WMMC | Registration Package

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

Welcome to the Whistler Medical Marijuana Corporation

Locally owned and operated, Whistler Medical Marijuana Corporation produces 100% organic, high quality 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

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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 or cannabis oil from another source; (4) An original Medical Document accompanies this application; (5) The Applicant will use dried marijuana or cannabis oil for their own medical purposes only; (6) The Applicant acknowledges that dried marijuana and cannabis oil are not approved drugs in Canada and thus the indications and safety risks of its use have not been adequately studied nor an appropriate dosage determined; (7) The Applicant acknowledges and agrees that he/she is using products obtained from Whistler Medical Marijuana Corporation (WMMC) at their 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 or cannabis oil 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	Today's Date	M	M	D	D	Y	Y	Y	Y

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

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

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

Medical Document

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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 ☐AB ☐BC ☐MB ☐NB ☐NL ☐NS ☐NT ☐NU ☐ON ☐PE ☐QC ☐SK ☐YT

Business Address (a stamp is acceptable here)	Consultation Address (if different than business address)

Phone	Fax	Email

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 Access To Cannabis 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

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.

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