Ordering Your Medication is Easy With a Few Simple Steps!

"Need Help?" Call Customer Care Toll Free 1-800-518-2344

CANADIAN MEDS

1. Complete all sections and sign where necessary. This will be required only the first time you register with us.
2. Mail or fax the prescription(s) along with this completed order form to:

Mail to : P.O. Box 121093, West Melbourne, FL 32912 Fax#: 800-475-2144

YOUR PERSONAL INFORMATION

Full Name:_____

Mailing Address:

Address:_____

City:_____ State:_____ Zip:_____

Day Phone: ( )_____

Evening Phone: ( )_____

Alternate Address (if any):

Address:_____

City:_____ State:_____ Zip:_____

Email Address:_____

How did you hear about us:

❑ Friend ❑ Flyers ❑ Website
❑ Television ❑ Search Engine ❑ Radio
❑ Newspaper/Magazine ❑ Associations
❑ Other_____

Referral/Promo # (optional):

YOUR MEDICAL PROFILE

Birthdate:_____/_____/_____ (month / day / year)

Height:_____ Weight:_____

❑ Male ❑ Female

Mark YES or NO for the following questions:

Have you had a physical exam in the last (12) months?
YES ❑ No ❑

Are you pregnant (or) nursing? **YES ❑ No ❑**

Are you a smoker? **YES ❑ No ❑**

Do you have any known allergies (incl. drug allergies)?
YES ❑ No ❑

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

_____

_____

_____

MEDICAL HISTORY

Please select all conditions that apply to you:

❑ Alcoholism	❑ Alzheimer's	❑ Anemia	❑ Asthma	❑ Blood Disorder
❑ Thyroid Disease	❑ Stroke	❑ Cholesterol	❑ Depression	❑ Emphysema
❑ Fluid Retention	❑ Glaucoma	❑ Heart Disease	❑ Diabetes	❑ Liver Disease
❑ Muscle Disorder	❑ Migraines	❑ High Blood Pressure	❑ Ulcers	❑ Psychiatric Disorder
❑ Rheum/Arthritis	❑ Lupus	❑ Nutrition Deficiency	❑ Recent Surgery	❑ Recent Hospitalization
❑ Chrohns/ Colitis	❑ Cancer	❑ Parkinson's Disease	❑ Bone/Joint Disorder	❑ Kidney Disorder

If checked above, please provide details:

_____

_____

YOUR PRIMARY PHYSICIAN

Physician's Full Name:_____

Phone #: ( )_____

Fax #: ( )_____

MEDICAL HISTORY

Please list all prescriptions and over the counter medications that you are currently taking:

Drug Name and Strength (e.g. Lipitor 20mg)	**Directions** (e.g. "1 tablet once daily")	**Comments**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

The pharmacy can only provide appropriate care if information provided is accurate and complete.

PAYMENT

(Payment is due at the time that the order is placed)

PAYMENT METHOD: ❑ Check ❑ Cashier's check

Please make your check of choice out to: **TCP International**

Final Check List

- Double check that all sections of this form are complete.
- Make sure you have signed the **required signature** on this profile form.
- Please fax/mail the prescription(s) you are ordering along with this completed 3-page order form.
- Fax this form and your prescriptions to our 24-hour Customer Fax 1-800-475-2144 or mail to us at the following address:

Canadian Meds
P.O. Box 121093
West Melbourne, FL 32912

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Mail to: P.O. Box 121093, West Melbourne, FL 32912 Fax#: 800-475-2144

CUSTOMER AGREEMENT

The undersigned, (hereinafter the "Client") being over the age of 21, hereby agrees that:

1. I am not legally restricted from making my own medical decisions and grant Canadian Meds, its pharmacy network, affiliates, agents, related companies, subsidiaries and parent companies (hereinafter the "Providers") a power of attorney for the limited purpose of signing any document required by Canadian authorities to permit the delivery of the ordered products to me, to the same extent as I could do if I were personally present taking those steps and signing those documents myself.
2. I confirm the prescription submitted was lawfully obtained from a physician licensed to practice within my place of residence, 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, if deemed appropriate.
3. 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 and will continue to rely 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 seem it advisable. I affirm that the Provider's review of my medical information is for the sole purpose of verifying 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 appropriateness of the prescription and is not intended to diagnose any medical condition nor is it a substitute for my duty to consult my physician.
4. 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 pharmaceuticals.
5. I understand the medications will be dispensed in their original manufacturer's packaging or in child resistant package, unless specified.
6. I agree that once shipped, no medications may be returned for refund or exchange and that orders canceled before shipping will be charged US $130.00 per prescription plus the price of the medication.
7. I release and discharge 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.
8. I acknowledge and agree that I am using Canadian Meds for the sole purpose of helping me comply with the documentation and communication necessary to service my request. I understand Canadian Meds 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.
9. I agree that any dispute that arises between me and the Providers shall be governed by the laws of the province of British Columbia and agree that the courts of the Province of British Columbia shall have sole and exclusive jurisdiction over any such dispute.
10. I have read and understood the terms and conditions set out in this Customer Agreement and agree, on behalf of myself, my heirs, successors, administrators and assigns, to be bound by these terms and conditions.

_____ / _____ /_____

Patient Signature (Required) | Print Name | Date