Applicable)

Mailing Address:
(If different from above residence address)
Address
City | Province | Postal Code

If you would like Pure Life Cannabis to ship product to an address other than the Residence Address provided above, please check the option that applies:

☐ Ship to Mailing Address above ☐ Ship to health care practitioner's address*

*Health Care Practitioner must consent to receive product by filling out Health Care Practitioner Information form.

The patient and the individual responsible for the patient (if applicable) must agree to the following:

- The information contained in this registration application and the medical document, or registration certificate as applicable, is correct and complete;
- The applicant (patient) is ordinarily resident in Canada;
- The medical document, or registration certificate as applicable, used for this application is not being used to seek or obtain dried marijuana from another source;
- The original of the medical document is provided in support of the application;
- The applicant (patient) will use fresh or dried marijuana or cannabis oil only for their own medical purposes;
- The indications, safety and risks of dried marijuana use have not been adequately studied and the appropriate dosage is unclear. Patient and caregiver (if applicable) acknowledge(s) that any medical marijuana product obtained from Pure Life Cannabis is done so at their own risk and release(s) ,along with its affiliates, partners, providers, directors, officers and employees 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 marijuana products;
- Patient and caregiver (if applicable) consent(s) to the health care practitioner named in his/her document disclosing required personal information to Pure Life Cannabis for the purposes of complying with the requirements of the Access to Cannabis for Medical Purposes Regulations. Patient and caregiver (if applicable) understand(s) and agree(s) that a copy of this consent and registration application, as well as information about the patient's registration status and usage patterns may be provided to the health care practitioner named in their medical document;
- Patient and caregiver (if applicable) consent to Pure Life Cannabis' collection, use and disclosure of necessary personal information in order to process this registration, to provide products or services, to comply with the Access to Cannabis for Medical Purposes Regulations (including disclosure of personal information to provincial licensing authorities upon request), and otherwise in accordance with Pure Life Cannabis policies.
- By signing this registration form, patient and caregiver (if applicable) allow Pure Life Cannabis to (a) send product and registration information to the physical and email addresses provided therein, and (b) communicate with them via email regarding registration status, product availability, order status, and other matters in accordance with Pure Life Cannabis' Privacy Policy.

Signature:

	Date:
Signature of Patient	Year / Month / Day

If there is a caregiver, both patient and caregiver must sign this form unless the caregiver is the patient's substitute decision maker (or equivalent) under applicable provincial law. If the patient does not sign, the caregiver, by signing below, attests that he or she is the patient's substitute decision maker (or equivalent) under applicable provincial law.

Signature:

	Date:
Signature of Individual Responsible (if applicable)	Year / Month / Day

Veterans Affairs Canada

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We just need a bit more information to properly submit your request for authorization.

For veteran patients: Would you like Pure Life Cannabis to seek approval from Veterans Affairs Canada (VAC) for medical cannabis reimbursement coverage on your behalf?

☐ Yes ☐ No

Has the patient registered as a VAC patient with another Licensed Producer?

☐ Yes ☐ No

Condition/Ailment:

VAC requires Pure Life Cannabis to report the specific condition on which your coverage is based.

VAC K Number:

Provide your VAC K number if you know it.

☐ I have selected Pure Life Cannabis to seek approval from Veterans Affairs Canada (VAC) for reimbursement, and authorize them to send the VAC a complete copy of the application and to bill the VAC directly for the cost of the patient's medical cannabis.

IMPORTANT: Pure Life Cannabis does not guarantee VAC approval. Once your Pure Life Cannabis application is approved, and until VAC approves your account, you will be able to make purchases with your own credit card. Once VAC approves your account they will cover the costs of your medicinal cannabis, up to the amount covered. Products other than medicinal cannabis are not eligible for VAC reimbursement and you will be responsible for payment for such items.

Signature:

Patient Signature

Date:

Year / Month / Day

Caregiver Information

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Caregivers **must** fill out this section.

Caregiver Name:
First Name | Last Name

Date of Birth:
Year / Month / Day

Contact Information:
Telephone | Email address (Required for Online Shopping with Pure Life Cannabis)
Address
City | Province | Postal Code

Contact Preference: ☐ Email ☐ Phone ☐ Mail

I,
Name of Individual or Caregiver Responsible

am responsible for
Patient's Name

Signature:
Signature of Individual Responsible for Patient

Date:
Year / Month / Day

Health Care Practitioner Information

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Must be completed by Health Care Practitioner who provided the medical document if they consent to receiving dried marihuana on behalf of the patient.

Health Care Practitioner's Title / Name:

Title | First Name | Last Name

Shipping Address:
Where you would like your product to arrive, if different from business address or consultation address provided on medical document.

- ☐ Same as Business Address provided on medical document
- ☐ Same as Consultation Address provided on medical document
- ☐ Other, please provide below:

Address

City | Province | Postal Code

I, _____
Health Care Practitioner's Name

consent to receive dried marihuana on behalf of _____
Patient's Name

Signature:

Signature of Health Care Practitioner

Date:

Year / Month / Day

Notice to the Health Care Practitioner:

Withdrawal of consent by the Health Care Practitioner:

If the health care practitioner ceases to consent and receive dried marihuana for the patient, the practitioner must send a written notice to that effect to the patient and the licensed producer.