VETERANS AFFAIRS CANADA ATTESTATION FORM

AGMEDICA BIOSCIENCE INC.
104-566 Riverview Drive | Chatham, ON N7M 0N2
tf. 1-844-5MY-CARE (1-844-569-2273) f. 1-866-927-8847
e. clientcare@agmedica.ca www.agmedica.ca

PART A

Complete Part A, as well as any section that applies to your current arrangements of receiving medical cannabis.

Client's Name

Given Name	Middle Name	Surname

Date of Birth (MM/DD/YYYY) ____________

Veterans Affairs Canada Health Benefit #: ____________

- ☐ New to AgMedica Bioscience Inc. *(see Part B)*
- ☐ Splitting Prescription between two Licensed Producers *(see Part C)*
- ☐ Switching from a different Licensed Producer to AgMedica Bioscience Inc. *(see Part D)*
- ☐ Switching from one Licensed Producer to multiple Licensed Producers *(see Part E)*
- ☐ Switching from multiple Licensed Producers to alternate multiple Licensed Producers *(see Part F)*

Before submitting this document please verify all information is correct and accurate to the best of your knowledge, and then sign and date Part G.

PART B: NEW TO AGMEDICA BIOSCIENC INC.

Complete this section ONLY if you are a new medical cannabis client and have NOT been registered with any other licensed producer previously.

I, ______________________________, certify that:
Given Name / Surname

- ☐ I do not have a medical cannabis prescription with any other Licensed Producer in Canada other than AgMedica Bioscience Inc.
- ☐ I am not registered with another Licensed Producer in Canada other than AgMedica Bioscience Inc.

PART C: SPLITTING PRESCRIPTIONS BETWEEN TWO LICENCED PRODUCERS

Complete this section ONLY if your total medical cannabis prescription is split between two Licensed Producers.

I, ______________________________, certify that effective today, I wish to split my medical cannabis prescription.
Given Name / Surname

My medical cannabis prescription is split between:

1. ______________________________ For ______________________________ grams per 30-day period

2. ______________________________ For ______________________________ grams per 30-day period

Please make the necessary notation in my profile.

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OR SCAN & EMAIL TO: clientcare@agmedica.ca

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PART D: SWITCHING FROM A DIFFERENT LICENSED PRODUCER TO AGMEDICA BIOSCIENCE INC.

Complete this section ONLY if you are switching from another Licensed Producer to AgMedica.

I, ________________________________, certify that effective today, I wish to change my licensed producer of choice.
Given Name / Surname

My medical cannabis prescription from:

________________________________ for ________________________________ grams per 30-day period will now be changed to: ________________________________ grams per 30-day period with AgMedica.

Please make the necessary adjustments to my file.

My last order of medical cannabis from ____________________________ was for ____________________ grams on ______________________.
(MM/DD/YYYY)

PART E: SWITCHING FROM ONE LICENSED PRODUCER TO MULTIPLE LICENSED PRODUCERS

Complete this section ONLY if you are switching from ONE Licensed Producer to multiple Licensed Producers.

I, ________________________________, certify that effective today, I wish to change my medical cannabis prescription of:
Given Name / Surname

__________ Grams per 30-day period with ____________________________ to:

__________ Grams per 30-day period with ____________________________ and

__________ Grams per 30-day period with ____________________________.

Please make the necessary notations and adjustments to my file.

PART F: SWITCHING FROM MULTIPLE LICENSED PRODUCERS TO ALTERNATE MULTIPLE LICENSED PRODUCERS

Complete this section ONLY if you are switching from multiple Licensed Producers to different Licensed Producers.

I, ________________________________, certify that effective today, I wish to change my medical cannabis
Given Name / Surname

prescription of:

__________ Grams per 30-day period with ____________________________ and

__________ Grams per 30-day period with ____________________________ to:

__________ Grams per 30-day period with ____________________________ and

__________ Grams per 30-day period with ____________________________.

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PART F cont.

Complete this section ONLY if you are switching from another Licensed Producer to AgMedica.

My last order with ______________________ was for __________ grams on ______________________.
(MM/DD/YYYY)

My last order with ______________________ was for __________ grams on ______________________.
(MM/DD/YYYY)

Please make the necessary notations and adjustments to my file.

PART G

ATTESTATION:

I attest that the information provided is true and accurate to the best of my knowledge. I understand that if any of the above statements are false or misleading I may be held liable for the cost of any medical cannabis, including applicable shipping and taxes, purchased from AgMedica Bioscience Inc. of which are not covered by my insurance because of the falsified statements in this document.

______________________________ Client Signature

______________________________ Date (MM/DD/YYYY)

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