PATIENT REGISTRATION FORM

Please note that the personal information provided on this Registration Form must match the information that appears on the Medical Document. For anyone completing this Registration Form on behalf of the Applicant, please complete the required sections and sign under "Individual Responsible for Applicant". If you require assistance, contact our Client Care Team at 1-888-594-4272.

1. PERSONAL INFORMATION

First Name:			
Last Name:			
Email:		Phone:	
Date of Birth: (YYYY/MM/DD)		Gender:	☐ M ☐ F ☐ U
Are you an existing JWC patient who is renewing?	☐ No ☐ Yes – Patient ID:		
Are you a veteran?	☐ No ☐ Yes – K #:		
Are you registered for Indian Status?	☐ No ☐ Yes – Registry #:		

2. CONTACT INFORMATION

Please provide the "**primary"** Canadian residence of the Applicant.

Address:		Apt. Unit #:	
City:		Province:	
☐ Use Primary Address as Shipping Address		Postal Code:	

3. SHIPPING

Please provide the shipping address **if different from address above**.

Address:		Apt. Unit. #:	
City:		Province:	
Shipping must be either your primary address or of an "Individual Responsible for Applicant".		Postal Code:	

4. INDIVIDUAL RESPONSIBLE FOR APPLICANT

To be completed by the "Individual Responsible for Applicant". In selecting a shipping address other than the primary residence, you are the "Individual Responsible for Applicant" according to the Access to Cannabis for Medical Purposes Regulations (ACMPR). The "Individual Responsible for Applicant" may assist the Applicant in all areas of their registration with JWC and is responsible for the Applicant and for legal compliance in all manner respecting the shipment.

Identification of Non-Primary Residence Type:			
☐ Individual Responsible ☐ Healthcare Practitioner ☐ Nursing/Care Home ☐ Social Services Establishments			
Name of Establishment:			
Relationship to Applicant:			
First Name:			
Last Name & Title (if any):			
Email:			
Phone:	Ext.	Fax:	

Continue on next page...

4a. CERTIFICATION BY (check appropriate box below):

☐ Individual Responsible ☐ Healthcare Practitioner ☐ Nursing/Care Home ☐ Social Services Establishments

- I hereby certify that I or the institution by or with which I am affiliated or employed is providing services to the Applicant.
- I hereby consent to receive cannabis on behalf of the Applicant listed above.
- I hereby certify that I am responsible for the Applicant named above.

Name:_____

Signature:_____ Date:_____

Note: If at any time you wish to withdraw consent to receive cannabis on behalf of the Applicant, you must provide written notice to that effect to both the Applicant and the Licensed Producer.

Note: If there is more than one individual responsible for the applicant, please complete and append extra pages as necessary.

5. APPLICANT DECLARATION

The following declaration should be signed either by the Applicant or the person responsible for the Applicant:

- I hereby certify that the Applicant named herein is normally a resident in Canada.
- I and/or the Applicant have read the "General Terms and Conditions" as published on the web site included in the "James Wagner Cultivation Network" (as therein defined) which I agree to incorporate into this document by reference, and to which I acknowledge that I am bound.
- I further certify that information given in this application and in any appended documents (i.e. proof of legal name change) is both correct and complete.

Name:_____

Signature:_____ Date:_____

THANK YOU FOR BECOMING A PART OF THE JWC FAMILY

James E Wagner Cultivation Ltd | PO Box 46015 Kitchener, ON N2E 4J3
TEL : 1-888-594-4272 | FAX : 1-855-787-3934
EMAIL : customerservice@jwc.ca