



Patient Application Form

Phone: 1-833-713-CARE (2273)

Secure Fax: 1-877-226-5909

Email: care@zyus.com

www.zyus.ca

Section 1 – Patient Information

Given Name		Surname	
Date of Birth MM/DD/YY		Gender	Male Female Prefer Not to Say
Telephone		Email	

Are you a Canadian veteran?

If so, please provide your Blue Cross Number. (Don't forget to provide a copy of your card and ensure your condition is recorded on the submission of your Medical Document as required by Veteran Affairs)

Veteran's Blue Cross Number	
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Type of Registration

New Patient Returning Patient

Section 2 – Patient Contact Information

A. Physical Address Must be a Canadian Residence (Section 2A is mandatory)

Physical Address		Apt			
City		Province		Postal Code	

B. Mailing Address (Only applicable if different from Section 2A)

Mailing Address		Apt			
City		Province		Postal Code	

C. Shipping Address (Only applicable if different from Section 2A)

Shipping Address		Apt			
City		Province		Postal Code	

I have requested that cannabinoid products be delivered to my healthcare practitioner's office, with their consent noted on the medical document.

Section 3 – Residence Type

Private Residence	Establishment* (long-term care, shelter, hostel)		
*Attestation of residence is required if the patient resides in an Establishment. Establishment manager must complete this section.			
I (Manager's name) _____ confirm that			
(Name of establishment) _____ provides food, lodging, or other social services to the patient.			
Type of Establishment			
Manager's Email			
Manager's Signature		Date MM/DD/YYYY	

Section 4 – Person Responsible/Caregiver Information (If Applicable)

A caregiver is a designated person who is responsible for the patient and/or applying on behalf of the patient.

Given Name		Surname	
Date of Birth MM/DD/YYYY		Gender	Male Female Prefer Not to Say
Relationship to the Patient			
Telephone		Email	

Person Responsible/Caregiver Acknowledgement and Confirmation

I, (Caregiver's name) _____ acknowledge that I am the caregiver for (Patient's name) _____ and take responsibility for the ordering, safe storage and administration of cannabinoid products.

Caregiver's Signature		Date MM/DD/YYYY	
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Section 5 – Declaration of the Applicant (or Person Responsible for the Applicant)

- The applicant acknowledges that cannabinoids have not been approved for use as a drug in Canada, that its indications, safety and risks have not been adequately studied and the appropriate dosage is unclear.
- The applicant acknowledges and agrees that he or she is using any cannabinoid product obtained from ZYUS Life Sciences Inc.(ZYUS) at his or her own risk and releases ZYUS, its affiliates, providers, directors, officers and employees 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 cannabinoids obtained from ZYUS.
- The applicant ordinarily resides in Canada.
- The information in this application and medical document or registration certificate is correct and complete.
- The medical document has not, to the knowledge of the applicant been altered.
- The medical document is not being used to seek or obtain cannabinoids from another source.
- The applicant intends to use any cannabinoid products supplied to them on the basis of this application only for their own medical purposes.
- The applicant consents to ZYUS' collection, use and disclosure of personal information contained in this patient registration form, medical document or registration certificate (if applicable), in order to complete registration of the applicant and communicate with the healthcare practitioner named in the medical document, licensing authorities and ZYUS' service providers , in accordance with ZYUS' privacy policy and applicable laws.
- If the applicant has a specified K number on this application, the applicant consents to ZYUS. Sharing personal details and information contained in this application with Veterans Affairs Canada or the applicant's insurance provider.
- The applicant consents and permits ZYUS to send product and registration information to the physical addresses identified in the patient registration form, and communicate with the applicant via email regarding registration status, product availability, order status, and other matters in accordance with ZYUS' privacy policy.

Section 6 – Signature of Patient or Person Responsible/Caregiver for the Patient

Signature of Patient		Date MM/DD/YYYY	
Signature of Person Responsible for Patient (if applicable)		Date MM/DD/YYYY	

Section 7 – How to Submit Application

Option 1: Online	Option 2: Email	Option 3: Secure Fax	Option 4: Mail
Register online at www.ZYUS.ca	Email your registration to care@zyus.com	1-877-226-5909	ZYUS Patient Care 204 - 407 Downey Road Saskatoon, SK S7N 4L8

Section 8 – This Section is Optional

I consent to receiving updates from ZYUS regarding clinical trials, news and educational material. I understand that I may withdraw my consent at any time.