TANTUSHEALTHCO

PATIENT REGISTRATION

Patient Information

Information must match medical registration

All fields are required unless otherwise noted. This form must be completed by the patient or a caregiver. If a caregiver is responsible for the patient, Caregivers must also complete the Caregiver Information form.

Caregiver Required? Yes* ☐ No ☐ *If yes, please complete the Caregive Information form and attach to this document.

Patient Name
First Name | Last Name

Email | **Telephone**

Date of Birth (Year / Month / Day) | **Referred by:**

Home Address
Address
City | Province | Postal Code

Form Valid Until
Year / Month / Day (max. 12 months)

If you would like products shipped to an alternate address other than the Home Addres provided, please indicate the option that applies and complete the following information.

☐ Ship to Home Address ☐ Ship to Alternate Shipping Location / Health Care Practitioner *

*Health Care Pracitioner must consent to receive product by completing the Health Care Practitioner Information form.

Alternate Shipping Location / Health Care Practitioner

(this is optional and only required if patient is NOT receiving at home address)

Location Description

Shipping Address
Address
City | Province | Postal Code

Contact Information
Email Address (required) | Phone (required) and Fax (optional)

By acknowledging and submitting this document, you herby affirm that the information presented herein is correct and that the medical documentation provided is accurate. You are providing consent to the use and disclosure of this information strictly for the intended purpose of verifying your eligibility to order and receive marijuana for medical purposes, that you, the patient, are the only intended recipient of any product ordered and received from this website. By signing this form, patient and medical practitioner allow us to send registration information and communications to the address(es), phone number(s) and/or email(s) indicated above.

Patient Signature
Patient Signature | Year / Month / Day

Practitioner Signature
Health Care Practitioner Signature (applicable for Alternate Shipping) | Year / Month / Day

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