CANADIANPHARMACYINFO.COM
PO Box 263, Suite 107-477 Peace Portal Dr. Blaine, WA 98230
Ph. 1.877.964.9833 Fx. 1.866.255.5243

Ordering Your Medication Is Easy With A Few Simple Steps!

"Need Help!" Call Customer Care Toll Free 1-877-964-9833

1. Confirm online drug prices and availability & write them on this 2-page order form.
2. Complete all sections and sign this 2-page order form. This will only be required the first time you register with us.
3. Mail or fax the prescription(s) and photo ID along with this 2-page completed order form to:

Mail to: ***Canadian Pharmacy Info. 161C Street, #263. Blaine, WA 98230*** **Fax #:** ***1-866-255-5243***

YOUR PERSONAL INFORMATION

____
Full Name

____
Street

____
City State Zip Code

( )______________( )______________
Day Phone Evening Phone

______ / ______ /______ ______ _______ _______
Birthdate (month / day / yr) Age Height Weight

E-mail Address: ______________________________

YOUR PRIMARY PHYSICIAN INFORMAITION

☐ Male ☐ Female

____
Physician's Full Name

____
Address

______________/______________/______________
City State Zip Code

( )______________ ( )______________
Phone # Fax #

How did you hear about us:

☐ Search Engine ☐ Associations ☐ Friend ☐ Flyers ☐ Newspaper/Magazine ☐ Website ☐ Radio ☐ Television ☐ Other______________

YOUR MEDICAL PROFILE

	YES	NO
Have you had a physical exam in the last (12) months?	☐	☐
Are you pregnant (or) nursing?	☐	☐
Do you drink alcohol?	☐	☐
Are you a smoker?	☐	☐
Will you accept generic version(s) of the medications?	☐	☐

	YES	NO
Do you have any known allergies (incl. drug allergies)?	☐	☐

If YES, please list description of reaction with date below:

____
____
____

Please select all conditions that apply to you:

☐ Alcoholism	☐ Alzheimer's	☐ Anemia	☐ Asthma	☐ Bone/ Joint Disorder	☐ Blood Disorder
☐ Breast Cancer	☐ Cholesterol Disorder	☐ Cervical Cancer	☐ Colon Cancer	☐ Depression	☐ Diabetes
☐ Emphysema	☐ Fluid Retention	☐ Glaucoma	☐ Liver Disease	☐ Lung Cancer	☐ Lupus
☐ Heart Disease	☐ High Blood Pressure	☐ Stroke	☐ Kidney Disorder	☐ Ovarian Cancer	☐ Migraines
☐ Prostate Cancer	☐ Parkinson's Disease	☐ Lupus	☐ Muscle Disorder	☐ Emotional Disorders	☐ Chrohns/Colitis
☐ Ulcers	☐ Nutrition Deficiency	☐ Rheum/Arthritis	☐ Thyroid Disease	☐ Surgery recently	☐ Hospitalized recently

If checked above, please provide details:

Referral / Promo #: **(optional)**

800

Please list all medications, dosages and frequency that you are currently using. (For Example) "Lipitor, 20mg, 1 per day"

Medication	Strength (mg)	Frequency

You have the right to receive consulting from a licensed Canadian pharmacist if you choose.

✔ ______________________________/____________
Patient's Signature Date

Fax this order form and your prescription sheets to our 24-hour Customer Fax 1-866-255-5243

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YOUR MEDICATION ORDER

If you have not confirmed drug pricing and availability of the medication(s) you are ordering online, please call our customer care toll free at 1-877-964-9833. We strongly recommend that you **pay by credit card**. By doing so your order will be delivered faster and refills can be ordered over the phone. **Below** enter the drug name, dosage, quantity, and price allowed for all medications you're ordering with www.canadapharmacyinfo.com. Drug pricing and availability is also online at www.canadianpharmacyinfo.com. Total the dollar amount of your order and add one shipping charge of $13.99.

DRUG NAME	GENERIC	DOSAGE (mg)	QUANTITY	PRICE
1.	❑			$
2.	❑			$
3.	❑			$
4.	❑			$
5.	❑			$
6.	❑			$
7.	❑			$
8.	❑			$

Subtotal: ______________________
Shipment Cost: 13.99 ______________.
Total (US$): ______________________

PATIENT ACKNOWLEDGEMENT

The undersigned, (hereinafter the "Client") being over the age of 21, hereby agrees that: I am not legally restricted from making my own medical decisions and grant the pharmacy network affiliated with ***Canadian Pharmacy Info*** (Canada Online Healthlink, Inc.), its affiliates, agents, related companies, subsidiaries and parent companies (The "Providers") a power of attorney for the limited purpose of signing any documents required by Canadian authorities to permit the delivery of the ordered products to me as if I had personally attended the Provider's place of business in Canada and to take any necessary steps for the order to be processed and the products delivered.

1. I confirm that the prescription submitted by me was lawfully obtained from a physician licensed to practice within the United States of America, that the prescription is for my personal use, that the prescription has not been altered or filled prior to submission and that the medications will only be used as re-prescribed by a licensed Canadian physician who will re-issue the prescription.
2. I affirm that, to the best of my knowledge, I have fully and truthfully disclosed all pertinent information and documentation to the Providers and that the Providers have only relied on the information provided by my physician and me. I accept that I am responsible for notifying the Providers of any change in my medical profile and authorize the providers to communicate with my physician if they so deem it advisable. I affirm that the Provider's review of my medical information is for the sole purpose of verifying the contents of the prescription and is not intended to diagnose any medical condition nor is it a substitute for my duty to consult my physician.
3. I affirm that I have been taking the prescribed medication for at least 30 days prior to submission, that I have had a medical examination in the past twelve months, that I will continue being monitored by my physician and that I will promptly contact my physician in the event of adverse effects from the use of the pharmaceuticals.
4. I understand the medications will be dispensed in their original manufacturer's packaging or in child resistant packaging.
5. For the purpose of maximizing my savings the Provider may dispense generic substitutions as approved by Canadian authorities using criteria similar to the US-FDA.
6. I agree that once shipped no medications may be returned for refund or exchange and that orders cancelled before shipping will be charged US$5.00 per prescription.
7. I release and discharge ***Canada Online Healthlink Inc.,*** the Providers, its officers, directors, employees and agents of any and all liabilities, claims and causes of action with respect to error, omissions, negligent acts or misrepresentations by my physician and the Canadian physician except as appropriate and usual when pharmaceuticals are provided, and also for the late delivery, non-delivery or missed delivery of the products by the company or agency responsible for transportation. I further agree that the Canadian physician shall not be liable for any liability, claim, loss, damage or expense caused directly or indirectly by any inadequacy, deficiency or unsuitability of the Canadian physician's review of my medical information and original prescription nor on the re-issue of the prescription. In no event will the Canadian physician be liable for or responsible whatsoever, including direct, indirect, putative, special or consequential damages, even if advised of that possibility.
8. I acknowledge and agree that I am using ***Canada Online Healthlink Inc.*** for the sole purpose of helping me comply with the documentation and communication necessary for the Providers to service my request. I understand ***Canada Online Healthlink Inc.*** is not a pharmacy and is not the seller and handler in any form or manner of prescription drugs and does not provide medical advice. I acknowledge and agree that this transaction is solely and strictly between the Providers and me.
9. I atone to the sole and exclusive jurisdiction of British Columbia (Canada), which laws shall apply to any and all disputes that may arise and agree that the courts of British Columbia shall hear any dispute.

____/_________________

Patient Signature Date

PAYMENT METHOD

Choose how to pay for your order:

☐ Visa ☐ Cashiers Cheque
☐ MasterCard ☐ Int'l Money Order

____________________________________ ______ ______
Credit Card Number (Month / Year) Expiration

____
Cardholder's Name (as it appears on the credit card)

____
Cardholder's Street Address

____
Cardholder's City State Zip Code

______________________ ________________
Cardholder's Signature Date

FINAL CHECKLIST

- ✔ Double check that all sections of this order form is complete.
- ✔ Call our customer care hotline to confirm drug price and availability.
- ✔ Make sure you have signed **all 3 required signatures** on this 2-page order form.
- ✔ Please fax/mail the prescription(s) you are ordering along with a photo ID and this completed 2-page order form.

Order payments are made directly to Canada Online Healthlink, Inc. Therefore, if this is your first order with us, please call your credit card company to lift the **"security lock"** on international orders. Otherwise your order may be delayed.

Fax this order form and your prescription sheets to our 24-hour Customer Fax 1-866-255-5243