ESTABLISHMENT AUTHORIZATION FORM

Medisenol®
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PLEASE NOTE: All fields on this form are mandatory. The information provided on this form must match the Medical Document form. Incomplete forms will result in a delay of registration. Completed form may be submitted by mail, email, or fax.

☐ New client ☐ Returning client Client ID (if returning client) _____

1. Applicant Information

First name _____ Last name _____ Phone _____

☐ Male ☐ Female ☐ Prefer not to disclose

Email (used to grant you access to the online store) _____ Date of birth (dd/mm/yy) _____

Mailing Address _____ Unit Number _____ City _____ Province _____ Postal Code _____

2. Establishment Information

Name of establishment _____ Type of establishment _____

Establishment street address _____ Unit Number _____ City _____ Province _____ Postal Code _____

Phone _____ Fax _____ Email _____

Manager's first name _____ Manager's last name _____

I , _____ attest that _____
Manager's name Name of establishment

provides food, lodging, or other social services to _____ .
Applicant's name

Manager's signature _____ Date (dd/mm/yy) _____

3. The Applicant or the Responsible Individual must acknowledge the following:

1. the applicant ordinarily resides in Canada,
2. the information in the application is correct and complete,
3. the medical document that forms the basis for the application has not, to the knowledge of the individual signing the statement, been altered,
4. the medical document is not being used to seek or obtain cannabis products from another source,
5. 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, and
6. in the case where an adult who is named under paragraph (f) is signing the statement, they are responsible for the applicant

☐ By checking this box you agree that you have read, acknowledged, understood, and formally agree to the statements above and that the information provided is accurate and complete.

Applicant/Responsible individual signature _____ Date (dd/mm/yy) _____