Client Registration

Version 1.7 November 2016

Form B: For applicants with no residence - Shelter, hostel or similar institution

IMPORTANT NOTE: When returning this application please include the original medical document signed & dated by your health care practitioner. The original copy of the medical document is required to complete your registration.

☐ **New Client** ☐ **Client Renewal** ☐ **Change of Address** Peace Naturals Client ID# _____

Applicant Information

Title	Given Name	Surname
Date of Birth MM / DD / YYYY	Gender ☐ Male ☐ Female	Veteran ☐ Yes VAC# _____
Email Address		☐ **Please sign me up for online shopping.** Email address is required.

Individual(s) Responsible for the Applicant - (If you have caregiver(s), please complete this section)

Person #1

Title	Given Name	Surname
Date of Birth MM / DD / YYYY	Gender ☐ Male ☐ Female	
Telephone Number	Email Address	

I, _____ am responsible for _____.
Individual Responsible / Caregiver — Applicant's Name

Individual Responsible for Applicant Signature	Date

Person #2

Title	Given Name	Surname
Date of Birth MM / DD / YYYY	Gender ☐ Male ☐ Female	
Telephone Number	Email Address	

I, _____ am responsible for _____.
Individual Responsible / Caregiver — Applicant's Name

Individual Responsible for Applicant Signature	Date

"Peace is its own reward." - Gandhi

The Peace Naturals Project

Mail or courier completed form to:
P.O. Box 999 | Stayner, ON | L0M 1S0

Toll Free: 1.888.64.PEACE (73223) | www.peacenaturals.com

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Establishment Information

Establishment Name		Establishment Type
Manager's Given Name	Manager's Surname	

Establishment Address

Address		
City	Province	Postal Code
Best Telephone Number	Fax Number	Alternate Telephone Number OPTIONAL
Preferred Time for Contact	Email Address	

Mailing Address - Where you receive correspondence from Peace Naturals ☐ **Same As Establishment Address**

Address		
City	Province	Postal Code

Shipping Address - Where you would like your medicine to arrive ☐ **Same As Mailing Address**

Address		
City	Province	Postal Code

I, _____ attest that _____
Manager's Name — Establishment's Name

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

Manager's Signature	Date

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Health Care Practitioner Information

Title / Profession	Given Name	Surname
Clinic / Business Name		
Address		
City	Province	Postal Code
Telephone No.	Fax No.	

Additional Information (Optional)

Please feel free to provide us with information regarding your medical condition(s), ailment(s) and symptom(s).

Please feel free to provide us with information regarding your medicinal Cannabis preferences (if applicable).

Ex., strain preferences and/or potency preferences.

Is there anything else you would like us to know?

Acknowledgment

The Applicant and/or the Person Responsible for the Applicant Must Read and Acknowledge the Following:

- The applicant is ordinarily a resident of Canada.
- The information in the application and medical document is correct and complete.
- The medical document is not being used to seek or obtain dried marihuana from another source.
- The original medical document accompanies this application.
- The applicant will use dried marihuana only for their own medical purposes.

Applicant / Individual Responsible Signature	Date

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