Dosecann
Cannabis Program

For Client

Dosecann Cannabis Program
1-833-565-2278
clientcare@dosecann.com
55 Bruce Crescent
Ottawa, Ontario K7C 3T3
Monday – Friday
9:00 AM to 5:00 PM EST

REGISTRATION FORM (1/2)

Note: To complete your application, your health care practitioner must provide us with an original **MEDICAL DOCUMENT**.
1. Please complete and sign this document and
2. Submit this document to clientcare@dosecann.com

PERSONAL INFORMATION

First Name _____ Last Name _____
Date of Birth _____ Gender ☐ Male ☐ Female ☐ Other
Status Card (First Nations) ☐ Yes ☐ No Veterans Affairs Canada Number _____
Primary Phone _____ Alternate Phone _____
Email Address _____

RESIDENCE ADDRESS

Street Address _____
City _____ Type of Residence
Province ☐ Private Residence (i.e. house, apartment, condo, etc.)
Postal Code _____ ☐ Establishment (i.e. long-term care, retirement home, etc.)

If you selected **ESTABLISHMENT** as your type of residence, please fill out the following:

Name of Establishment _____ Type of Establishment
Phone (if applicable) _____ ☐ Independent Living
Fax (if applicable) _____ ☐ Assisted Living
Email Address (if applicable) _____ ☐ If Other, please indicate _____

I, _____ agree to accept delivery on behalf of applicant and confirm this institution provides food, lodging and other social services to the applicant.
Signature _____
Date _____

SHIPPING ADDRESS

Street Address _____ City _____
Province Postal Code _____

BILLING ADDRESS

Street Address _____ City _____
Province Postal Code _____

The Dosecann Cannabis Program is serviced by Kolab Project Inc., a federal cannabis licence holder.

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REGISTRATION FORM (2/2)

CAREGIVER INFORMATION (IF APPLICABLE)

First Name _____ Last Name _____
Date of Birth _____ Gender ☐ Male ☐ Female ☐ Other
Primary Phone _____ Alternate Phone _____
Email Address _____

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 by your health care practitioner.
- 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 Dosecann Cannabis Program is serviced by Kolab Project Inc. The Dosecann Cannabis Program 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 clientcare@dosecann.com with any questions that you may have. Our privacy policy can be accessed at: dosecann.com/privacy

Applicant Signature _____
Date _____
Caregiver Signature (if applicable) _____
Date _____

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