Zenabis™

STEP 1: Application for Medical Marijuana

SECTION 1: APPLICANT / PATIENT INFORMATION

***IMPORTANT:* FORM MUST BE COMPLETELY FILLED IN OR APPLICATION WILL BE REFUSED.**

GIVEN NAME

LAST NAME

BIRTHDATE

YEAR 0 0 0 0 MONTH 0 0 DAY 0 0

GENDER

☐ MALE ☐ FEMALE

CONTACT INFORMATION *(PRIMARY RESIDENCE MUST BE IN CANADA)*

UNIT #

STREET ADDRESS

IS THE ADDRESS ABOVE A BUSINESS?

☐ NO ☐ YES

BUSINESS NAME *(IF YES, STATE BUSINESS NAME AND TYPE OF BUSINESS)*

BUSINESS **TYPE**

CITY / TOWN

PROVINCE

POSTAL CODE

PHONE NUMBER

FAX NUMBER *(IF APPLICABLE)*

EMAIL ADDRESS

MAILING ADDRESS

☐ **CHECK BOX** *IF SAME AS RESIDENTIAL*

(where you receive Zenabis Products)

UNIT #

STREET ADDRESS

CITY / TOWN

PROVINCE

POSTAL CODE

CLINIC **ADDRESS**

UNIT #

STREET ADDRESS

PROVINCE

POSTAL CODE

☐ **CHECK BOX IF SHIPPING TO HEALTHCARE PRACTITIONER** » ***(FILL OUT SECTION 3 ON PAGE 2)*** ☐ NOT APPLICABLE

SECTION 2: CERTIFICATION INFORMATION

Whether you are the Applicant or the Individual Responsible for the Applicant, you need to sign this application form certifying that:

» The Applicant is ordinarily a resident in Canada. » The information in this application and the accompanying Medical Document is correct and complete. » The Medical Document is not being used to seek or obtain dried marijuana from another source. » The **original** Medical Document accompanies this application. » The Applicant will use dried marijuana only for their own medical purposes. » The Applicant consents to the healthcare practitioner named in the accompanying Medical Document disclosing required personal health information to Zenabis for the purposes of complying with the requirements of the Access to Marijuana for Medical Purposes Regulations. » The Applicant (or Individual responsible) acknowledges that he / she has read and agrees to Zenabis Ltd.'s Terms & Conditions and Privacy Policy, available at www.zenabis.com. The Applicant (or Individual responsible) further acknowledges that medical marijuana is not approved for use as a drug in Canada, and that its indications, safety and risks have not been adequately studied and the appropriate dosage is not clear. The Applicant (or Individual responsible) acknowledges and agrees that he / she is using any medical marijuana obtained from Zenabis at his / her own risk and releases Zenabis Ltd. 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 obtained from Zenabis. » The Applicant authorizes Zenabis to send emails as part of the relationship (note: this is required to order online).

» Zenabis Ltd. makes no representations and gives no warranties or conditions, whether express, implied, statutory, or otherwise, including, without limitation, any warranties or conditions of merchantability, merchantable quality, durability, or fitness for a particular purpose, all of which are hereby disclaimed. Zenabis takes its product very seriously, as well as its obligations under the ACMPR to investigate all customer complaints. If at any time you have an issue with your Zenabis medical marijuana, we encourage you to contact us.

IMPORTANT: APPLICANT OR INDIVIDUAL RESPONSIBLE FOR APPLICANT MUST SIGN, PRINT NAME AND DATE BELOW.

APPLICANT OR INDIVIDUAL WHO IS RESPONSIBLE FOR APPLICANT / SIGNATURE ▼ PRINT NAME BELOW

DATE

YEAR 0 0 0 0 MONTH 0 0 DAY 0 0

X

In compliance with ACMPR subsection 130, 159(2) and SOP ZB/CS/001-02

ZSC-001-D0

MAIL THIS DOCUMENT TO:

Zenabis Ltd., 1668 Fosters Way, Delta, BC V3M 6S6

Zenabis™

Application for Medical Marijuana

FILL OUT SECTION 3 ONLY IF THE HEALTHCARE PRACTITIONER WHO SIGNED THE MEDICAL DOCUMENT WILL BE RECEIVING THE DRIED MARIJUANA ON BEHALF OF THE PATIENT.

☐ **SECTION 3 NOT APPLICABLE**

SECTION 3: HEALTHCARE PRACTITIONER INFORMATION

HEALTHCARE PRACTITIONER TITLE ☐ DOCTOR ☐ NURSE PRACTITIONER

GIVEN NAME | LAST NAME

UNIT # | STREET ADDRESS

CITY / TOWN | PROVINCE | POSTAL CODE

PHONE NUMBER | FAX NUMBER | EMAIL ADDRESS

PROFESSION | LICENSE # | CLINIC / BUSINESS NAME

I hereby attest that I consent to receive dried marijuana on behalf of the Applicant *(sign, print name and date below).*

HEALTHCARE PRACTITIONER SIGNATURE TO RECEIVE DRIED MARIJUANA

X

▼ PRINT NAME BELOW

DATE YEAR 0000 | MONTH 00 | DAY 00

ONLY COMPLETE SECTION 4 IF YOU ARE THE INDIVIDUAL RESPONSIBLE FOR THE PATIENT

☐ **SECTION 4 NOT APPLICABLE**

SECTION 4: INDIVIDUAL RESPONSIBLE FOR THE APPLICANT (CAREGIVER INFO)

GIVEN NAME | SURNAME

BIRTHDATE YEAR 0000 | MONTH 00 | DAY 00

GENDER ☐ MALE ☐ FEMALE

UNIT # | STREET ADDRESS

CITY / TOWN | PROVINCE | POSTAL CODE

PHONE NUMBER | EMAIL ADDRESS

I AM RESPONSIBLE FOR: *(PRINT NAME OF APPLICANT)* | **INDIVIDUAL RESPONSIBLE** RELATIONSHIP TO PATIENT:

Individual Responsible: I hereby attest that I am responsible for the Applicant listed above *(sign, print name and date).*

X

▼ PRINT NAME BELOW

DATE YEAR 0000 | MONTH 00 | DAY 00

In compliance with ACMPR subsection 130, 159(2) and SOP ZB/CS/001-02

MAIL THIS DOCUMENT TO:

Zenabis Ltd., 1668 Fosters Way, Delta, BC V3M 6S6