Martin Medical Services MMS Corp
604 3rd Avenue
Whitewood, Saskatchewan, Canada, S0G 5C0
questions@marijuanamailorders.com
1-306-735-7537

CAREGIVER APPLICATION FORM

Name of Qualified Member:_____ Member #: _____

Caregiver's Name: _____
First Last

Address:_____ City: _____

Province: _____ Postal Code: _____ Date of Birth: ___/___/_____
D M Y

Phone Number (s): _____ Email:_____

PLEASE CHECK THE FOLLOWING STAMENTS TO INDICATE YOUR AGREEMENT:

☐ I will act as Caregiver of the above mentioned Martin Medical Services MMS Corp Member and am allowed to assist them with the purchase of medical cannabis.

☐ I may purchase medical cannabis for the above mentioned Martin Medical Services MMS Corp Member if they are unable to come into the dispensary themselves.

☐ I am NOT qualified to purchase and use medical cannabis for myself.

CAREGIVER'S SIGNATURE: _____

DATE SIGNED: _____

Martin Medical Services MEMBER TO COMPLETE THE FOLLOWING:

☐ I authorized the above signed Caregiver to make purchases from Martin Medical Services MMS Corp on my behalf.

Print Name:_____ Date:____ / ____ / _____
D M Y

Signature:_____