★ STARSEED Medicinal Inc.

CANDIDATE- Registration Application (page 1 of 4)

Mail/Fax to: Starseed Medicinal Inc.
PO Box 279
Bowmanville, ON L1C 3L1

T: 1-844-756-7333
S-Fax: 1-844-756-0470

info@starseed.com
www.starseed.com

This form must be filled out by the patient (if the patient is applying on his/her own behalf) or a caregiver (i.e. individual responsible for the patient) applying on behalf of the patient. **Caregivers must also complete Section 7: Caregiver Information on page 4 of this application.**

SECTION 1: Patient Information

First Name:

Last Name:

Date of Birth (MMM/DD/YY):

Male: ☐ Female: ☐ Other: ☐

Email:

Phone #:

Fax # (if applicable):

SECTION 2: Insurance Information (optional)

This section is for Union members only. Ensure to select the appropriate box to confirm your status with the union.

Insurance Company:

Group Policy #:

Cert / Member #:

If you are part of a union local, please indicate which local # here:

Active Member: ☐ Active Dependant: ☐ Retiree Member: ☐ Retiree Dependant: ☐

SECTION 3: Residence Address

Residence address must be in Canada ☐ Use residence address as my shipping address

Address:

Address 2:

Unit #:

City:

Province:

Postal Code:

Phone #:

Email / Fax # (if applicable):

Type of Residence Address

If candidate is with a hostel, shelter, etc., a manager's signature is required on page 3 of this form.

Private residence: ☐ Establishment: ☐

Type of establishment (long term care facility, shelter, etc.):

Name of establishment, if not private residence:

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SECTION 4: Alternative Mailing Address (optional)

To be completed if: Residence address in Section 3 is not your shipping and/or mailing address or if the applicant does not have a permanent address. If the manager from a specified institution provides services to the applicant, the manager must also sign below.

Alternative address must be in Canada ☐ Use this alternative mailing address as my shipping address

Address:

Address 2: | Unit #: | City:

Province: | Postal Code: | Phone #: | Email / Fax # (if applicable):

Type of Alternative Address Private residence: ☐ Establishment: ☐

Type of establishment (long term care facility, shelter, etc.): | Name of establishment, if not private residence:

If the patient lives in a resident type that requires a manager's signature (i.e. shelter, hostel, etc.), please complete this section:

I, _____ (Manager's Name), confirm that _____ (Establishment Name)

provides lodging or other social services to _____ (Applicant's Name)

Manager's Signature:

Date Signed (MMM/DD/YYYY):

SECTION 5: Health Care Practitioner Information (optional)

If the health care practitioner who provided the medical document has agreed to receive cannabis products on behalf of the applicant, please complete this section.

☐ Use health care practitioner address as shipping address

First Name: | Last Name:

Address:

Address 2: | City:

Province: | Postal Code: | Phone #: | Email / Fax # (if applicable):

I hereby consent to receive cannabis on behalf of the patient listed on page 1.

Health care practitioner signature:

Date Signed (MMM/DD/YYYY):

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SECTION 6: Authorization of Applicant

As applicant or a responsible individual you acknowledge, attest, agree and consent to the following:

(i) the applicant ordinarily resides in Canada;
(ii) the information in the application is correct and complete;
(iii) the medical document that forms the basis for the application has not, to the knowledge of the individual signing the statement, been altered;
(iv) the medical document is not being used to seek or obtain cannabis products from another source;
(v) 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;
(vi) in the case where an adult who is responsible for the applicant is signing the statement, they are responsible for the applicant; and
(vii) I authorize Starseed and my healthcare practitioner to disclose my personal health information consisting of: dose information of cannabis used for medical purposes, as a verification of the healthcare practitioner's orders, as required and on a continuous basis. I have been informed of how my personal health information will be used and understand the purpose for disclosing my personal health information noted above. I understand that I can refuse to sign this consent, and this may be withdrawn or amended at any time.

The applicant acknowledges that cannabis products are not an approved therapeutic products and cannabis has not been authorized through the standard Health Canada drug approval process because the available scientific evidence does not establish the safety and efficacy of cannabis to the extent required by the Food and Drug Regulations for marketed drugs in Canada.

The applicant acknowledges that they are using any medical cannabis or related product obtained from Starseed Medicinal Inc. at their own risk. The applicant also specifically releases Starseed Medicinal Inc. (and its service providers, officers, directors and staff) from any and all actions, claims, complaints and demands for damages, loss or injury whatsoever, whether arising directly or indirectly as a consequence of the use of Starseed's products or services.

In order to receive our products and services, the applicant or authorized person gives consent to Starseed Medicinal Inc. to disclose the necessary personal information to Starseed's service providers, including North Star Wellness Inc., and including without limitation, the health care practitioner named in this registration, in accordance with Starseed's Privacy Policy (www.starseed.com/privacy/).

The applicant and/or authorized person consents to the healthcare practitioner named in this registration application disclosing to Starseed Medicinal Inc. the applicant's personal health information by phone, physical means or digital means (including Starseed's online portal or SFax secure system) for the purposes of processing this registration (which may include the submission of my Medical Document by digital means), client service and complying with the requirements of the Cannabis Regulations. The applicant understands and agrees that a copy of this consent and registration application may be provided to the healthcare practitioner named in this registration.

☐ I consent to the terms above.

Applicant Signature:

Date Signed (MMM/DD/YYYY):

Please send this completed document and your Medical Document to Starseed at the contact information above.