



## Welcome to the Whistler Medical Marijuana Corporation

Locally owned and operated, Whistler Medical Marijuana Corporation produces 100% organic, high quality non-irradiated and non-milled crops. We grow in real soil, using glacier-fed river water and a passionate attention to detail.

Life is hectic enough, getting your medicine shouldn't be.

## How to Sign Up

This registration package consists of two forms that BOTH need to be completed to register.

### Form 1 - Application For Medical Marijuana

To be filled out by the APPLICANT or the person responsible for the Applicant, referred to as the CAREGIVER.

### Form 2 - Medical Document

To be filled out by your HEALTH CARE PRACTITIONER.

PLEASE NOTE: It is VERY IMPORTANT that ALL mandatory sections are completed. If any of the fields in the mandatory sections are blank we won't be able to accept your application.

## How To Submit Your Registration Package

Once you have completed the application package please return BOTH forms TOGETHER to us in ONE of the following ways:

### By Fax to (604) 962-3443

Please be aware that registration faxes must be sent directly from your Healthcare Practitioner's office. Faxes received from alternative numbers cannot be accepted.

### By Mail to WMMC, 113-1330 Alpha Lake Road, Whistler BC V0N 1B1

If sending by mail ensure that the documents you send are ORIGINALS. Health Canada regulations do not allow us to accept photocopies

## What Happens Next?

We'll phone you as soon as we receive your completed registration package so you know it has arrived safely. Next, we'll contact your Health Care Practitioner by phone or fax to verify your **Medical Document**. Once everything is confirmed we'll call you again and send out your Notification of Registration document which contains your personal *Client Identification Number*. Once you have that number you can begin placing orders immediately.

Most importantly, we are here to help. If you have any questions, or would like to know more about our current strains, feel free to give us a call at (604) 962-3440 (We promise a real person will answer, no automated-robots here— they can't handle Whistler's mountainous terrain).

Kind Regards,

The Team at Whistler Medical Marijuana Corporation



# Application For Medical Marijuana

Whistler Medical Marijuana Corporation  
113 - 1330 Alpha Lake Rd.  
Whistler, B.C. V0N1B1  
P: (604) 962 - 3440 F:(604) 962-3443

To be completed by the Applicant

## Section 1: Applicant Information - THIS SECTION IS MANDATORY

First Name(s)				Middle Name(s)				Last Name				
Date Of Birth	M	M	D	D	Y	Y	Y	Y	Gender	Phone		
Email								Fax				

**Primary Residence Address** (if this is not a private residence please complete the name and type of establishment in Section 3)

Unit No.		Street No.		Street Address					
City				Province			Postal Code		

**Shipping / Mailing Address** (where you would like to receive your medication)  check box if same as **Primary Residence Address**

Unit No.		Street No.		Street Address					
City				Province			Postal Code		

**The Applicant and/or the Caregiver must agree to the following:** (1) The Applicant is ordinarily a resident of Canada; (2) The information in the Application For Medical Marijuana and Medical Document is correct and complete; (3) The Medical Document accompanying this application is not being used to seek or obtain dried marijuana from another source; (4) An original Medical Document accompanies this application; (5) The Applicant will use dried marijuana only for their own medical purposes; (6) The Applicant acknowledges that dried marijuana is not approved for use as a drug in Canada and that its indications, safety and risks have not been adequately studied and the appropriate dosage is unclear. The Applicant acknowledges and agrees that he/she is using any medical marijuana obtained from Whistler Medical Marijuana Corporation (WMMC) at his or her own risk, and releases WMMC (and its production partners) from any and all actions, claims, complaints, and demands for damages, loss, or injury whatsoever arising directly or indirectly as a consequence of the use of dried marijuana obtained from WMMC.

**Consent to Release Health Information:** By signing below the Applicant or the Caregiver responsible for the Applicant, consents to the disclosure of the Applicant's information to the Health Care Practitioner who has signed their medical document. By signing below, the Applicant or Caregiver responsible for the Applicant, understands that they may have chosen to refuse to sign the consent form and chosen not to submit their application.

Signature				Date	M	M	D	D	Y	Y	Y	Y
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## Section 2: Caregiver Information - If you would like to authorize someone to talk with WMMC on your behalf please provide their information below

If you wouldn't like to authorize anyone to communicate with WMMC on your behalf you can leave this section blank.

First Name(s)				Middle Name(s)				Last Name				
Date Of Birth	M	M	D	D	Y	Y	Y	Y	Gender	Phone		

By signing below, the Caregiver agrees that they are responsible for the Applicant listed in Section 1.

Caregiver Signature				Date	M	M	D	D	Y	Y	Y	Y
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## Section 3: Residents of carehomes, shelters, hostels or similar institutions that provide social services to applicant

If you don't live in a care home, shelter, hostel or similar institution you can leave this section blank.

Name of Establishment						Type of Establishment					
Phone				Fax		Email					

Please have the manager of the establishment sign below to confirm that the institution provides food, lodging or other social services to the applicant

Name Of Residence Manager				Signature Of Residence Manager				Date	M	M	D	D	Y	Y	Y	Y
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## Section 4: Ship to your Healthcare Practitioner - If you would like to authorize your health care practitioner to receive your medication on your behalf

If the shipping address you provided in Section 1 is your Healthcare Practitioners Office please have them sign this section to consent to receiving the product on your behalf.

Name Of Healthcare Practitioner				Signature Of Healthcare Practitioner				Date	M	M	D	D	Y	Y	Y	Y
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# Medical Document

Whistler Medical Marijuana Corporation  
113 - 1330 Alpha Lake Rd.  
Whistler, B.C. V0N1B1  
P: (604) 962 - 3440 F:(604) 962-3443

To be completed by the Health Care Practitioner.

## Section 1: Patient Information - THIS SECTION IS MANDATORY

First Name(s)				Middle Name(s)				Last Name				
Date Of Birth	M	M	D	D	Y	Y	Y	Y	Gender			

## Section 2: Health Care Practitioner Information - THIS SECTION IS MANDATORY

First Name(s)				Middle Name(s)				Last Name			
Profession				Medical License Number(s)				Provinces Licensed In <input type="checkbox"/> AB <input type="checkbox"/> BC <input type="checkbox"/> MB <input type="checkbox"/> NB <input type="checkbox"/> NL <input type="checkbox"/> NS <input type="checkbox"/> NT <input type="checkbox"/> NU <input type="checkbox"/> ON <input type="checkbox"/> PE <input type="checkbox"/> QC <input type="checkbox"/> SK <input type="checkbox"/> YT			

Business Address (a stamp is acceptable here)

Consultation Address (if different than business address)

Phone	Fax	Email
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Please indicate the Health Care Practitioner's preferred method of contact for medical document verifications (phone, fax, email):

## Section 3: Written Order - THIS SECTION IS MANDATORY

NOTE - The maximum quantity of dried marijuana a client may possess at any time cannot exceed the lesser of: 150g or 30 times the daily maximum amount prescribed below, as per the Marijuana for Medical Purposes Regulations.  
- The prescription period cannot exceed one year and will begin on the day this document is signed by the Health Care Practitioner.

Medical Diagnosis	
Daily Prescribed Maximum Quantity Of Dried Marijuana (g/day)	Prescription Period (maximum 12 months) _____ Days _____ Weeks _____ Months

Please have the Health Care Practitioner sign below to confirm that the information listed above is correct and complete.

Signature of Health Care Practitioner	Date	M	M	D	D	Y	Y	Y	Y
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## Section 4: Submission

### FAX

Fax submissions must be initialed below and sent from the Health Care Practitioner's office.

Initials of Health Care Practitioner

By initialing, the Health Care Practitioner acknowledges that if the Medical Document was faxed to WMMC the faxed copy constitutes the original Medical Document and that he/she will retain a copy of this document for their records. The Health Care Practitioner also attests that this Medical Document will not be faxed or provided to any party other than WMMC.

**WMMC FAX (604) 962-3443**

### MAIL

Mailed submissions must contain the **ORIGINAL** of this document and a completed Application Form.

**Whistler Medical Marijuana Corporation**  
**113 - 1330 Alpha Lake Rd.**  
**Whistler, British Columbia**  
**V0N1B1**