

CANADA D	
Personal Information:	

Full Name (Please pr	int clearly)		── ○ Male ○ Female
Street Address			
City () Phone (Home)	State/Province	Country () Phone (Other)	Zip/Postal Code
•	re placing this order for a pet. Other (Please specify)	Birth Date (MM/DD/YY)	
Please fill out this se		norized Contact): ent, or to update your informati	on on file.
Authorized Co	ntact:		
Full Name of Second	lary Contact (Please print clear	y) ()	
Relationship to you		Phone	
Clinic Name/Street A	ddress		
City	State/Province	Country	Zip/Postal Code
() Phone	Ext.	() Fax	
	LXI.	Tux	
Allergies: Do you have any sev	ere allergies?	NO If yes, please describe l	below:
	ebook for Discounts a	and Special Offers:	
Join us on F <u>ac</u>			
Join us on Fac			

CODE:	MKT:		AFF:	
Phone: 1-83 Fax: 1-833-	33-200-5343 345-0422		scountcanadad countcanadadr	
Medication:				
as obtained through Upload, Email, or Fa: International Pharm	at you wish to order, plea our website or customer x. Please follow up by ma acy Association standard: uples need to fill ou	r service center. We wi ailing in the original p s. (Pricing in \$US).	Il accept a copy of your rescription, to compl	ur prescrip y with Can
Generic OK?	Medication	Strength		Prio
			_	
				<u> </u>
			SHIPPING:	\$9.9
			TOTAL:	
purchasing), to com	Continued): ional medications, vitam ply with Canadian Intern rdication	national Pharmacy Ass		ou will not Frequer

Please complete to earn a \$20.00 credit for yourself and the person who referred you!

Full Name of person who referred you

Join us on Facebook for Discounts and Special Offers:
To scan a QR Code open the camera app on your phone and select the rear facing camera. Hold your device so that the QR Code appears on your screen. Your device will recognize the QR Code and show a notification, tap on the notification to be brought to our Facebook page!

	1
Patient's Signature	Date (MM/DD/YY)
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Phone



CODE:	MKT:	AFF:

Fax: 1-833-345-0422

Phone: 1-833-200-5343 Email: info@discountcanadadrugs.com Web: www.discountcanadadrugs.com

Plea	Please list the medications you would like us to contact your Doctor for, or to transfer from another Pharmacy:				
	Medication Name	Strength	Directions	Rx Number	
We a	re able to contact your Doctor and/or trans	sfer your prescription ((only available to residents of the United States and Canada).		
Pati	ent Authorization (Please check one):				
	pursue international prescription service pharmacy. The	following terms and conditions	Ianitoba, Canada, specializing in the business of assisting pharmacies both within Canada s govern the sales as between DiscountCanadaDrugs™ authorized dispensary (the"Pharm he Pharmacy. The Patient herein represents to the Pharmacy that,		
	1. I have fully and accurately disclosed my personal information and personal health information and consent to its use by the Pharmacy, 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 by a Pharmacy operating within a unique international jurisdiction and in a manner consistent with the laws of that jurisdiction.				
	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 the jurisdiction of the Pharmacy. This authorization may be revoked at any time and shall continue until I revoke it.				
	4. I understand that the Pharmacy is legally incorporated and authorized by law to carry on business in the jurisdiction of the Pharmacy, and that I am purchasing medications that have been approved for sale in the jurisdiction of the Pharmacy of the Pharmacy. Title to my medications passes from the Pharmacy to me in the jurisdiction of the Pharmacy when my medications leave the Pharmacy. All agreements reached or contracts formed with the Pharmacy shall be deemed to be made in the jurisdiction of the Pharmacy, the laws of the jurisdiction of the Pharmacy, 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 BI	E BINDING UPON ME AND MY ASSIGNS, HEIRS AND PERSONAL REPRESENTATIVES	5."	
	OR				
	"I am the parent/legal guardian/power of attorney for the the Patient's behalf."	Patient disclosed herein, am o	over the age of majority, and have full authority to sign for and provide the above represen	ntations to the Pharmacy on	

Patient's Signature

Date (MM/DD/YY)



CODE: MKT:	AFF:
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Phone: 1-833-200-5343 Email: info@discountcanadadrugs.com Web: www.discountcanadadrugs.com

	(i icase provide you	r banking Check information):
Your Routing Number		
our Account Number		
Please include a cop	y of a voided check	for verification purposes:
NAME		0123
ADDRESS CITY, STATE, ZIP	æ	01-23456789
	- 10	
PAY TO THE ORDER OF		\$
		DOLLAR
BANK NAME ADDRESS		
CITY, STATE, ZIP	•	
	 01234567890123 ॥"	0123
1,0123430781,1	71234307890123	
		This is your check number.
Routing Number	Account Number	
Routing Number Your routing number	Account Number Your account number	Don't enter this.

Payment Option 2:	
Personal Check, Cashier's Check or International Please make Personal Check or International Ecom Paym	Money Order paid to:
I will send a PERSONAL check. I will send a CASHIER'S check. I will send an International Money Order. (Included with forms)	DiscountCanadaDrugs.com PO Box 16002 Centennial PO Winnipeg, MB, Canada R3A 0E1

Mailing/Information Contact:

Option 1:

Please mail your prescription and these forms to the address above:

Option 2:

Contact My Doctor Please mail these forms to the address above and make sure that your Doctor's information is accurately filled out on page 1.

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			_

Please mail these forms to the address above and transfer my prescription from another Pharmacy .

Rx Number of prescription

Pharmacy Name (Please print clearly)

Street Address

 City
 State/Province

 (_____)
 Phone

 Ext.
 Ext.

Zip/Postal Code

Phone Ext.

Please use this form to submit your prescription(s), and send it back to us to complete your order.

	1
Patient's Signature	Date (MM/DD/YY)

Country