APPLICATION & PATIENT MEDICAL HISTORY

COMPLETE AND FAX TO 1-866-767-1011 OR MAIL TO 7039 GATEWAY BLVD., EDMONTON, ALBERTA, CANADA T6H 2J1

Who will the prescriptions be for?

First Name _____ Last Name _____

Street Address _____ City _____ State _____ Zip Code _____

Email Address _____ ❑ Yes, send me the CMM newsletter via email containing special offers, promotions and health related information (FREE).

Tel ( ) _____ Fax ( ) _____ Business ( ) _____

Date of Birth (dd/mm/yyyy) _____ Height (ft/inch) _____ Weight (lbs) _____ Gender: ❑ Male ❑ Female

Have you had a physical examination in the last 12 months? ❑ Yes ❑ No

(To process your order, it is mandatory to have had a physical examination in the last 12 months)

Please check any current medical conditions and illnesses that apply to you.

Heart Condition or Blood Pressure ❑ Yes ❑ No

❑ Angina ❑ Arrhythmia
❑ Atrial Fibrillation ❑ Heart Attacks
❑ Congestive Heart Failure ❑ High Blood Pressure
❑ Mitral Valve Disease ❑ Stroke (CVA)
❑ Other: _____

Respiratory Condition ❑ Yes ❑ No

❑ Allergic Rhinitis ❑ Asthma
❑ Chronic Bronchitis ❑ Emphysema
❑ Other: _____

Diabetes, Thyroid, Endocrine Condition

❑ Yes ❑ No
❑ Diabetes Type 1 ❑ Diabetes Type 2
❑ Hyperthyroidism ❑ Hypoglycemia
❑ Hypothyroidism ❑ Thyroid Disease
❑ Other: _____

High Cholesterol ❑ Yes ❑ No

If Yes, diagnosed at what age:_____

Is it a common problem in your family?

❑ Yes ❑ No
❑ High Triglycerides ❑ Other: _____

Colon or Prostate Disorders ❑ Yes ❑ No

❑ Benign Prostatic Hypertrophy
❑ Colon Disorders ❑ Other: _____

Gastrointestinal ❑ Yes ❑ No

❑ Acid Reflux/Gerd ❑ Hiatal Hernia
❑ Stomach Ulcers ❑ Rectal Bleeding
❑ Lactose Intolerance Black Stools
❑ Ulcerative Colitis ❑ Crohn's Disease
❑ Irritable Bowel Syndrome
❑ Other: _____

Cancer ❑ Yes ❑ No **If yes, please specify type:**

_____

Neurological or Psychological ❑ Yes ❑ No

❑ Anxiety
❑ Attention Deficit Disorder (ADD)
❑ Bipolar disorder ❑ Depression
❑ Insomnia ❑ Migraines
❑ Panic Disorder ❑ Epilepsy
❑ Parkinson ❑ Other:

_____

Muscle, Bone or Joint Disorder ❑ Yes ❑ No

❑ Arthritis ❑ Back/Spine Disorders
❑ Gout ❑ Osteoporosis
❑ Other: _____

Chronic Illness ❑ Yes ❑ No

❑ Chronic Fatigue Syndrome ❑ Fibromyalgia
❑ Chronic Pain ❑ Multiple Sclerosis
❑ Other: _____

Kidney or Liver Disorders ❑ Yes ❑ No

❑ Renal (kidney) Failure ❑ Require dialysis
❑ Hepatitis ❑ Cirrhosis of the Liver
❑ Other: _____

Eye Disorders ❑ Yes ❑ No

❑ Glaucoma ❑ Cataracts
❑ Retinal Problems ❑ Other:

_____

Other Medical Conditions ❑ Yes ❑ No

❑ Acne ❑ AIDS
❑ Anemia ❑ Eczema/Psoriasis
❑ Smoking
Amount per day _____
How many years _____
❑ Alcohol (How often_____)
❑ Menopause ❑ Pregnancy
❑ Blood Disorders ❑ Herpes Simplex
❑ Obesity
❑ Sleeping Pills/Tranquilizers
❑ Other: _____

If you answered YES to any of the above questions please elaborate in the area below

(i.e. duration of illness, any treatment or surgery received)

PATIENT FAMILY HISTORY

(include your parents and siblings)

Diabetes, thyroid or other endocrine disorder ❑ Yes ❑ No
Relationship _____

Breast Cancer ❑ Yes ❑ No
Relationship _____

Hypertension *(high blood pressure)* ❑ Yes ❑ No
Relationship _____

Cardiovascular *(heart or artery disease)* ❑ Yes ❑ No
Relationship _____

Lipid (cholesterol) disorder ❑ Yes ❑ No
Relationship _____

Prostate Cancer ❑ Yes ❑ No
Relationship _____

Other forms of Cancer ❑ Yes ❑ No
Relationship _____

Migraine Headaches ❑ Yes ❑ No
Relationship _____

Other illnessess not previously noted:

Please list any pills or medications you are CURRENTLY taking *(drugs, natural or herbal supplements, vitamins and all other forms of medication):*

Please list all known allergies below *(including drug allergies):*

PAYMENT INFORMATION & CUSTOMER CONSENT AND WAIVER FORM

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Please choose one payment method:

1

CREDIT CARD (recommended for fastest delivery service)

❑ Please use this credit card information for my future prescription orders.

Name of Cardholder _____

Credit Card Number _____

Expiry Date ____ /____ ❑ Visa ❑ Mastercard

Cardholder Signature X _____

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❑ **Money Order:** I will send a money order for each prescription order that I place.

Referred by

Do you have a promotional code number? _____ **Where did you hear about us?** _____

The customer consent and waiver form is for you to read, date and sign. This form is a document containing the terms and conditions of joining our program. This form is used to ensure that you understand program rules such as…

- You are not a minor in the place that you reside
- That you are **not** going to share your medications with anyone
- That you understand that your US physician is your primary care physician
- That we are not allowed to accept returns of medications
- That you will not reuse your prescription form once your medications have been filled by the pharmacy
- And that Canada Medicine Mart is an agent that sends your medications

ON BEHALF OF MYSELF, MY HEIRS, ASSIGNS AND SUCCESSORS, I HEREBY AGREE TO ALL OF THE FOLLOWING TERMS AND CONDITIONS, REPRESENT THAT I UNDERSTAND ALL OF THE FOLLOWING TERMS AND CONDITIONS AND THAT I HAVE HAD ADEQUATE OPPORTUNITY TO CONSULT ANY ADVISORS NECESSARY, WHETHER MEDICAL, LEGAL OR OTHERWISE.

AUTHORIZATION AND CONSENT

- I hereby appoint Canada Medicine Mart, a division of Pharma Group USA Ltd. ("CMM"), its delegates and contractors as my agent and attorney for the purpose of obtaining a prescription from a Medical Doctor in Canada (the "Canada MD") which corresponds to the prescription included in this order. The steps to obtain a prescription from the Canada MD may include directly contacting my prescribing physician, and purchasing and arranging delivery of the medications prescribed in the Canadian prescription, substantially on the terms set forth below, all to the same extent I could if I personally took such steps.
- I hereby consent to CMM, the Canada MD and any pharmacy supplying my order, collecting my personal and medical information, maintaining the information necessary to quickly process future orders and retaining on file my name, address, phone number, payment and other information and verifying future orders.
- I confirm that my personal information will be handled only by CMM's order-processing employees and contractors (including physicians, nurses, pharmacists and pharmacy technicians) which may be updated from time to time.

DISCLOSURE AND REPRESENTATIONS

I represent that all of the following statements are true and agree that CMM and its contractors (physicians, nurses, pharmacists and pharmacy technicians) are relying on these representations:

1. I am of the age of majority or older where I reside;
2. I can make my own medical decisions according to the law of the place I reside;
3. The prescription I am requesting CMM to assist me in obtaining was prescribed by a qualified physician licensed where I obtained the prescription;
4. The prescription I am requesting CMM to assist me in obtaining has not been altered in any way nor has it been filled prior to submission to CMM. I agree to mail in original prescription and understand it is null and void once faxed into CMM unless not filled by CMM.
5. I am not violating any laws where I reside by placing this order;
6. I will use any medication obtained for me by CMM strictly as prescribed by the duly qualified medical practitioner who originally issued the prescription to me.
7. I am placing this order for medication for my sole use and I will not provide any quantity of this medication to any other person;
8. I am not seeking or relying on any medical information from CMM and I have consulted a qualified physician licensed where I obtained the prescription within the last year.
9. I will immediately contact the physician who provided my prescription included with this order in the event that I suffer any unexpected side effects from any medication obtained for me by CMM.
10. CMM has made no representations or warranties to me, including, without limitation, representations or warranties with respect to any delivered medications' usefulness or fitness for a particular purpose (including, without limitation, its appropriateness for curing or helping relieve any particular ailment, illness or disease, or its potential or actual side or adverse effects whether previously known or unknown).
11. I understand that the Canada MD with CMM is not my treating physician, has not established a physician-patient relationship with me, and has not provided any medical treatment or advice to me, nor has the Canada MD independently prescribed medication for me for any medical condition, and especially the medical condition that the prescription to be filled by CMM is intended to treat. I also understand that the limited role of any Canada MD is solely to facilitate the delivery of prescription medication from CMM as ordered by my regular treating physician, and the Canada MD has no duty to independently determine whether any prescribed medication is appropriate for the treatment of my medical condition. I agree to look exclusively to my regular treating physician should any medical issues related to my medical condition or the prescription arise. In the event that I am seeing a Canadian & American licensed physician (dual doctor) in the United States then it is understood that CMM acts solely as the agent to facilitate the delivery of prescription medications as written by the dually-licensed physician.

RELEASE AND WAIVER

I, hereby release and save CMM and its employees and contractors (including CMM physicians and nurses, pharmacists and pharmacy technicians) harmless from any and all suits, demands, liabilities, claims, actions, expenses, losses and damages of any kind or nature whatsoever, including, without limitation, general, direct, special, indirect and consequential damages and costs of litigation (including reasonable attorney fees) arising from:

1. My use of the medication obtained for me by CMM including, without limitation, any and all side effects whether previously known or unknown;
2. CMM's or its contractors' manner or timeliness of completing any actions I have authorized above, including, without limitation, their manner or timeliness in prescribing the appropriate strength, dosage, or dispensing generic drugs and non-child-protective packaging; and
3. Injury or illness, including death, arising from the fact that the prescription prescribed by my regular treating physician was not the appropriate medication, or was prescribed in an inappropriate dosage, for the treatment of my condition; and
4. My breach of any terms, conditions or representations or warranties in this agreement. Nothing in this release shall be deemed to release any CMM pharmacy or pharmacist contractors from compliance with the applicable standards of practice or usual professional duties and obligations, which a pharmacist owes.

PURCHASE AND SALE TERMS

The Canadian pharmacy will charge my credit card the following amounts: the medication price, SHIPPING COST for each order CMM ships and any applicable taxes.

In the event my payment is not authorized, CMM has the right to cancel my order and attempt to provide me with notice of such cancellation.

CMM reserves the right to refuse to assist me in obtaining any order in its sole discretion, in which event I will be entitled to a refund for monies paid for such order.

CMM does not provide its agent or attorney services as a substitute for health care or the advice of a physician.

CMM will not exchange medication or return any monies paid once an order is filled, unless the medication provided to me by the supplying pharmacy does not correspond with my prescription.

GOVERNING LAW

This agreement, along with any disputes that may arise, will be governed by and construed in accordance with the laws of the Province of Alberta, Canada.

I have read and understood all of the foregoing.

Signed this _____ day of _____, 200__

Applicant Signature:

Print Name of Applicant (Please print clearly)**:**

Signature of Witness:

Print Name of Witness: