CanadaRxConnection.com

Patient Order Form

Phone: 1-866-896-7099 Fax: Internet: www.CanadaRxConnection.com

Mailing Address: 1203 Richard Ave, Winnipeg, Canada R3E 3H3

Personal Information

Full Name (please print clearly) ⬭ Male ⬭ Female

Street Address

City State/Province Country Zip/Postal Code

( ) ( )

Phone (Home) Phone (Other)

/ /

Email Birthdate (MM/DD/YY)

Best time to be contacted

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

⬭ Cat ⬭ Dog ⬭ Other _____(Please specify)

Would you like to receive a call to remind you of future refills? ⬭ Yes ⬭ No

Medication

For medication(s) that you wish to order, please enter the quantity, and listed price, as obtained through our website or customer service center. An original prescription from your doctor's office is required (mailed, emailed or called in from your Doctor).

GENERIC OK?	MEDICATION	STRENGTH	QTY	PRICE
			SHIPPING	$15.00
⬭ Check box if you do NOT want childproof caps			TOTAL:	

Payment Options

Credit Card ⬭ Visa ⬭ MasterCard ⬭ Other

Cardholder's Name

Cardholder's Address

City State/Province Country Zip/Postal Code

Credit Card Number

/

Credit Card Expiry (MM/YY) CVV Code

OR Check
USA/Canada Only

If sending a check or international money order send to:

CanadaRxConnection

1203 Richard Ave
Winnipeg, Canada
R3E 3H3

First Time Patients

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

Secondary Contact

Full Name of Secondary Contact

( )

Relationship To You Phone Number

Your Physician

Primary Physician's Name

Clinic Name, Street Address

City State/Province Country Zip/Postal Code

( ) ( )

Phone Number Ext Fax Number

Allergies

Do you have any known drug allergies? ⬭ Yes ⬭ No

If yes, please enter the drug(s) you are allergic to:

Patient Authorization (Please Check One)

CanadaRxConnection is an international prescription service specializing in the delivery of mail order pharmaceuticals.

The following terms and conditions govern the sales between CanadaRxConnection (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. I 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 in a manner consistent with the laws of Canada.

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 Canada. This authorization may be revoked at any time and shall continue until I revoke it.

4. I understand that CanadaRxConnection is legally incorporated and authorized by law to carry on business in Canada. All agreements reached or contracts formed with the Pharmacy shall be deemed to be made in Canada, the laws of Canada shall govern all transactions, and I attorn to the courts of Canada, 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)