



**Customer Agreement**  
Version 4.0 - effective February 21, 2005

**NOTE:** Prescriptions cannot be filled unless you: (1) sign and date a copy of this Agreement and (2) complete and sign our Patient Profile. Please **send all pages of both of them together** to Granville Pharmacy Ltd., by mail to #205 – 3077 Granville Street, Vancouver, B.C. Canada V6H 3J9, or by toll free fax to: 1-877-919-7347. Our toll free phone number is 1-888-730-3338

I hereby represent and confirm to Granville Pharmacy Ltd. ("**GPL**") and its affiliates, related companies, subsidiaries and parent companies (in this Agreement, collectively or respectively referred to as the "**GP Group**") and I agree with GPL (and I also agree with the British Pharmacy, unless I mark the box NO to British Medications on the Patient Profile), as follows:

1. I am at least 21 years old and legally competent. The pharmaceutical(s) ("**Medications**") I will order from GPL were lawfully prescribed to me by a medical doctor ("**my doctor**") licensed to practice medicine where I reside or where I sought medical treatment, and I will only use Medications strictly according to my doctor's instructions to me. The prescription(s) (each, a "**Prescription**") for the Medications have not been altered in any way nor will any Prescription ever have been filled before I submit them to GPL.

2. I do not and will not seek or rely on any medical information from anyone other than my doctor. I have consulted my doctor within the last year. I will immediately contact my doctor if I suffer any unexpected side effects from Medications. It is solely my responsibility to have regular medical examinations and tests by my doctor, responsible for my care, especially with regard to my use of Medications.

3. GPL will rely on the accuracy of the information and documentation I provide (including the Patient Profile). I have fully disclosed all pertinent information and documentation to GPL. I will notify GPL in writing of any changes to my physical or medical condition by providing to GPL an updated Patient Profile.

4. I hereby authorize and appoint GPL, as my agent and attorney for the limited purpose of taking all steps (including signing all documents on my behalf) necessary to obtain prescriptions in Canada (unless I mark the box NO on the Patient Profile as to British Medications) and in England, equivalent to the Prescriptions I sent to GPL, to the same extent as I could do personally if I were present taking those steps and signing those documents myself. My authorization shall include, but not be limited to: (a) collecting personal health information about me, collecting similar information from my doctor or pharmacist, (b) disclosing such information to GP Group employees, agents and independent service providers including the Canadian or, as applicable, the British medical doctor (as the case may be, the "**Doctor**") retained on my behalf, as required, for the limited purpose of obtaining Medications, (c) taking all steps and signing all documents on my behalf necessary to package or re-package Medications and to have them delivered and shipped to me as if I had done so personally to my own home address.

5. All services and Medications I receive in Canada connected in any way with GP Group are all being contracted for by me and received by me in Canada and, in that regard, my only contract and agreement is with GPL, though all members of the GP Group and the British Pharmacy may rely on this Agreement. Unless I mark the box NO on the Patient Profile as to British Medications, all services and Medications I receive from and in England connected in any way with GP Group are all being contracted for by me and received by me in England, and in that regard: (a) then my further separate contract and agreement, equally on the terms of this Agreement, is directly with the licensed British pharmacy (the "**British Pharmacy**") selected by GPL for me and on my behalf, (b) my British Medications will be dispensed by and sold to me 'ex works' (meaning from the site in England where the Medications are shipped) and shipped to me by the British Pharmacy, and (c) all members of the GP Group and the British Pharmacy may also rely on such further contract and agreement.



6. The GP Group will be transmitting my personal health information by electronic and other means, and I consent to the GP Group and British Pharmacy doing so (for example, fax or internet) to its employees, agents, affiliates and service providers including the Doctor. I initiated contact with GPL only and I know that no GP Group member is nor is the British Pharmacy located in the United States.

7. All agreements made and contracts formed throughout the course of the relationship between me and GPL shall be deemed to be made in the Province of British Columbia, Canada and accordingly shall be governed only by the laws of the Province of British Columbia and the laws of Canada applicable in British Columbia, and that any dispute arising between me and any member of the GP Group shall be governed only by the laws of the Province of British Columbia and the applicable laws of Canada, and the courts of the Province of British Columbia shall have sole and exclusive jurisdiction over any such dispute. Further, all further agreements made and contracts formed throughout the course of the relationship between me and the British Pharmacy shall be deemed to be made entirely in England and accordingly shall be governed only by the laws of England applicable to such contracts and agreements, and the courts of the England shall have sole and exclusive jurisdiction over any dispute in that regard.

8. I authorize GPL to have my credit card charged the following amounts: (a) the price of the Medications plus shipping (in US Dollars) as posted on the applicable GP Group web site on the day GPL receives my order; and (b) if my payment is not authorized by the credit card issuer, GPL may cancel my order.

9. GPL and the British Pharmacy shall be entitled to substitute a brand name Medication with a generic Medication, where available, unless my doctor has written on the Prescription that there be "no substitution". Once purchased and shipped, no Medications may be returned or exchanged unless, if GPL agrees, the Medication provided does not correspond with my Prescription.

I have read and understood all the terms and conditions set out in this Agreement and agree I am and all my personal representatives and assigns are legally bound by this Agreement.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_

x \_\_\_\_\_  
My signature

\_\_\_\_\_  
My name [please print]



**Patient Medical History and Order Form**

**Patient Information**

Full Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

Birthdate (mm/dd/yy) \_\_\_\_/\_\_\_\_/\_\_\_\_ Male/Female Wt \_\_\_\_\_

Best time to contact you (circle one) Mornings Afternoons Evenings after 5 pm

**Shipping Address** (if different from above)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Secondary Contact**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Relationship to you \_\_\_\_\_

**Your Primary Physician**

Name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

I have seen my primary physician in the last 12 months Yes / No

Allergies to drugs (please list by name)

-I will accept generic drugs where available to help save money? Yes / No

- If you would prefer us not to use safety caps, please check this box

- If you do NOT want medications from a British Pharmacy, please check this box

- Please enter all medications you wish to order. Also list medications that you are currently taking but do NOT wish to order at this time (quantity=0)

- Please mail original prescription(s) OR have your doctor fax a copy to us toll-free at **1-866-91-**

**DRUGS**

| Drug Name | Strength | Directions for use | How long have you been taking this drug? | Quantity requested | Medical condition this drug is used to treat |
|-----------|----------|--------------------|--|--------------------|--|
| Name      | 12mg     | 1 tablet a day     | 8 months                                 | 90 pills           | Thyroid                                      |
|           |          |                    |  |                    |  |
|           |          |                    |  |                    |  |
|           |          |                    |  |                    |  |
|           |          |                    |  |                    |  |
|           |          |                    |  |                    |  |
|           |          |                    |  |                    |  |
|           |          |                    |  |                    |  |

Medical conditions not listed above

**Payment information**

Credit Card type VISA / MasterCard Card holder name \_\_\_\_\_

Credit card number \_\_\_\_\_ Exp date \_\_\_\_\_

Agent Number (for internet use only) \_\_\_\_\_