CANADA OUTREACH PHARMACY

PHONE:	FAX:	INTERNET:
MAILING ADDRESS:		

Step 1 – Personal Information

First Name (Middle Name) Last Name ☐ Male ☐ Female DOB (MM/DD/YY)

Street Address City State Country Zip Code

Phone (Home) Phone (Other) Email

Please Check if you're placing this order for a pet. ☐Cat ☐Dog ☐Other ( )

Step 2 – Order Details

Generic OK?	Medications	Strength	Quantity	Have you used this medication before? (Y/N)	Price (USD)
Shipping Options:				SHIPPING	
$13.75 – Standard Shipping (ETA 14 days)					
$18.75 – Expedited Shipping (ETA 10 days)				TOTAL	
$22.00 – Express Shipping (ETA 7 days)					
$25.00 – Refrigerated Shipping (ETA 7 days)					

Step 3 – Medical Information

Do you have any known allergies?
If yes, what are they:

Medication,OTC,Herbal products you are currently taking

☐ Please contact me about my order.

☐ I have questions about my medication for the pharmacist .

☐ I am currently pregnant or attempting to get pregnant.

☐ I am currently breastfeeding.

Step 4 – Payment Information

☐Visa ☐ Amex ☐ Mastercard ☐Discover

Credit Card Number

Cardholder Name Expiry (MM/YY) CCV (picture)

Billing address (if different from shipping address)

Billing address (if different from shipping address)

Patient Authorization (Please Check One)

Cloud Pharmacy operates a pharmacy in Vancouver, British Columbia, Canada specializing in the business of assisting pharmacies both within Canada and internationally. The following terms and conditions govern the sales between **Cloud Pharmacy** (The "Pharmacy) and the individual (the patient) regarding the products and services offered by the Pharmacy. The Patient represents to the pharmacy that,

☐ **"I am over the age of majority and:** 1) I have disclosed my personal and health information accurately and fully consent to its use by the Pharmacy. I have had a physical examination by a medical doctor in the last 12 months and do not require a physical examination. 2) I understand that all the products sold and dispensed operate within a unique international jurisdiction in a manner consistent with the laws. **OR**

☐ **" I am the parent/legal guardian/power of attorney for the patient disclosed. I am over the age of majority and have full authority to sign and provide the above Information to the pharmacy on the patient's behalf."**

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Patient's Signature Date (MM/DD/YY)