

# Re-Order Form Canadian Discount Rx Services

Name (required)

Email Address (required)

Address, City, State, Zip

Home or Cell Phone (required)

Additional Phone Number (optional)

Requested Medication

	Medication	Brand/Generic	Dose	Quantity	Price
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## CANADIAN DISCOUNT RX SERVICES USER AGREEMENT FORM

No prescription will be filled without a signed and dated copy of the form.

The undersigned, (hereinafter the Patient) confirms that:

1. The Patient is of the age of majority in the jurisdiction, in which the patient resides and is full competent to make their own health care decisions.
  2. The Patient confirms that the pharmaceutical(s) ordered by the Patient ("the ordered product") were prescribed by a duly qualified medical practitioner in the place of residence of the Patient. The Patient had not violated any laws in obtaining the prescription and that the Ordered Product will not be used by no other person and in no manner except as prescribed by the original prescribing physician ("The Patient's Physician").
  3. The Patient agrees to direct all questions to The Patient's Physician. The Patient will consult the Patient's Physician before taking any new drug, natural product, or changing their daily health regimen.
  4. The dispensing Pharmacy requires the patient to submit a new medical questionnaire every time there is a change to their medical status. The Patient understands that it is their responsibility to have the Patient's Physician conduct regular physical examinations (minimum every 12 months), including any and all suggested testing by the Patient's Physician to ensure that they have no medical problems which would constitute a contradiction to them taking medications prescribed for them. The Patient agrees that should they suffer any adverse effects while taking any prescription medication that they will immediately contact the Patient's Physician and that in the event they come under the care of another physician, the Patient will inform this physician of any and all medications that have been prescribed.
  5. The Patient must take responsibility to secure their own medication stock from a local pharmacy in the interim if such an event was to evolve, ensuring that at no point they are without medication.
  6. The Patient grants Limited Power of Attorney to Dispensing Pharmacy, for the limited purpose of signing any documents as required by the laws of the Province of Manitoba (Canada), which are necessary to permit the delivery of the Ordered Product to the Patient, in the same manner as the Patient could, if the Patient had personally attended the pharmacy in Winnipeg, Manitoba, Canada.
  7. The Patient agrees that any dispute that arises between Him or Her and Dispensing Pharmacy shall be heard by the courts of Manitoba, Canada. The courts of Manitoba, Canada shall have the sole and exclusive jurisdiction, and that the laws in force in Manitoba, Canada, shall apply to any and all disputed that may arise.
  8. The Patient must honestly report all requested and immediately update any changes to his or her record.
  9. RETURN POLICY: Neither we, nor Canadian pharmacies can accept returns. Canadian law states – "The pharmacist shall not accept the return for use or re-use of any portion of any drug or non-prescription medication (College of Pharmacist Standard 5.1 (m) Standards of Practice-The Pharmacist, Jan. 1, 1996.)"
- BY SIGNING THIS DOCUMENT THE PATIENT CONFIRMS THAT HE OR SHE HAS READ AND UNDERSTOOD EACH OF THE ABOVE TERMS AND HAS AGREED TO EACH ONE. The authorizations within this customer agreement shall continue until revoked.

Please type your full name as an electronic signature to confirm you understand and agree with the terms set forth.

6. The Patient grants Limited Power of Attorney to Dispensing Pharmacy, for the limited purpose of signing any documents as required by the laws of the Province of Manitoba (Canada), which are necessary to permit the delivery of the Ordered Product to the Patient, in the same manner as the Patient could, if the Patient had personally attended the pharmacy in Winnipeg, Manitoba, Canada.

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Please sign your full name to confirm you understand and agree with the terms set forth.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

**Fax this reorder request to 352-347-2034. Or you may call in the reorder request to 352-347-0403.**

Please note, for new prescriptions and reorders: a valid prescription is required for all purchases.