PATIENT REGISTRATION FORM

Licensed under the Cannabis Act by HydRx Farms Ltd.

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

☐ New Client ☐ Returning Client Referring Clinic (if applicable) _____

1. Applicant Information

First name _____ Last name _____ Date of birth (dd/mm/yy) _____

☐ Male ☐ Female ☐ Prefer not to disclose

Phone _____ Email (used to grant you access to the online store) _____

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

Tell us how you would prefer us to contact you: ☐ Email ☐ Phone

Additional Applicant Information (optional)

Do you wish to self-identify as an Aboriginal person in Canada? ☐ Yes ☐ No

Veteran K No. _____ (please complete VAC Consent to Disclose)

2. Shipping Address

Please check one.

☐ Shipping address is the same mailing address in section 1.

☐ Shipping address is different from the mailing address in section 1. Please fill out shiping address below.

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

3. Responsible Individual Information (if applicable)

Only complete this section if you are an Individual Responsible for the Applicant and applying on their behalf. A Responsible Individual may act on behalf of the registered client. They may make inquiries, changes, and orders on behalf of the client.

First name _____ Last name _____

Date of birth _____ Phone _____ Email _____

☐ Male ☐ Female ☐ Prefer not to disclose

The undersigned attests that he/she is the Responsible Individual for the Applicant.

Responsible Individual Signature _____ Date (dd/mm/yy) _____

For More Information c/o HydRx Farms Ltd.
209 Dundas St.E., PO Box 31
Whitby, ON,
Canada L1N 5R7

1-844-493-7922
customercare@hydrx.ca

Secure Fax Line
(866) 775-7552

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4. Authorization of Applicant or Responsible Individual

Please sign below to certify that you understand and agree to 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.
6. in the case where an adult who is named under section 3 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 applicant information provided is accurate and complete.

Signature _____ Full Name _____ Date (dd/mm/yy) _____

Once completed, this Registration Form may be submitted to HydRx Farms Ltd. in one of the following ways:

Mailing Address
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Whitby, ON, Canada L1N 5R7

1-844-493-7922
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(866) 775-7552

This application can only be processed once we receive your original Medical Document from your Health Care Provider.

5. Staying in Touch

Subscribe to our mailing list to stay informed

Share your contact details and we'll let you know when new products and formats are available for prescription. We respect your privacy. Your contact details will be held in confidence in accordance with our privacy policy.

☐ Yes, I want to stay up to date on products and promotions.