



Kelz

#140-2410 Dewdney Avenue, Regina, SK S4R 1H6
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CAREGIVER APPLICATION FORM

Caregiver's Name: _____ Date of Birth: _____
FIRST LAST M D Y

Address: _____
STREET CITY PROVINCE POSTAL CODE

Phone number(s): _____ Email: _____

Name of Qualified Member: _____ Member#: _____

PLEASE CHECK THE FOLLOWING STATEMENTS TO INDICATE YOUR AGREEMENT:

- I will act as Caregiver of the above mentioned Kelz Member and I am allowed to assist them with the purchase of medical cannabis.
- I may purchase medical cannabis for the above mentioned Kelz Member if they are unable to come into the dispensary themselves.
- I am NOT qualified to purchase and use medical cannabis for myself.

DATE: _____ CAREGIVER'S SIGNATURE: _____

KELZ MEMBER COMPLETE THE FOLLOWING:

- I authorize the above signed Caregiver to make purchases from Kelz on my behalf.

Print Name: _____ Member#: _____

DATE: _____ MEMBER SIGNATURE: _____