Attn: Patient Care Team, PO Box 50024
205 Pleasant St., Dartmouth, NS B2Y 3R0
Tel: 902-932-8584
info@eastcann.ca www.eastcann.ca

Form C - Caregiver Application

To be completed by Caregiver / Person Responsible

Section 1: PATIENT INFORMATION

First Name:

Last Name:

Date of Birth: (MM/DD/YY)

Gender

Email Address:

Phone Number:

Alternate Number:

Are you a Veteran?

If yes, please provide your Veterans Blue Cross Number:

YES

By indicating you are a veteran, you give permission for EASTCANN to share your details with Veterans Affairs Canada.

Section 2: SHIPPING INFORMATION

Primary Residence must be in Canada

Use Primary Residence as my shipping address

Unit#:

Street Address:

City:

Province:

Postal Code:

RESIDENCE TYPE: Private Residence: Nursing/Care Home: Shelter: Hostel: Group Home: Other:

If other, please specify:

Name of establishment (if not private residence):

More establishment information (if necessary):

ALTERNATE SHIPPING ADDRESS: *Applicable ONLY if your primary residence has no postal service*

Unit#:

Street Address:

City:

Province:

Postal Code:

Section 3: INTERIM SUPPLY

Have you obtained a registration certificate from Health Canada to grow your own cannabis? YES NO

If you selected yes above: are you registering with EASTCANN to receive a interim supply of cannabis? YES NO

If you selected yes above: are you currently obtaining an interim supply from another licensed producer? YES NO

If yes, please provide your Health Canada issued Registration Certificate number:

(Please submit a copy of your Registration Certificate with this application)

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Form C - Caregiver Application

To be completed by Caregiver / Person Responsible

Section 4: CAREGIVER INFORMATION

First Name:

Last Name:

Date of Birth: (MM/DD/YY)

Gender:

Email:

Phone #:

Alternate Number:

CAREGIVER/PERSON RESPONSIBLE DECLARATION:

I (caregiver/person responsible) Full Name:

Am responsible for: **Patient's Full Name**

Caregiver's Signature:

Date Signed: (MM/DD/YY)

OTHER PERSON(S) RESPONSIBLE FOR THE APPLICANT (Multiple Caregivers)

First Name:

Last Name:

Date of Birth: (MM/DD/YY)

Gender:

Email:

Phone #:

Alternate Number:

CAREGIVER/PERSON RESPONSIBLE DECLARATION:

I (caregiver/person responsible) Full Name:

am responsible for: **Patient's Full Name**

Caregiver's Signature:

Date Signed: (MM/DD/YY)

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Form C - Caregiver Application
To be completed by Caregiver / Person Responsible

SECTION 5: AUTHORIZATION OF APPLICANT

Declaration of the Applicant or the Person Responsible for the Applicant

Important - please read and sign below:

- The Applicant acknowledges that medical cannabis is not approved for the use as a drug in Canada, that its indications, safety and risks have not been adequately studied and the appropriate dosage is unclear.
- The Applicant acknowledges and agrees that he or she is using any medical cannabis product obtained from EASTCANN at his or her own risk, and releases EASTCANN (and its production partners) 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 cannabis obtained from EASTCANN.
- The Applicant is ordinarily a resident in Canada.
- The information in the application and Medical Document is correct and complete.
- The original Medical Document is provided in support of this application or has/will be sent separately.
- The Medical Document is not being used to seek or obtain fresh or dried cannabis, or cannabis extracts from another source.
- The Applicant will use fresh or dried cannabis, or cannabis extracts, only for their own medical purposes.
- The Applicant gives consent to EASTCANN to forward the necessary personal information to our production licensed producer, the applicant's health care practitioner, and service providers for purchasing, shipping, verification and distribution purposes only.
- The Applicant gives consent to his or her health care practitioner to forward the necessary personal information to EASTCANN in order to register the Applicant and fulfill his or her orders.
- The Applicant may revoke the consent given at any time by providing written notice to EASTCANN.

SIGNATURE ____________________________________ Date ______________

Applicant/Person Responsible for Applicant (MM/DD/YY)

Please send both this completed document AND your ORIGINAL Medical Document, or copy of Health Canada Registration Certificate, to us at:

EASTCANN
Attn: Patient Care Team
PO Box 50024, 205 Pleasant Street
Dartmouth, NS B2Y 3R0

This form may be filled out electronically or printed and completed by hand.