



Unit #201 - 8181 120A Street
Surrey, British Columbia
Canada V3W 3P2

Tel: 1-877-888-3784
Fax: 1-866-364-9987
www. Medisave.ca

STEP 1: Please complete this form, all fields with * must be filled out to be valid.
Read and sign the Authorizations and Release Form.
All information provided will be kept confidential.

STEP 2: Get your prescriptions from your doctor(s).

STEP 3: Please return the forms along with your prescriptions back to us either by mail or by fax.

Please be advised to contact Medisave.ca 2-3 weeks prior to requirement of refill prescriptions.

***MEDICATIONS BEING ORDERED**

☺ Please note that all prices and quantities will be confirmed with you before processing your order.

BRAND	GENERIC	MEDICATION NAME	DOSAGE	QUANTITY
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

***HOW DID YOU FIND Medisave.ca?**

- Internet (link, search engine, etc.) Print Ad Doctor
 Referred by: _____ Other

***HAVE YOU PREVIOUSLY FILLED OUT THIS FORM?**

(Please check one appropriate field)

- Yes No

If yes please describe any changes to your health, medications, or exercise routine since the last time you gave information:

Please print clearly and FAX to: 1-866-364-9987
or MAIL to: Unit #201 8181 120A Street, Surrey, BC Canada V3W 3P2

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CANADA'S LEADING ONLINE PHARMACY.



***PATIENT INFORMATION FORM:**

* Fields must be filled to be valid

*Last Name:	*First Name:
*Telephone: ()	*Alternate No: ()
*E-Mail Address:	*Mailing Address: Apt #/Street:
*City:	*State/Zip Code:
*Date of Birth (mm/dd/yy): / Age:	**Sex Male Female
*Height: ft. inches	*Weight: lbs.

***WHAT MEDICAL CONDITION(S) ARE YOU BEING TREATED FOR?**

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Fluid Retention | <input type="checkbox"/> Migraines | |

OTHER/COMMENTS:

***DO YOU SMOKE?**

- Yes No

***DO YOU DRINK ALCOHOL?**

- Yes No

***ARE YOU PREGNANT OR BREASTFEEDING AT THIS TIME?**

- Pregnant Breastfeeding No

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***PLEASE INDICATE ANY DRUGS ALLERGIES THAT YOU MAY HAVE:**

***PLEASE LIST BELOW ALL PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS THAT YOU ARE CURRENTLY USING:**

MEDICATION NAME	DOSAGE	QUANTITY
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	
_____	_____	

***PAYMENT OPTIONS**

Visa Master Card Money Order Certified Check

* Name as printed on Card:

X _____

* Credit Card Expiry Date: (mm/yy)

X _____ / _____

* Credit Card Number:

*Credit Card Verification Number:
(last 3 digits printed on back of your card)

Billing Address (if different from above)	Suite #:
Street Address:	Zip / Postal Code:
City:	State/Province:

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*Cardholder Signature:	*Date (mm/dd/yy):

Note: All prices are in US funds and there is a \$14 shipping fee per order.

***AUTHORIZATION AND RELEASE FORM:**

*Patient Signature:	*Witness Signature:
*Patient Printed Name:	*Witness Printed Name:
*Date:	*City/Town where signed:

By signing above, I agree to all of the following terms and conditions on behalf of myself, my heirs, assigns and successors. I further 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. In the event that I am placing the order on behalf of someone else, I also represent that I have all necessary consent, permission and authorization to do so on behalf of that person and their heirs, assigns and successors.

AUTHORIZATION AND CONSENT

For all prescription medications a written prescription from your physician is required. I hereby appoint **Candrug Health Solutions. ("MediSave.ca")** and its delegates (**MediSave.ca**) as my agent and attorney for the purposes of obtaining a prescription from a medical doctor in Canada (the "Canadian Doctor") that corresponds to the prescription included in this order. The acts authorized may include directly contacting my prescribing medical practitioner, and purchasing and arranging delivery of the medications prescribed in the Canadian prescription, substantially on the terms set forth below, and all to the same extent that I could if I personally took such steps. I hereby consent to and authorize **MediSave.ca**, the Canadian Doctor and any Canadian pharmacy with which **MediSave.ca** may partner (the "Partnered Canadian Pharmacy") to collect my personal medical information and to maintain on file the information necessary to verify and process future orders, including but not limited to my name, address, phone number and payment information. I understand that my personal information will be handled only by **MediSave.ca** the Canadian Doctor, and the Partnered Canadian Pharmacy's processing employees and contractors (including physicians and nurses, pharmacists and pharmacy technicians).

DISCLOSURE AND REPRESENTATIONS

I represent that all of the following statements are true and understand that **MediSave.ca**, it's Partnered Canadian Pharmacy, their employees and contractors (physicians and nurses, pharmacists and pharmacy technicians) are relying on the following representations:

1. I am of the age of majority or older according to the laws of the state in which I reside ("My Place of Residence").
2. I can make my own medical decisions according to the laws of My Place of Residence.
3. A duly qualified medical practitioner in My Place of Residence ("My Medical Practitioner") prescribed the pharmaceutical product(s) ("the Ordered Product") that I am requesting **MediSave.ca** to assist me in obtaining.
4. The prescription that I am requesting **MediSave.ca** to assist me in obtaining has not been altered in any way nor has it been filled prior to submission to **MediSave.ca**. I agree to immediately destroy all copies of my prescription once it has been filled.

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5. I will use any medication obtained for me by **MediSave.ca** strictly in accordance with the instructions provided by My Medical Practitioner.
6. I place this order for medication for my sole use and I will not provide any of this medication to another person. I am not seeking or relying on any medical information from **MediSave.ca**.
7. I will immediately contact My Medical Practitioner in the event I suffer any unexpected side effects from any medication(s) provided to me by **MediSave.ca's** Partnered Canadian Pharmacy. **MediSave.ca** has made no representations or warranties to me, including, without limitation, representations or warranties regarding the use or fitness for any particular purpose of the medication(s) delivered (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).

PURCHASE AND SALE TERMS

1. If I choose to pay for my order by credit card, **MediSave.ca** and the Partnered Canadian Pharmacy will charge my credit card the following amounts (all prices in US funds):
 - a. The medication price as posted on **MediSave.ca** website on the day **MediSave.ca** receives my order,
 - b. A \$10.00 Shipping/Insurance Fee for each package **MediSave.ca** ships; and
2. In the event my payment is not authorized by my credit card company, **MediSave.ca** has the right to cancel my order and attempt in good faith to promptly notify me of such cancellation.
3. **MediSave.ca** reserves the right, in its sole discretion, to refuse to process any order, in which event I will be entitled to a prompt refund of all monies paid for such order, if any.
4. Whenever possible, and unless otherwise instructed by My Medical Practitioner or by myself, **MediSave.ca's** Partnered Canadian Pharmacy will substitute lower cost generic drugs for any prescribed brand name prescription drugs.
5. **MediSave.ca** does not fill any orders using child protection packaging.
6. **MediSave.ca** is not providing its services as agent or limited power of attorney as a substitute for health care or the advice of a licensed medical practitioner.
7. **MediSave.ca** 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.
8. I am solely responsible and take full possession of my order at the time of shipment (or point of origin) from **MediSave.ca** and its Partnered Pharmacy(s).

RELEASE AND WAIVER

I hereby release and hold harmless **MediSave.ca**, its Partnered Canadian Pharmacy, the Canadian Doctor, their officers and directors, agents, employees and contractors (including physicians and nurses, pharmacists and pharmacy technicians) 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(s) provided to me by **MediSave.ca's** Partnered Canadian Pharmacy including, without limitation, any and all side effects whether previously known or unknown;
2. The manner or timeliness of completion by **MediSave.ca** or its Partnered Canadian Pharmacy of any of the actions I have authorized; and
3. My breach of any terms, conditions or representations or warranties in this agreement.

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 British Columbia, Canada. I have read and understand all of the foregoing.

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