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CANNABIS

Central Plains Cannabis Registration Form

www.centralplainscannabis.com | clients@centralplainscannabis.com
Toll Free: 1.855.987.1767 | Fax: 1.833.261.9880

Complete this form to register as a customer for the purchase of medical cannabis.

1. Instructions

A. Complete Registration Form

To register as a customer for the purchase of medical cannabis, complete and sign this Registration Form and send it to us by one of the following:

1. Secure Fax Line - 1.833.261.9880

2. Email - clients@centralplainscannabis.com

3. Online - www.centralplainscannabis.com

4. Mail - 34 Beaver Street North, Newcastle, ON L1B 1H6

Your health care professional can also send us your Registration form by secure fax along with your Medical Document.

B. Complete a Medical Document with your Healthcare Professional

We will also need the original version of your Medical Document, completed by your healthcare professional. We can accept this document by fax only directly from your healthcare professional's office. Otherwise, you or your doctor will need to mail us the original paper version. If you need assistance with this, we'll be pleased to arrange for the collection of your forms and/or to provide you with a self-addressed, prepaid envelope upon request.

Once we receive your Registration Form and Medical Document, we will verify the documents. A confirmation email will be sent to you after verification is complete. Once you receive your confirmation email, you can place your first order.

Have Questions?

To reach our team, and/or receive help for filling out this Registration Form, contact us by telephone at **1.855.987.1767** or by email at **clients@centralplainscannabis.com**

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Registration Application

This form must be filled out by the patient (if the patient is applying on their own behalf) or a caregiver (i.e. individual responsible for the patient) applying on behalf of the patient. Caregivers must also complete Section 6: Caregiver Information on page 4 of this application.

1. Patient Information

First Name _____ Last Name _____ Date of Birth _____

Email _____

Phone Number _____

☐ Male ☐ Non-binary

☐ Female ☐ Prefer not to say

2. Residence Address

Address _____

City _____ Province _____ Postal Code _____

Please indicate if the above address is

☐ A private residence (e.g. a house, apartment, condo, etc.).

☐ An establishment (e.g. a long-term care facility, shelter, etc.).

Please complete this section if you selected 'An establishment'.

Name of Establishment _____

Type of Establishment _____

Certification by Healthcare establishment. I hereby certify that I am a manager of the above-listed establishment and that we provide food, lodging or other social services to the patient listed above.

Signature _____ Name _____ Title _____

Email _____ Phone _____ Date _____

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3. Shipping Address

☐ Use Residence Address (Can only be selected if this is your primary address with Canada Post)

☐ Use Healthcare Practitioner Address ☐ Use Alternative Address

Address _____ Care of _____

City _____ Province _____ Postal Code _____

Please complete this section if the health care practitioner who provided the medical document has agreed to receive cannabis products on behalf of the applicant.

First Name _____ Last Name _____

Address _____

City _____ Province _____ Postal Code _____

Phone _____ Fax _____

I hereby consent to receive cannabis on behalf of the patient listed on page 1.

Signature _____ Date _____

4. Direct Billing for Canadian Forces Veterans

In order for us to bill Veterans Affairs Canada directly for the cost of your medicine, we require the following information.

(a) Your doctor MUST provide a diagnosis on your Medical Document.

(b) Your Veterans Affairs Canada Health Benefit Card Number _____

☐ The applicant consents to Central Plains Cannabis' disclosing the applicant's personal information and documentation with Veterans Affairs Canada and/or the applicant's insurance provider (if applicable).

I hereby acknowledge and agree, that in connection with my acceptance of the Veterans' pre-approval coverage, I have not previously registered for coverage with another licensed producer, and that Central Plains Cannabis will submit the payment request to Veterans Affairs Canada on my behalf.

Note: Direct billing is subject to approval by Veterans Affairs Canada.

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5. Authorization of Applicant

As applicant or a responsible individual you acknowledge, attest, agree and consent to the following:

(i) the applicant ordinarily resides in Canada;
(ii) the information in the application is correct and complete;
(iii) the medical document that forms the basis for the application has not, to the knowledge of the individual signing the statement, been altered;
(iv) the medical document is not being used to seek or obtain cannabis products from another source;
(v) in the case where the applicant is signing the statement, they intend to use any cannabis product that is supplied to them on the basis of the application only for their own medical purposes;
(vi) in the case where an adult who is responsible for the applicant is signing the statement, they are responsible for the applicant; and
(vii) I authorize Central Plains Cannabis and my health care practitioner to disclose my personal health information consisting of: dose information of cannabis used for medical purposes, as a verification of the health care practitioner's orders, as required and on a continuous basis. I have been informed of how my personal health information will be used and understand the purpose for disclosing my personal health information noted above. I understand that I can refuse to sign this consent, and this may be withdrawn or amended at any time.

☐ I consent to the terms above

The applicant acknowledges that cannabis products are not an approved therapeutic products and cannabis has not been authorized through the standard Health Canada drug approval process because the available scientific evidence does not establish the safety and efficacy of cannabis to the extent required by the Food and Drug Regulations for marketed drugs in Canada.

The applicant acknowledges that they are using any medical cannabis or related product obtained from Central Plains Cannabis at their own risk. The applicant also specifically releases Central Plains Cannabis (and its service providers, officers, directors and staff) from any and all actions, claims, complaints and demands for damages, loss or injury whatsoever, whether arising directly or indirectly as a consequence of the use of Central Plains Cannabis' products or services. In order to receive our products and services, the applicant or authorized person gives consent to Central Plains Cannabis to disclose the necessary personal information to Central Plains Cannabis service providers, including Beyond The High Special Access Clinic, and including without limitation, the health care practitioner named in this registration, in accordance with Central Plains Cannabis Inc.'s Privacy Policy (https://www.centralplainscannabis.com/privacy-policy).

The applicant and/or authorized person consents to the health care practitioner named in this registration application disclosing to Central Plains Cannabis the applicant's personal health information by phone, physical means or digital means (including Central Plains Cannabis' online portal or SFax secure system) for the purposes of processing this registration (which may include the submission of my Medical Document by digital means), client service and complying with the requirements of the Cannabis Regulations. The applicant understands and agrees that a copy of this consent and registration application may be provided to the health care practitioner named in this registration

☐ The applicant consents to Central Plains Cannabis' disclosing the applicant's personal information, including account issues and order history, with the clinic that submitted the applicant's Medical Document.

☐ The applicant consents to Central Plains Cannabis' disclosing the applicant's personal information and communicating directly with CNeSST and/or the applicant's insurance/claim provider.

By signing this Registration Application, you give us permission to send medical cannabis and your registration information to the shipping address provided. You also give us permission to communicate with you at your listed email address or phone number so that we can provide you with information related to your account and purchases.

Signature _____ Date _____

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6. Individual Responsible for the Applicant (optional)

If required, caregivers must fill out this section. A caregiver is a responsible individual for the applicant who is able to complete the documents on their behalf.

If there is a caregiver, both patient and caregiver must sign this form unless the caregiver is the patient's substitute decision maker (or equivalent under applicable provincial law). If the patient does not sign, the caregiver, by signing below, attests that they are the patient's substitute decision maker (or equivalent under applicable provincial law).

Applicant's Name _____ Date of Birth _____

Caregiver's Information

First Name _____ Last Name _____ Date of Birth _____

Email _____ Phone Number _____ Relationship _____

I, _____ am responsible for _____

Signature _____ Date _____