ZYUS™

# 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

First Name _____ Last Name _____

Date of Birth (MM/DD/YYYY) _____ Telephone _____ Email _____

☐ New Patient ☐ Returning Patient

☐ Are you a Canadian Veteran? If so, please provide your Medavie Blue Cross Number for billing purposes: _____

## Section 2 – Patient Contact Information

**A. Residential and/or Land Location Address (must not be PO Box)**
**(If you do not have a fixed address, please contact ZYUS' Patient Care Team for further assistance)**

Physical Address _____ Apt. _____

City _____ Province _____ Postal Code _____

Type of Residence: ☐ Private Residence ☐ Establishment (long-term care)

*If the patient resides in an Establishment, please provide the following information:*

Type of Establishment _____ Name of Establishment _____

**B. Mailing Address (Complete this section only if it is different from above)**

Mailing Address _____ Apt. _____

City _____ Province _____ Postal Code _____

**C. Please confirm where you would like your cannabinoid products to be delivered to (select one of the following):**

☐ Physical Address ☐ Mailing Address

☐ I have requested that cannabinoid products be delivered to my Healthcare Practitioner's office, with their consent noted on the Medical Document.

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## Section 3 – Person Responsible/Caregiver Information (if applicable)

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

First Name of Person Responsible/Caregiver _____

Last Name of Person Responsible/Caregiver _____

Date of Birth (MM/DD/YYYY) _____

Telephone _____

Email _____

## Section 4 – Declaration of the Applicant (or Person Responsible/Caregiver)

- 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 consented to direct billing (i.e. WCB, insurance provider, Veteran Affairs) the applicant consents to ZYUS sharing personal details and information contained in this application with the third party.
- 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.

**By signing here, I confirm that the above statements are correct.**

Signature of Patient _____

Date (MM/DD/YYYY) _____

Signature of Person Responsible/Caregiver (if applicable) _____

Date (MM/DD/YYYY) _____

## Section 5 – How to Submit Patient Application

| Option 1: Online | Option 2: Email | Option 3: Secure Fax | Option 4: Mail |
|---|---|---|---|
| www.ZYUS.ca | care@zyus.com | 1-877-226-5909 | ZYUS<br>Attention: Patient Care<br>407 Downey Road, Unit 204<br>Saskatoon, SK S7N 4L8 |

## Section 6 – 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.