

REGISTRATION FORM C – DELIVERY TO HEALTH CARE PRACTITIONER OR CAREGIVER

Note: To complete your application, an original medical document is also required.

PERSONAL INFORMATION

First Name _____ Last Name _____
Date of Birth _____ Gender Male Female Other
Type of Residence House Apartment Other _____
Street Address _____
City _____ Province _____ Postal Code _____
Native Status Yes No VAC Number _____
Primary Phone _____ Alternate Phone _____
Email Address _____

HEALTH CARE PRACTITIONER INFORMATION

Title/Profession _____ Institution Name _____
First Name _____ Last Name _____
Institution Address _____
Phone _____ Fax _____ Email Address _____
Shipping Address (if different than above) _____

CAREGIVER INFORMATION

First Name _____ Last Name _____
Date of Birth _____

ACKNOWLEDGEMENT

The applicant acknowledges the following:

- The applicant is ordinarily a resident of Canada.
- A valid, original medical document accompanies this application, or will be forwarded once received.
- The information in this application and in the medical document is correct and complete.
- The medical document is not being used to acquire cannabis product from another source.
- The applicant will use cannabis product only for their own medical purposes.
- The caregiver acknowledges that they are responsible for the client (if applicable).

The applicant acknowledges that Kolab Project may share the applicant's personal information with our employees, contractors, consultants, affiliates, and other parties who require such information to assist us with managing our relationship with you, including, for example, any third party subcontractors that we may engage from time to time to fulfill your orders with us. Please contact our Privacy Officer at info@kolabproject.com (attention: Privacy Officer) with any questions that you may have. Our privacy policy can be accessed at: www.kolabproject.com/pages/privacy

Applicant Signature _____ **Date** _____
Caregiver Signature (if applicable) _____ **Date** _____
Health Care Practitioner consent to receive cannabis _____ **Date** _____

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