

HOW DO I PLACE MY ORDER?

1 REGISTER
for our program by filling out
and sending the attached
registration forms

2 SEND
your prescriptions
to our toll free fax
or by mail

3 WAIT
for your
medications
to arrive at your
home

It's that easy!

HOW CAN YOUR SERVICE LOWER MY MEDICATION COSTS?

We are able to offer you the same prescription medications that you are currently taking at considerably lower prices by shipping them direct to you from a country that has government price controls on prescription medications.

IS IT SAFE?

All medications purchased through our service are shipped from licensed pharmacies that follow stringent regulatory guidelines similar to the American system.

HOW DO I PLACE AN ORDER?

Register for our program, visit your doctor to obtain a three-month prescription (with refills) and mail or fax us at our toll free number – It's that easy.

HOW LONG DOES IT TAKE TO RECEIVE AN ORDER?

98% of shipments are received within 10 days from the day you send us your order.

WHAT IF I HAVE A QUESTION?

Just contact customer service through our toll free number and they will assist you. Professional questions will be answered by one of our licensed pharmacists.

WHERE DO I OBTAIN CURRENT PRICES?

Customer service is available to provide you with price quotes 24 hours a day, 7 days a week. You can also obtain pricing by visiting us online at www.canadaprescriptionsplus.com.



Suite #551 102-17750 #10 Hwy, Surrey, BC CANADA V3S 1K4
Tel 1-866-779-7587 • Fax 1-877-979-7587 • www.canadaprescriptionsplus.com

COMPLETE AND FAX TO: 1-877-979-7587

OR MAIL TO: CANADA PRESCRIPTIONS PLUS, Suite #551 102-17750 #10 Hwy, SURREY, BC CANADA V3S 1K4
 (NOTE: IF MAILING THIS FORM, ADDITIONAL POSTAGE IS REQUIRED. CHECK WITH YOUR LOCAL POST OFFICE FOR AMOUNT.)

MEMBERSHIP REGISTRATION FORM

Did someone refer you to our program? No Yes Referrer's Name or email address: _____

Patient's First Name: _____ Last Name: _____ Mr. Mrs. Ms. Dr.

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Tel: (____) _____ Bus. Tel (____) _____

Email: _____ Yes, send me email messages containing special offers, promotions, and health-related information

Date of Birth: (month, day, year) _____ Height: (ft./inch) _____ Weight: (lbs) _____

Communications: English Spanish Gender: Male Female For Group enrollment, specify organization: _____

If new member is a minor or an adult in the care of a guardian, please specify name of parent/guardian responsible for keeping the member record up to date

Name: _____ Relationship: _____

Where did you hear about Canada Prescriptions Plus? Doctor/Hospital Internet Family/Friend TV/Radio/Magazine/Newspaper/Mailing
 Employer Trade Show Other (specify) _____

MEDICAL INFORMATION

Have you had a physical examination in the last 12 months? Yes No
 (It is mandatory that you have had a physical examination in the past 12 months, otherwise, we cannot process your first order.)

HEALTH CONDITIONS Please check off any current medical conditions that apply to you.

HEART DISEASE OR STROKE	HIGH BLOOD PRESSURE	BLOOD DISORDERS	LUNG OR UPPER RESPIRATORY DISORDERS SUCH AS ASTHMA, EMPHYSEMA, ETC.	ENDOCRINE CONDITION	DIABETES, THYROID, ETC.	KIDNEY DISEASE	LIVER DISEASE	HIGH CHOLESTEROL	COLON OR PROSTATE DISORDERS	CANCER	IMMUNE DISORDERS SUCH AS HIV/AIDS, LUPUS, ETC.	FIBROMYALGIA, CARPAL TUNNEL, ETC.	MUSCLE OR JOINT DISORDERS SUCH AS ARTHRITIS, GOUT, ETC.	EMOTIONAL DISORDERS SUCH AS DEPRESSION, PSYCHOSIS, ETC.	NEUROLOGICAL DISORDERS SUCH AS PARKINSON'S, SEIZURES, STROKE, MIGRAINES, ETC.	GLAUCOMA OR OTHER EYE DISORDERS	GASTROINTESTINAL DISEASES SUCH AS GASTROESOPHAGEAL REFLUX, ULCERS, GASTROENTEROPATHY, CROHN'S DISEASE, ETC.	ULCERATIVE COLITIS, COLON'S DISEASE, ETC.	NEUROLOGICAL DISORDERS SUCH AS SEIZURES, STROKE, MIGRAINES, ETC.	PARKINSON'S, SEIZURES, STROKE, MIGRAINES, ETC.	GLAUCOMA OR OTHER EYE DISORDERS	EDEMA OR EXCESSIVE FLUID RETENTION	SKIN DISORDERS SUCH AS ACNE, PSORIASIS, ETC.	ANY KNOWN NUTRITIONAL DEFICIENCY (INCLUDING MINERALS AND ELECTROLYTES)	SMOKER
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

List other illnesses not noted above and/or elaborate on the details of any conditions checked off (i.e. duration of illness, treatment or surgery received):

Do you exercise regularly? Yes No If yes, please state type, frequency and duration:

Please list all known allergies including drug allergies:

Please list all medications, vitamins or herbal supplements that you are currently taking:

Print Name: _____ Sign Name: _____ Date: _____

PAYMENT INFORMATION & PATIENT AGREEMENT

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: _____

1

OR

MONEY ORDER (note that payment must be received prior to shipping your medications)

I will send a money order for each prescription order that I place.

2

FOR OFFICE
USE ONLY

The customer agreement 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 Prescriptions Plus is an agent that sends your medications

I, as the undersigned, being over the age of 21, hereby:

DISCLOSURE AND REPRESENTATIONS

Represent and confirm to **Canada Prescriptions Plus**, its affiliates, related companies, subsidiaries and parent company (hereinafter collectively referred to as "**CPP**") and to **canadaprescriptionsplus.com** that:

1. The pharmaceutical(s) to be delivered to me were prescribed by a doctor licensed to practice medicine in the country, state or other applicable jurisdiction in which I reside or where I sought treatment.
2. The prescription(s) for the pharmaceutical(s) were lawfully obtained from that physician.
3. I will use any medication obtained for me by **CPP** strictly according to the instructions provided by the physician who prescribed the medication.
4. The pharmaceutical(s) will only be used as directed and only by the person for whom the pharmaceutical(s) were prescribed.
5. I can make my own medical decisions according to the law of the place where I reside.
6. The prescription(s) I am requesting **CPP** to assist me in obtaining has not been altered in any way nor has it been filled prior to submission to **CPP**. I agree to immediately destroy all copies of my prescription(s) once it has been filled.
7. I am not seeking or relying on any medical information from **CPP** and I have consulted a qualified physician licensed where I obtained the prescription within the last year.
8. I will immediately contact the physician who provided my prescription included with this order in the event I suffer any unexpected side effects from any medication obtained for me by **CPP**.
9. I understand that it is my responsibility to have regular physical examinations by my primary US licensed physician that is responsible for my care including all suggested testing to ensure that I have no medical problems which would constitute a contradiction to me taking the medications being prescribed.
10. I acknowledge that **CPP**'s employees and agents have relied on the information and documentation that I am providing (including the Patient Profile) and I represent and confirm that I have fully disclosed all pertinent information and documentation to **CPP**. I agree to notify **CPP** of any changes to my physical or medical condition by providing an updated Patient Profile.

AUTHORIZATION AND CONSENT

11. I hereby authorize and appoint **CPP**, as my agent and attorney for the limited purpose of taking all steps and signing all documents on my behalf necessary to obtain a prescription in **Canada** that is the equivalent of the prescription that I sent to **CPP**, to the same extent as I could do personally if I were present taking those steps and signing those documents myself. This authorization shall include, but not be limited to: collecting personal health information about me; collecting similar information from my prescribing physician or pharmacist, and disclosing that personal health information to **CPP** employees, agents and service providers including the **Canadian** physician being retained on my behalf, as required, for the limited purpose of obtaining the **Canadian** prescription. The authorizations and consents that I am providing to **CPP** commence on the date I have signed this

agreement and shall continue until I revoke them. I understand that I can revoke the consents and Authorizations I have granted to **CPP** at any time.

12. I hereby specifically acknowledge that I am aware that **CPP** will be transmitting my personal health information by electronic means (for example fax, secure internet) to its employees, agents, affiliates and service providers including the Canadian physician retained on my behalf. I understand that the use of electronic means will enhance the efficiency and timeliness of processing my order. I also understand that **CPP**, as a custodian of my personal health information will take all appropriate precautions to protect my personal health information from improper disclosure or use. I hereby consent to **CPP**'s transmission of my personal health information by electronic means.

13. If I was directed to **CPP**'s services through an affiliate or intermediary (for example Pharmacy Benefit Manager, Health Management Organization, or other healthcare service provider), I hereby authorize **CPP** to release the following data to such an intermediary:

- a. a numerical identifier indicating that I was a patient referred from that source;
- b. financial information that will permit the processing of any claims on my behalf;

It is my understanding that all such intermediaries will enter into Confidentiality Agreements where they agree to abide by the privacy policies of **CPP** relating to the protection of my personal health information. I specifically consent to the transmission of the forgoing information by electronic means.

14. I authorize and appoint **CPP** as my agent and attorney for the purpose of taking all steps and signing all documents on my behalf necessary to package or re-package the pharmaceutical(s) and to deliver them to me, to the same extent as I could do if I were personally present taking those steps and signing those documents myself.

15. I authorize and appoint **CPP** as my agent and my attorney for the purpose of taking all steps and signing all documents on my behalf necessary for shipping my prescribed pharmaceutical(s) to me as if I had shipped the prescribed pharmaceutical(s) to my own address.

16. I acknowledge and agree that I initiated a consultation with **CPP** and that **CPP** is not located in the United States. I also acknowledge that the pharmacists working for **CPP** and the physicians contracted by **CPP** on my behalf are located and licensed to practice medicine or pharmacy in **Canada** and that all services that I receive from the **Canadian** pharmacy and the pharmacist are being received in **Canada**.

17. I further agree that any and all agreements reached or contracts formed throughout the course of the relationship between me and **CPP** shall be deemed to be made in **the Province of British Columbia, Canada and accordingly shall be governed by the laws of the Province of British Columbia and the laws of Canada applicable to such contracts and agreements.**

18. I agree that any dispute that arises between me and **CPP**, its affiliates, related companies, subsidiaries, parent company, officers, directors, employees, agents and contractors shall be governed by the laws of **the Province of British Columbia and the laws of Canada applicable to contracts formed in British**

Columbia, and I agree that the courts of the Province of British Columbia shall have sole and exclusive jurisdiction over any such dispute.

PURCHASE AND SALE TERMS

19. **CPP** will charge my credit card or will withdraw funds from my bank account through online checking for the following amounts:

- a. the medication price and shipping (in **US Dollars**) as posted on the **CPP** web site on the day **CPP** receives my order; and
- b. in the event my payment is not authorized, **CPP** has the right to cancel my order and attempt to provide me with notice of such cancellation.

20. The pharmaceutical(s) will be packaged in child protected packaging, unless requested otherwise by me on the Patient Questionnaire.

21. **CPP** shall be entitled to substitute a brand name prescription drug with a generic prescription drug, where available, unless the physician has indicated that there be "no substitution" or dispensed as written. That once purchased and shipped, no pharmaceutical product may be returned or exchanged.

22. **CPP** 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.

23. **CPP** does not provide its agency or attorney services as a substitute for healthcare or the advice of the customer's primary care physician.

24. **CPP** 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.

CANADIAN DOCTOR DECLARATION

I provide my consent to allow a physician licensed in Canada to obtain my medical history, drug history, contact information and other necessary documentation from my U.S. physician. In this context, I further consent to both the Canadian physician and my U.S. physician being able to contact one another to discuss my medical condition, as it pertains to the prescribing of the medication(s) in question. I understand that the reason for this consent is to provide the Canadian physician with a full opportunity to conduct an independent analysis of whether the medication(s) prescribed by my U.S. physician is appropriate, and discuss any potential medical complications that may arise. I further understand that my medical information will not be used for any other reason, and will be kept in strict confidence. I further agree to regularly visit my U.S. physician(s) and to promptly advise the Canadian physician of any changes to my medical condition or prescriptions.

I have read and understood the terms and conditions set out in this Agreement and agree, on behalf of myself, my heirs, successors, administrators and assigns to be bound by these terms and conditions.

Signed this _____ day of _____, 20____.

(Signature)

(Print Name) (Please Print Clearly)

TEAR ALONG PERFORATION

