15693 Highway 4 Wentworth, NS B0M 1Z0
Toll Free Phone: **1.833.295.3200**
Email: orders@breathinggreen.com

CLIENT AMENDMENT FORM

CLIENT'S UNIQUE IDENTIFIER: _____ ☒ CHECK BOXES IF APPLICABLE

CLIENT'S INFORMATION

AMENDED ☐ *If checked, provide new (changed) information for this section below.*

Proof of Client's information change under this section must be provided.

CLIEN'TS NAME: _____ _____
Surname Given Name

DATE OF BIRTH: _____ _____ _____ **GENDER:** ☐ **MALE** ☐ **FEMALE**
Day Month Year

PART A: CLIENT'S RESIDENCE

AMENDED ☐ *If checked, provide new (changed) information for this section below.*

RESIDENCE (must be in Canada and cannot be Post Office Box)
The address of the place in Canada where the Client ordinarily resides.
If the Client ordinarily resides in Canada but has no dwelling place (e.g a Client is a homeless person), complete this section below, providing the address information for a shelter, hostel or similar institution, located in Canada, that provides food, lodging or other social services to the Client.

ADDRESS: _____

CITY: _____ **PROVINCE:** _____ **POSTAL CODE:** _____

TELEPHONE: _____ **FAX:** _____ **E-MAIL:** _____

The above address is one of the following:

☐ a private residence (e.g house or apartment)

☐ An establishment that is not a private residence (e.g. hospice, hospital, nursing home, etc.)
If checked, complete details for the establishment

ESTABLISHMENT TYPE: _____

ESTABLISHMENT NAME:_____

☐ An institution that provides food, lodging or other social services to the Client (e.g. shelter, hostel or similar institution)
If checked, complete details for the institution and attestation of residence.

INSTITUTION TYPE: _____

INSTITUTION NAME:_____

ATTESTATION OF RESIDENCE:
To be completed by a manager of the specified above institution (shelter, hostel or similar institution):

I _____ attest and confirm that institution specified above, located at the address referred to in the "Residence"
Insitution Manager's Name

section of this application, provides food, lodging or other social services to the following Client _____
Client's Name

MANAGERS SIGNATURE: _____ **DATE:** _____

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CLIENT AMENDMENT FORM

PART B: CLIENT'S MAILING AND SHIPPING ADDRESS

To be completed by the Client or by an individual who is responsible for the Client and referred to in Part C of this application.

MAILING ADDRESS: (must be in Canada)

AMENDED ☐ *If checked, provide new (changed) information for this section below.*

The mailing address of the place referred to in section "Residence" above, if different from the address provided under that section.

SAME AS RESIDENCE: ☐

ADDRESS: _____

CITY: _____ **PROVINCE:** _____ **POSTAL CODE:** _____

SHIPPING ADDRESS: (must be in Canada)

AMENDED ☐ *If checked, provide new (changed) information for this section below.*

Indicate which one of the following is to be the shipping address:

☐ SAME AS RESIDENCE; OR

☐ SAME AS MAILING ADDRESS; OR

☐ THE BUSINESS ADDRESS OF THE HEALTHCARE PRACTITIONER WHO PROVIDED THE MEDICAL DOCUMENT TO THE CLIENT (1)

(1) If the shipping address is the address of the Healthcare Practitioner who provided the Medical Document to the client, the consent statement in Part D of this application must be signed and dated by that Healthcare Practitioner.

PART C: INDIVIDUAL(s) RESPONSIBLE FOR THE CLIENT (complete if applicable)

This Part C of the application must be completed if the Client has changed information regarding a person (Caregiver) who is responsible for the Client

RESPONSIBLE INDIVIDUAL (I):

AMENDED ☐ *If checked, provide new (changed) information for this section below.*

The mailing address of the place referred to in section "Residence" above, if different from the address provided under that section.

NAME: _____ _____
Surname Given Name

DATE OF BIRTH: _____ _____ _____ **GENDER:** ☐ **MALE** **FEMALE**
Day Month Year

TELEPHONE: _____ **FAX:** _____ **E-MAIL:** _____

I _____ attest that I am an individual who is responsible for the

Client _____

CLIENT AMENDMENT FORM

PART D: HEALTHCARE PRACTITIONER WHO PROVIDED MEDICAL DOCUMENT TO THE CLIENT

To be completed by the Client or by an individual who is responsible for the Client and referred to in Part C of this application.

HEALTHCARE PRACTITIONER'S CONSENT TO RECEIVE DRIED MARIHUANA ON BEHALF OF CLIENT.
(complete if applicable)

AMENDED ☐ *If checked, provide new (changed) information for this section below.*

I _____ do hereby attest and confirm my consent to receive medical marihuana
Print Healthcare Practitioner's Name

on behalf of the Client _____ at my business address specified in this section
Client's Name

below, which is the same as my business address specified on the Medical Document that I provided to the Client.

BUSINESS NAME: _____

ADDRESS: _____

CITY: _____ **PROVINCE:** _____ **POSTAL CODE:** _____

TELEPHONE: _____**FAX:** _____ **E-MAIL:**_____

HEALTHCARE PRACTITIONER'S SIGNATURE:_____ **DATE:**_____
Day / Month / Year

PART E: STATEMENTS AND SIGNATURE BY CLIENT OR RESPONSIBLE INDIVIDUAL

To be completed by the Client or by an individual who is responsible for the Client and referred to in Part C of the application or Part C of this registration Application. IMPORTANT: Carefully read all statements below before signing the application.

By signing this document below the Client and/or individual who is responsible for the Client is attesting that:

(a) The Client is ordinarily resident in Canada;
(b) The information in the application is correct and complete;
(c) The responsible individual is an individual who is responsible for the Client.

The Client and/or individual who is responsible for the Client acknowledge that marihuana for medical purposes, or cannabis generally, is not approved for the use as a drug, natural health product or food in Canada, and that is use of any kind, indications, efficacy, safety and risks have not been adequately identified or studied, and the appropriate dosage is unclear.

The Client and/or individual who is responsible for the Client acknowledge and agree that they are using any marihuana for medical purposes product obtained from Breathing Green Solutions, at their own risk, and releases Breathing Green Solutions, including directors, officers, employees, contractors and affiliates of Breathing Green Solutions, 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 marihuana for medical purposes obtained from Breathing Green Solutions. There fore the Client and/or individual who is responsible for the Client acknowledge and agree that they voluntarily accept and assume the risks and dangers associated with the use of marihuana for medical purposes obtained from Breathing Green Solutions.

The Client and/or individual who is responsible for the Client give their consent to Breathing Green Solutions to receive, retain, use and disclose their personal information as it necessary Breathing Green Solutions to (i) process this application (ii) as is required by the Marihuana for Medical Purposes Regulations.

CLIENT, OR RESPONSIBLE INDIVIDUAL

SIGNATURE: _____ **DATE:** _____
Day / Month / Year

PRINT NAME: _____