Delta 9 Bio-Tech

PO Box 68096 Osborne Village
Winnipeg, MB R3L 2V9
info@delta9.ca
Fax: 1-204-975-9396
Phone: 1-855-245-1259

Instructions

How to Complete the Application Form

This Application Form is for applicants who wish to register with Delta 9, to receive medicinal marihuana (Cannabis) under the ACMPR. Please submit this form to Delta 9 by mail, email or fax. Any **errors or missing information** will result in having your application form sent back. **Note:** A Medical Document is required and must be completed by your health care practitioner.

Please follow these steps to complete your application form correctly.

Section 1: Applicant Information (All is required).

1) Clearly print your first and last name. **Note:** Your name must match what is on the medical document.

2) Print your date of birth and check mark your gender (Male or Female).

3) Print your home number with area code (required), a cell number or fax number (if applicable).

5) Clearly print your email address (if applicable).

6) Provide your Canadian primary address (This is the physical address of where you live. **Do not** write a PO Box number). If you do not have a permanent residence, complete section 2 along with the shipping/mailing address.

7) Print your shipping/mailing address. **This is where your package will be delivered**. Please enter it here if :
A) If shipping address is different than primary address, **B)** You have a PO box number etc., **C)** You do not have a permanent residence, or **D)** The health care practitioner's address that was check marked on the medical document to receive cannabis on your behalf.

Section 2: Residents of Care Homes, Shelters, Hostels or similar institutions. If you are an applicant **without** a private Canadian residence, complete this section, **otherwise leave blank.**

1) Print the name of the establishment, along with the type of establishment.

2) Write the phone number and area code of establishment (required), fax number and email (if applicable).

3) Write the first and last name of the residence manager.

4) The residence manager **must** sign and date the declaration in section 2.

Section 3: Caregiver/Individual Information (Responsible for Applicant). If you would like to authorize an individual to speak with Delta 9, or place orders on your behalf, please provide their information below, **otherwise leave blank**.

1) Clearly print the Caregiver/Individual's first and last name.

2) Print the Caregiver/Individual's date of birth, and gender (Female or Male).

3) Print the Caregiver/Individual's phone number.

4) The Caregiver/Individual **must** sign and date the declaration in section 3.

Section 4: Consent Form. The Applicant or Caregiver/Individual must consent to the terms and conditions listed in this section.

1) Sign and date the consent form.

Review: Look back over your application form for any errors or missing information. If all is correct, submit this 2-page form to Delta 9 Bio-Tech by mail, email or fax. Any questions, concerns or if you require assistance, contact our office toll free at 1-855-245-1259. Have your Health Care Practitioner submit the Medical Document from their office by fax. You will be notified once we begin to process your registration.

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Application Form

To register with Delta 9, complete this 2-page Application Form and return to us by mail, email or fax. A medical document completed by a health care practitioner is required, and may be sent by fax or mail from that doctor's office. ***Please follow the instructions as any errors/missing information will result in having your application form sent back.***

Section 1: Applicant Information

First Name _____ Last Name _____

Date of Birth: Month_____ Day_____ Year_____ Gender: ◯ Male ◯ Female

Home Number _____ Cell Number _____ Fax Number (if applicable) _____

Email Address _____

Primary Residence Address: ***Do not** put your PO Box Number here** (If this is not a private residence, Section 2 must be completed along with the Shipping/Mailing Address).

Unit or Apt # _____ Street Address _____

City _____ Province _____ Postal Code _____

Shipping/Mailing Address: **(Where your medicine will be delivered)** If different then primary residence, or you have a **PO Box Number,** or have completed section 2, write it here.

Unit or Apt # _____ Street Address / PO Box Number _____

City _____ Province _____ Postal Code _____

Section 2: Residents of Care Homes, Shelters, Hostels or similar institutions

Name of Establishment _____ Type of Establishment _____

Phone Number _____ Fax Number _____ Email Address _____

The Manager of the establishment listed above confirms that the institution provides lodging, food, or other social services to the Applicant.

Name of Residence Manager _____ Signature of Residence Manager _____ Date _____

Section 3: Caregiver/Individual Information (Responsible for applicant)

If you would like to authorize someone to speak with Delta 9 or place orders on your behalf, please provide that information below.

First Name _____ Last Name _____

Date of Birth: Month_____ Day_____ Year_____ Gender: ◯ Male ◯ Female Phone Number _____

I agree that I am responsible for the above-named applicant.

Caregiver/Individual Signature _____ Date _____

*****Continue to next page to sign and date the Consent Form*****

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Section 4: Consent Form

The Applicant and/or Caregiver/Individual must agree and warrants the following:

(1) The applicant ordinarily resides in Canada.

(2) The information in the application and medical document is correct and complete.

(3) The medical document is not being used to seek or obtain fresh or dried marihuana or cannabis oil from another source.

(4) The original medical document accompanies this application and/or is being sent from your doctor's office by fax or mail.

(5) The applicant will use fresh or dried marihuana or cannabis oil only for their own medical purposes.

(6) The applicant understands and acknowledges that fresh or dried marihuana or cannabis oil is not approved for use as a drug in Canada and that its safety and risks have not been adequately studied and the appropriate dosage is unclear.

(7) The applicant acknowledges and agrees that he/she is using any medical marihuana product obtained from Delta 9 at his or her own risk, and releases Delta 9 (and its partners, providers, officers, directors and staff) from any and all actions, claims, complaints, and demands for damages, loss or injury whatsoever arising directly or indirectly from the use of medicinal marihuana obtained from Delta 9.

(8) The applicant consents to Delta 9 collecting and disclosing necessary personal information in order to process this registration and fulfill orders for medicinal marihuana in accordance with Delta 9's privacy policy (www.delta9.ca/privacy_policy.html).

(9) The applicant consents to the health care practitioner named in the medical document accompanying this form to disclose personal health information to Delta 9 for the purposes of complying with the requirements of the Access to Cannabis for Medical Purposes Regulations (ACMPR). The applicant understands and agrees that a copy of this consent & application may be provided to the health care practitioner named on the medical document.

By signing below, the Applicant attests that the information contained herein is correct and complete, and agrees to the terms and conditions listed above.

_____ _____

Applicant/Caregiver/Individual Signature | Date

Please review your application form for completeness, as any errors or incomplete sections will result in us having to refuse your application form. Please send your completed application form to Delta 9 Bio-Tech by one of the following options:

Mail to:

Delta 9 Bio-Tech LP
PO Box 68096 Osborne Village
Winnipeg, MB R3L 2V9

Email to:

info@delta9.ca

Fax to:

204-975-9396

Office Use Only:

Client ID#	**Unique Identifier**	**Date Registered**	**Admin. Initials**
_____	_____	_____	_____