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### CAREGIVER'S APPLICATION FOR REGISTRATION

To be completed by caregiver:

Caregiver's Name: \_\_\_\_\_ (please print)

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I understand that as a caregiver I am not entitled to consume any cannabis purchased on behalf of the MediCanna member.

Caregiver's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Member's Name: \_\_\_\_\_ Member Number: \_\_\_\_\_

Caregiver must provide a photocopy of government issued photo ID. Attach to this form.

To be completed by MediCanna member:

I authorize the above signed person to make purchases from MediCanna on my behalf.

Member's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date Signed: \_\_\_\_\_