Client Account Application

For approved individual under ACMPR

www.Avanti Rx.com
Ph. 416 – 548 – 5998
Fax 416 – 548 - 5990

Please include a copy of your health care practitioner authorization with this application

Client Identification Number: (For office use only) **CIN - -**

Under the New Access to Cannabis for Medical Purposes Regulations (ACMPR) individuals with a medical need, and who have the authorization of their health care practitioner, will now be able to access cannabis in three ways; they can continue to access quality-controlled cannabis by registering with licensed producers, they can register with Health Canada to produce a limited amount for their own medical purposes, or they can designate someone else to produce it for them.
ARA - Avanti Rx Analytics Inc. a Health Canada approved organization can provide full analytical testing services to those registered and approved individuals whom wish to determine the quality, safety, and efficacy of their cannabis and its extracts.

Client: ______ (Title) ______ (First Name) ______ (Last Name) Date of Birth: ______ (Year) ______ (Month) ______ (Day) Gender: ☐ Male ☐ Female

CONTACT INFORMATION

Residence Address:

Address:	
City:	
Province:	
Postal Code:	

Mailing Address: (if different)

Address:	
City:	
Province:	
Postal Code:	

Main Phone No.: ______ Mobile No.: ______ Fax. No.: ______

E-mail Address: ______

REFERENCE & CREADIT INFORMATION

References	Organization	Contact Name	Affiliation	Phone No.	Fax No.	Mobile	E-mail
Bank:							
Reference 1:							
Reference 2:							
Reference 3:							

AUTHORIZATION

Please read the information on this form carefully and completely.

I have provided information about my credit application. I authorize the ARA – Avanti Rx Analytics Inc. to conduct a reference check with those individuals listed above. I understand that reference information may include, but not be limited to, verbal and written inquiries or information about my credit history and business ratings.

Name: ______ Signature: ______ Date: ______
Name: ______ Signature: ______ Date: ______
Name: ______ Signature: ______ Date: ______

CREDIT CHECK AUTHORIZATION

Upon approval of credit, I agree to honor the ARA – Avanti Rx Analytics Inc. credit terms of net 30 days in Canadian or US Dollar funds. If payment is not made in accordance of terms, I understand that a service charge of 1.8 % per month on past due accounts will accrue.

I hereby grant to ARA – Avanti Rx Analytics Inc. authorize release ratings and payment record information as required to ARA – Avanti Rx Analytics Inc. to obtain a standard factual data credit report through a credit reporting agency chosen by ARA – Avanti Rx Analytics Inc.

My signature/s below authorize the release to the credit reporting agency a copy of my credit application if required. I understand that all information released to ARA – Avanti Rx Analytics Inc. will be held in strict confidence.

Authorized Person's Name: ______ Title: ______ Signature: ______ Date: ______