CANADIAN PHARMACY STORE

CODE: MKT: AFF:

Phone: 1-844-768-3221
Fax: 1-844-912-0147
Email: info@canadianpharmacystore.com
Web: www.canadianpharmacystore.com

Personal Information:

Full Name (Please print clearly) ○ Male ○ Female

Street Address

City State/Province Country Zip/Postal Code

( ) ( )
Phone (Home) Phone (Other)

Email Birth Date (MM/DD/YY)

Please check if you are placing this order for a pet.

○ Cat ○ Dog ○ Other (Please specify) _____

First Time Patient Information (Authorized Contact):

Please fill out this section if you are a first time patient, or to update your information on file.

Authorized Contact:

Full Name of Secondary Contact (Please print clearly)

( )
Relationship to you Phone

Your Physician:

Primary Physician's Full Name (Please print clearly)

Clinic Name/Street Address

City State/Province Country Zip/Postal Code

( ) ( )
Phone Ext. Fax

Allergies:

Do you have any severe allergies? ○ YES ○ NO If yes, please describe below:

Join us on Facebook for Discounts and Special Offers:

To scan a QR Code open the camera app on your phone and select the rear facing camera. Hold your device so that the QR Code appears on your screen. Your device will recognize the QR Code and show a notification, tap on the notification to be brought to our Facebook page!

Medication:

For medication(s) that you wish to order, please enter the quantity (max 3 month supply), and listed price, as obtained through our website or customer service center. We will accept a copy of your prescription by Upload, Email, or Fax. Please follow up by mailing in the original prescription, to comply with Canadian International Pharmacy Association standards. (Pricing in $US).

Remember! Couples need to fill out and submit separate order forms!

Generic OK?	Medication	Strength	Qty	Price
			SHIPPING:	$0.00
			TOTAL:	

Medication (Continued):

Please list any additional medications, vitamins, minerals, and herbs you are taking (you will not be purchasing) , to comply with Canadian International Pharmacy Association standards.

Medication	Dosage	Frequency

Referral Program:

Please complete to earn a $20.00 credit for yourself and the person who referred you!

( )
Full Name of person who referred you Phone

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

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Please list the medications you would like us to contact your Doctor for, or to transfer from another Pharmacy:

Medication Name	Strength	Directions	Rx Number
We are able to contact your Doctor and/or transfer your prescription (only available to residents of the United States and Canada).			

Patient Authorization (Please check one):

Canadianpharmacystore.com™ operates a marketing and call centre business in Winnipeg, Manitoba, Canada, specializing in the business of assisting pharmacies both within Canada and internationally pursue international prescription service pharmacy. The following terms and conditions govern the sales as between Canadianpharmacystore.com™ authorized dispensary (the"Pharmacy") and the individual (the "Patient") regarding the products and services (the "Products") offered for sale by the Pharmacy. The Patient herein represents to the Pharmacy that,

☐ "I am over the age of majority, and:

1. I have fully and accurately disclosed my personal information and personal health information and consent to its use by the Pharmacy, have had a physical examination by a physician within the last 12 months, and do not require a physical examination.

2. I understand that all Products shall be sold & dispensed by a Pharmacy operating within a unique international jurisdiction and in a manner consistent with the laws of that jurisdiction.

3. I authorize and appoint the Pharmacy, as my attorney and agent, to take all steps, sign all documents and to act on my behalf as if I were personally present and acting myself for the limited purposes of (a) obtaining a valid prescription for any prescription which I have sent the Pharmacy; and (b) packaging my prescriptions and delivering them to me. This authorization shall include, but not be limited to: collecting and using my personal and personal health information as reasonably necessary for the fulfillment of my order, including disclosure to a licensed physician if required for the issuance of a valid prescription in the jurisdiction of the Pharmacy. This authorization may be revoked at any time and shall continue until I revoke it.

4. I understand that the Pharmacy is legally incorporated and authorized by law to carry on business in the jurisdiction of the Pharmacy, and that I am purchasing medications that have been approved for sale in the jurisdiction of the Pharmacy. Title to my medications passes from the Pharmacy to me in the jurisdiction of the Pharmacy when my medications leave the Pharmacy. All agreements reached or contracts formed with the Pharmacy shall be deemed to be made in the jurisdiction of the Pharmacy, the laws of the jurisdiction of the Pharmacy shall govern all transactions, and I attorn to the courts of the jurisdiction of the Pharmacy, which shall have sole and exclusive jurisdiction over any dispute arising between me and the Pharmacy, its affiliates, officers and directors.

I HAVE READ AND UNDERSTAND THESE TERMS AND AGREE THAT THEY SHALL BE BINDING UPON ME AND MY ASSIGNS, HEIRS AND PERSONAL REPRESENTATIVES."

OR

☐ "I am the parent/legal guardian/power of attorney for the Patient disclosed herein, am over the age of majority, and have full authority to sign for and provide the above representations to the Pharmacy on the Patient's behalf."

_____ / _____

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

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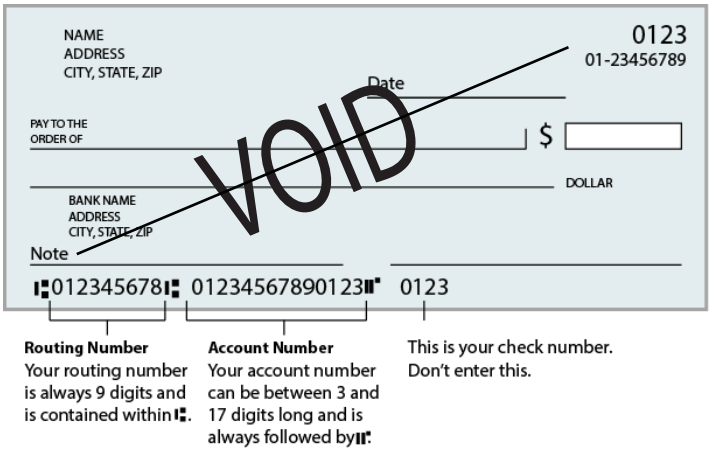
Payment Option 1:

Electronic Checking (Please provide your banking Check information):

Your Routing Number

Your Account Number

Please include a copy of a voided check for verification purposes:



Routing Number
Your routing number is always 9 digits and is contained within ⑆.

Account Number
Your account number can be between 3 and 17 digits long and is always followed by ⑈.

This is your check number. Don't enter this.

Payment Option 2:

Personal Check, Cashier's Check or International Money Order:

Please make Personal Check or International Money Order paid to:

Ecom Payments

- ◯ I will send a PERSONAL check.
- ◯ I will send a CASHIER'S check.
- ◯ I will send an International Money Order. (Included with forms)

Canadian Pharmacy Store
PO Box 20, St. Boniface
Winnipeg, MB, Canada
R2H 3B4

Mailing/Information Contact:

◯ Option 1:

Please mail your prescription and these forms to the address above:

◯ Option 2:

Contact My Doctor Please mail these forms to the address above and make sure that your Doctor's information is accurately filled out on page 1.

◯ Option 3:

Please mail these forms to the address above and transfer my prescription from another Pharmacy .

Rx Number of prescription

Pharmacy Name (Please print clearly)

Street Address

City | State/Province | Country | Zip/Postal Code

( ) | Ext. | ( )
Phone | Fax

Please use this form to submit your prescription(s), and send it back to us to complete your order.

/

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