REGISTRATION APPLICATION

PureSinse Inc. Phone: 1-866-899-7873 | Secure Fax: 1-888-216-6798 | P.O Box 2247, Brampton, ON L6T 3Y9 | https://puresinse.com

PureSinse is required to collect the following information of the Applicant pursuant to the Cannabis Act and may be amended from time to time. PureSinse collects, uses and discloses personal information only in accordance with the provisions of the *Personal Information Protection and Electronic Documents Act,* the *Ontario Personal Information Protection Act*, the *Cannabis Act,* and PureSinse's Privacy Policy and only for the purpose of providing medical marihuana and related services to Applicants.

At any time, Applicants may access their personal information contained in PureSinse's records and correct such information if necessary by submitting an Amendment Application to PureSinse.

All fields are mandatory unless specified with an * and relative notes. Clarification to those fields may be provided. Information provided

Applicant Information (The "Applicant")

Please note that the personal information provided on this form must match the information that appears on your Medical Document. Please contact our client care team at **1-866-899-7873** if you require any assistance while completing this application.

Client Name

Given Name | Middle Name | Surname

Date of Birth

Year | Month | Day

Gender ☐ Male ☐ Female

Contact Info
(Complete one or more)

Phone | Email | Fax or secondary phone

Residing Address

Residing Address | Unit Number (If applicable)

City | Province | Postal Code

If your residing address is not a private residence, please Check the box and fill out section A on the following page ☐

Mailing Address of Residence

Please provide the mailing address associated with the residence listed above.

Same as residential address above ☐

***Mailing Address (If different from above)**

Mailing Address | Unit Number (If applicable)

City | Province | Postal Code

Shipping Address

NOTE: This is the address we will ship your product to.

This address must be either your residing address, the mailing address of the residence, or the business address of the Health Care Practitioner who completed the Medical Document and has consented to receive marihuana on your behalf (please note: Applicants without a residential address must have their product shipped to the Health Care Practitioner who completed their Medical Document.)

☐ Same as residing address

☐ Same as mailing address

☐ Health care practitioner's business address as specified in the Medical Document (please fill out section B on the following page)

Section A: Non-Private Residence

*Required If address is non-private

Type (Example: nursing or care home)

Name Name of Establishment

Contact Info (Complete one or more)

Phone | Email | Fax

Signature

Signature of Manager

Date Year | Month | Day

I hereby certify that I am a manager of the above listed establishment and that we provide food, lodging, or other social services to the Applicant listed above.

Section B: Health Care Practitioner Delivery

*Required if shipping product to Health Care Practitioner

Have your health care practitioner complete this section if they have agreed to receive medical marihuana on your behalf. Product will ship to the business address specified on the Medical Document.

Practitioner Title and Name

Title | Given Name | Surname

Name of Health Care Practitioner , agree to receive medical marihuana on behalf of Name of Applicant

Signature

Signature of Health Care Practitioner

Date Year | Month | Day

Note to health care practitioners: If at any time you cease to consent to receive dried marihuana on behalf of the client, you must send a written notice to that effect to both the client and the licensed producer.

Individual Responsible for Applicant

*To be completed by the individual responsible for the Applicant (if applicable).

Name

Given Name | Surname

Date of Birth

Year | Month | Day

Gender ☐ Male ☐ Female

Contact Info (Complete one or more)

Phone | Email | Fax or secondary phone

Name of Responsible Individual , attest that I am responsible for Name of Applicant

Signature

Signature of Responsible Individual

Date Year | Month | Day

Acknowledgement of Applicant or Responsible Individual

- The Applicant acknowledges that some of the information provided in this document may be shared with our service providers for shipping purposes only.
- The Applicant understands and acknowledges that any Medical Documents sent with this form can not be returned once registration is complete.
- The Applicant acknowledges that, where the Applicant has been referred to PureSinse by a third-party intermediary, PureSinse may share some personal information collected by PureSinse, including information provided in this document, with the applicable third-party intermediary.
- The Applicant ordinarily resides in Canada.
- The information in this application and the Medical Document is correct and complete.
- The Medical Document that forms the basis for this application has not, to the knowledge of the individual signing the statement, been altered.
- The Medical Document is not being used to seek or obtain dried marihuana from another source.
- The original of the Medical Document accompanies the application.
- The Applicant will use dried marihuana only for their own medical purposes.
- In the case where the individual signing is not the Application, they acknowledge they are responsible for the Applicant.

Signature

Signature of Applicant

OR

Signature of Responsible Individual (if applicable)

Date

Year Month Day

☐ I agree to receive PureSinse's newsletter and other electronic messages containing news, updates and promotions regarding PureSinse's products and activities. You may withdraw your consent at any time.