Application Form A

Health Care Practitioner to receive Applicants product

Complete this form if your Healthcare Practitioner is consenting to receive your product for you.

Health Care Practitioner information can be filled out on page 2 of this form. He/she must sign the declaration at the bottom of that page.

If you are a person responsible for the applicant, please complete page 3 of this form and include it in the application package.

Applicant information

First Name	Last Name	DOB (mm/dd/yyyy)	Gender M / F

Optional Information	Health Insurance

Contact information

Physical address – Primary Physical Residence must be in Cayman Islands. If providing a box # you must also include your physical residence.

Address Line 1			Address Line 2	
Town			Postal Code	KY1-
Phone #	Cell	Fax	E-mail address (required for online orders)	

Mailing Address – Address where you receive your usual mail correspondence. If different than above.

Address Line 1	Address Line 2	
Town	Postal Code	KY1-

Declaration of Applicant or the Person Responsible for the Applicant

Important, please read and sign below:

- The applicant acknowledges that cannabis extracts and tinctures of cannabis are approved for medical and therapeutic purposes only under the supervision of a medical practitioner. This indicates that 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 medical cannabis product obtained from FARSIDE TheraMed ltd. at his or her own risk, and releases FARSIDE TheraMed ltd. [and its partners, including FARSIDE TheraMed (Jamaica) ltd. or FARSIDE medical consultants] 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 cannabis extract obtained from FARSIDE TheraMed ltd.
- The applicant is ordinarily a resident of the Cayman Islands.
- The information in the application and the medical document or Registration Certificate is correct and complete.
- The Medical Document or Registration Certificate is not being used to seek or obtain cannabis extracts and tinctures of cannabis from another source.
- The original Medical Document or copy of Registration Certificate (to provide interim supply) is provided in support of this application or has/will be sent separately.
- The applicant will use cannabis extracts and tinctures of cannabis, only for their own medical purposes.
- The applicant gives consent to FARSIDE TheraMed ltd. to forward the necessary personal information to our production licensed producer, the applicants' health care practitioner and service providers for purchasing, shipping, verification and distribution purposes only. **Note:** this consent is required to receive our products.
- The applicant gives consent to his or her health care practitioner to forward the necessary personal information to FARSIDE TheraMed Ltd. in order to register the applicant and fulfill his or her orders.

Signature	Date
Applicant/Person Responsible for Applicant	DD/MM/YYYY

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Health Care Practitioner information

First Name	Last Name
Date of birth	Medical Licence Number

Clinic/Business Name		
Address Line 1	Address Line 2	
Town	Postal Code	KY1-
E-mail address		

Shipping Address- Address where products will be shipped. If different than above

Address Line 1	Address line 2	
Town	Postal Code	KY1-

I, _____ consent to receive cannabis extracts and tinctures on behalf

Health Care Practitioners names

of _____.

Applicants Name

Notice to the Health Care Practitioner

If the Health Care Practitioner no longer wants to receive cannabis extracts and tinctures of cannabis on behalf of a patient, he or she must send a written notice to FARSIDE as well as the patient. Notice can be sent to FARSIDE at:

Cardinal Plaza, Cardinal Ave
P.O. Box 481
Grand Cayman, CI KY1-1111

Phone: 1.345.938.XXXX
Email: info@farsidetheramed.com