

STEP 3: SUPPLEMENTAL ATTESTATION FORM

Individual(s) responsible for the applicant (caregiver info)

Given Name: _____ Birthdate: _____
YEAR | MONTH | DAY

Surname: _____ Gender: Male Female Unspecified

Phone Number: _____ Email: _____

I am responsible for: *(Print name of applicant)* _____ Relationship to applicant: _____

Individual Responsible (Caregiver): I hereby attest that I am responsible for the Applicant listed above (sign, print name and date). Check here if all Emerald correspondence should be sent to caregiver instead of the client.

▼ Signature ▼ Print Caregiver Name Below _____ ▼ Date Signed _____
YEAR | MONTH | DAY

Additional Caregiver (optional)

Given Name: _____ Birthdate: _____
YEAR | MONTH | DAY

Surname: _____ Gender: Male Female Unspecified

Phone Number: _____ Email: _____

I am responsible for: *(Print name of applicant)* _____ Relationship to applicant: _____

Individual Responsible (Caregiver): I hereby attest that I am responsible for the Applicant listed above (sign, print name and date). Check here if all Emerald correspondence should be sent to primary caregiver instead of the client.

▼ Signature ▼ Print Caregiver Name Below _____ ▼ Date Signed _____
YEAR | MONTH | DAY

Healthcare Practitioner attestation to receive dried cannabis or cannabis oil for client

Healthcare Practitioner Title: Doctor Nurse Practitioner

Name (Given/Surname): _____ Clinic/Business Name: _____

Street Address: _____ Unit #: _____ Buzzer Code (optional): _____

City/Town: _____ Province: _____ Postal Code: _____

I hereby attest that I consent to receive dried cannabis or cannabis oil on behalf of the Applicant (sign, print name and date below).

▼ Signature ▼ Print Name Below _____ ▼ Date Signed _____
YEAR | MONTH | DAY