



Personal Information:

Full Name (please print clearly) Male

Street Address Female

City State Country Zip Code

Phone (home) Phone (other)

Email Address Birthdate (MM/DD/YY)

It is mandatory that you have had a complete **physical exam** in the last 12 months.
Has this been done? Yes ___ No ___

Your medication will be packaged in **child proof containers** unless you decline.
Do you decline child proof containers? Yes ___ No ___

Authorized Contact:

()
Full Name of Authorized Contact Phone #
Relationship to You: _____

Medication

For medication(s) that you wish to order, please enter the quantity, (max of 3 month supply) and price, as listed on our website or quoted by customer service. An original prescription from your doctor's office is required (may be mailed, emailed or called in from your Doctor's office).
PRICING IS IN \$US DOLLARS.

Please check if you are placing this order for a pet.

Pet Name: _____

Generic Y/N	Medication	Strength	Qty	Price
Shipping				
Total				

Medication, OTC, Herbal Products You Are Taking
(only list medications you are not ordering)

New Customers (or to update information)

Your Physician

Primary Physician Full Name

Street Address

City State Country Zip Code

Phone (office) Fax

Do you have any Severe ALLERGIES Yes ___ No ___
(if yes please describe below)

Height: _____(ft) Weight: _____(lb) Smoker: _____

Referral Rewards Program

You and your friend both earn \$15.00 off your next order!
Simply share with us who referred you.

Full Name of person who referred you Phone Number

Please send me information on our Friends and Family program.

Other ways to Save

GENERICS Visit <https://ycdsc.com/faq/>



Payment Options:

PERSONAL CHECK

I will email a signed, void check to
PO Box 48066 Lakewood PO
Winnipeg, MB
R2J 4A3
Canada

CREDIT CARD: **Visa** **MasterCard**

Cardholder's Name _____

Cardholder's Address _____

City _____ State/Province _____ Country _____ Zip/Postal Code _____

Credit Card Number _____ Expiry(MM/YY) _____ CVV Code _____ 

Prescription Submission

Option 1: Email Prescriptions to (scan or take picture)
rx@ycdsc.com

Option2: Fax Prescription with this form to
1-833-495-5107

Option3: Mail Prescription with this form to
PO Box 48066 Lakewood PO
Winnipeg, MB
R2J 4A3
Canada

Option 4: *Contact My Doctor*

_____ / _____ / _____
Dr. Name Phone # Fax #

Patient Authorization (Please Check One)

YourCanadaDrugStore.com Customer Care operates a marketing and call centre business in Winnipeg, Manitoba, Canada, specializing in the business of assisting pharmacies both within Canada and internationally pursue international prescription services. The following terms and conditions govern the sales as between the YourCanadaDrugStore.com Customer Care authorized dispensary (the "Pharmacy") and the individual (the "Patient") regarding the products and services (the "Products") offered for sale by the Pharmacy. The Patient herein represents to the Pharmacy that, "I being over the age of majority, and:

- 1. I have fully and accurately disclosed my personal information and personal health information and consent to its use by the Pharmacy. I have had a physical examination by a physician within the last 12 months, and do not require a physical examination.
- 2. I understand that all Products shall be sold & dispensed by a Pharmacy operating within a unique international jurisdiction and in a manner consistent with the laws of that jurisdiction.
- 3. I authorize and appoint the Pharmacy, as my attorney and agent, to take all steps, sign all documents and to act on my behalf as if I were personally present and acting myself for the limited purposes of (a) obtaining a valid prescription for any prescription which I have sent the Pharmacy; and (b) packaging my prescriptions and delivering them to me. This authorization shall include, but not be limited to: collecting and using my personal and personal health information as reasonably necessary for the fulfillment of my order, including disclosure to a licensed physician if required for the issuance of a valid prescription in the jurisdiction of the Pharmacy. This authorization may be revoked at any time and shall continue until I revoke it.
- 4. I understand that the Pharmacy is legally incorporated and authorized by law to carry on business in the jurisdiction of the Pharmacy, and that I am purchasing medications that have been approved for sale in the jurisdiction of the Pharmacy. Title to my medications passes from the Pharmacy to me in the jurisdiction of the Pharmacy when my medications leave the Pharmacy. All agreements reached or contracts formed with the Pharmacy shall be deemed to be made in the jurisdiction of the Pharmacy, the laws of the jurisdiction of the Pharmacy shall govern all transactions, and I attorn to the courts of the jurisdiction of the Pharmacy, which shall have sole and exclusive jurisdiction over any dispute arising between me and the Pharmacy, its affiliates, officers and directors.

I HAVE READ AND UNDERSTAND THESE TERMS AND AGREE THAT THEY SHALL BE BINDING UPON ME AND MY ASSIGNS, HEIRS AND PERSONAL REPRESENTATIVES."

OR

- "I am the parent/legal guardian/power of attorney for the Patient disclosed herein, am over the age of majority, and have full authority to sign for and provide the above representations to the Pharmacy on the Patient's behalf."

Patient's Signature

_____/_____/_____
Date (MM/DD/YY)