TANTUSHEALTHCO

PATIENT WITH CAREGIVER

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 below.

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 Caregiver as Alternate Shipping Contact *

*Health Care Practioner must consent to Caregiver receiving product by completing the Health Care Practitioner Information form. (this is optional and only required if patient is NOT receiving at home address)

Caregiver Information

Caregiver Name: First Name ______ Last Name ______

Relationship to Patient ______

Caregiver Address: Address (if being used as Alternate Shipping Contact) ______

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 the patient is the only intended recipient of any product ordered and received from this website. By signing this form, patient, caregiver 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 and/or Caregiver Signature: ______ Patient and/or Caregiver Signature ______ Year / Month / Day

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

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