

Getting Started



Thank you for your interest in our prescription service. American patients can save from 30-85% on the cost of their medications by getting their prescriptions filled through The Canadian Pharmacy (TCP). TCP allows U.S. patients to access the same medications available in the U.S., but at much lower Canadian Prices.

If you need any information regarding the price of your prescription(s) or have any questions please contact us toll free at **1-866-335-8064** or visit our website at **www.TheCanadianPharmacy.com**.

HOW TO ORDER

Step 1: Please complete and sign the New Customer Package (i.e. Medication Order Form, Health Questionnaire and Customer Agreement). You will only have to fill out these forms the first time you order. Any information you provide will be kept strictly confidential.

Step 2: Simply mail your completed New Customer Package to us along with your original prescriptions (with additional refills indicated), OR to save mailing time, fax it **toll-free to 1-866-795-5627**.

Mail to: The Canadian Pharmacy
84 – 1313 Border Street
Winnipeg, Manitoba CANADA, R3H 0X4

CHARGES

1. Drug prices as quoted by TCP's staff. (Prices subject to change)
2. Shipping fee is a flat rate of \$15.00 per package. (Not per drug, but per shipment)

PAYMENT

We accept VISA, MasterCard, Personal checks and money orders made out to The Canadian Pharmacy.

SHIPPING AND PROCESSING

Once we receive your completed order, we require 2 weeks for processing and shipping. All orders are shipped via Canada Post and the U.S. Postal Service.

REFILL POLICY

When obtaining your new prescription please make sure that it has refills on it. Having refills on a prescription makes re-ordering your medications quicker and easier. No additional information is required for refills unless your medical condition has changed. After your refills are completed, a new prescription from your physician is required.

PLEASE BE ADVISED

The U.S. FDA limits the quantity of medication that you can order to a maximum of a 3-month supply. If your prescription allows refills, simply call us to order your refill.

We are not allowed to ship controlled substances such as amphetamines, benzodiazepines (e.g. Valium), or narcotics such as codeine and morphine, or refrigerated products.

Most American insurance companies will accept receipts issued from a Canadian pharmacy, however, patients with drug insurance plans should contact their insurance company first before ordering.

Our service is open to anyone. Please feel free to provide our toll-free number or contact information to friends and family, or make copies of these forms as you require. Thank you.

Please keep this page for your records. You do not need to fax or mail this page.



To place an order, complete this Medication Order Form and return it by fax or mail along with: 1) Original Prescription(s)* 2) Health Questionnaire Form 3) Customer Agreement Form
 * Original prescriptions are void if altered.



RxCanadaPharmacy.com

Toll Free Phone: (866) 335-8064

info@RxCanadaPharmacy.com

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 Winnipeg, Manitoba, CANADA R3H 0X4
 Toll-Free Phone: 1.866.335.8064
 Toll-Free Fax: 1.866.795.5627
www.TheCanadianPharmacy.com
info@TheCanadianPharmacy.com

Date: _____
 (DD/MM/YYYY)

SHIPPING INFORMATION:

Patient Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone: _____ (day) _____ (evening)

Email Address: _____

(Please check ✓)				Medication Name	Strength	Quantity	Price (USD)
Brand Only	Generic Preferred	International Permitted	Is this a New Medication?				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				\$
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				\$
Prescription Drug Total							\$
Add \$15.00 Shipping (Insured, trackable ExpressPost USA)							\$15.00
Total (U.S. Funds)							\$

Please Note: Due to supply restrictions imposed on TCP and other Canadian IPS pharmacies by certain pharmaceutical manufacturers, pricing may vary. Supply is subject to availability.

BILLING INFORMATION: **VISA** **MasterCard**
Desired Payment Method: **Personal Check** **Money Order**

Credit Card #: _____ **Expiry Date** _____

Name on Credit Card: _____

Cardholder's Signature: X _____
 (I authorize The Canadian Pharmacy to bill my credit card for this order)

When is the most convenient time for a pharmacist to contact you? During the Day? Evenings?

Child resistant closures, where appropriate, are mandatory in Manitoba unless patients decline their use. If you DECLINE child resistant safety closures please check here.

Safeguarding the confidentiality of your personal information is a primary concern at TCP. TCP will not release any personal, medical or financial information to anyone other than the health professionals responsible for filling your prescriptions, without your written consent.

Medication Order Form

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Date: _____
 (DD/MM/YYYY)

Patient Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone: _____ (day) _____ (evening)

Email Address: _____

Sex: Male Female **Date of Birth:** _____ **Weight:** _____
 (DD/MM/YYYY) (Pounds)

Known Drug Allergies:

Prescribing Physician Information:

Name: _____
Telephone: _____
Fax: _____

TCP requires ALL patients to have a complete physical examination each calendar year.
When was your last physical examination? _____ (MM / YYYY)

Please list all Prescription, Over-the-Counter and Nutritional Supplements you are using (E.g. Premarin, Zocor, Tylenol, TUMS, Vitamins, etc.):

Medication Name	Strength E.g. 10 mg	How Often? E.g. times/day	Taken Since? E.g. Since 1995

Please identify all current Medical Conditions:

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Disease (please describe below) |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis (Rheumatoid, Osteoarthritis & Lupus) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Cancer (please describe below) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney / Renal Disease | <input type="checkbox"/> COPD – Bronchitis & Emphysema |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes (please describe below) |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Thyroid Disorders |

Others not listed above:

Patient Signature: X _____ **Date:** _____

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Customer Agreement Form

In consideration of 4741677 Manitoba Ltd. (operating as The Canadian Pharmacy (TCP)) filling the prescription for my medication, I agree that the following information is correct and provide the following releases:

A. About my medication

1. I confirm that the medications I have requested dispensed to me were originally lawfully prescribed by a qualified and licensed physician in the jurisdiction where I live after the appropriate personal examinations as determined by my jurisdiction's Standards of Practice; and
2. I confirm that the duty of care in respect to the prescribing of my medication is the responsibility of my physician; and
3. I will not use my medication except as directed by my physician, under whose care I continue to be; and
4. I will be the only person using the medication obtained from TCP; and
5. I acknowledge that I cannot return my medication for refund or exchange; and
6. I acknowledge that no child protective packaging will be used for my medication if I so indicate; and
7. I confirm that my original prescription has not been altered in any way.

B. About me

1. I am of the age of majority in the jurisdiction where I live; and
2. I am entitled to make my own medical decisions under the laws of that jurisdiction; and
3. In obtaining the prescription for my medication, I have not broken any laws in that jurisdiction.

C. My Appointment of TCP as my attorney to engage International Referral Pharmacies on my behalf

1. I understand, authorize, agree and direct that, as a result of restrictions on supply of certain pharmaceuticals placed on TCP by certain manufacturers, I appoint TCP as my agent and attorney whereby TCP may engage other pharmacies licensed under applicable law in any one or more of the United States, United Kingdom, New Zealand, Australia, Israel, or members of the European Union or elsewhere to dispense any or all of my Pharmaceutical(s) and I hereby expressly appoint TCP as my agent and attorney to do so. I acknowledge that in the event that I do not wish to have my Pharmaceuticals dispensed by an International Provider, I will provide notice to TCP in writing to the time of my medication order; and
2. I understand, authorize, agree and direct that my Pharmaceutical(s) will be shipped directly to me (and that I am purchasing My Pharmaceutical(s) from) the dispensing pharmacy which may be TCP in Canada or an International Referral Pharmacy and that it is only those pharmaceuticals dispensed by TCP that I am purchasing from TCP. I further acknowledge that if My Pharmaceutical(s) are dispensed by an International Referral Pharmacy that they will be dispensed and arrive at my address separately.

D. Acknowledgement of Location of Dispensing and Delivery of Medications

1. I grant authority to TCP as my attorney for the purpose of signing any documents required by the laws of the Province of Manitoba in Canada to expedite the delivery to me of my medication, as I would sign if I had purchased my medication from TCP at its retail outlet in Winnipeg, Manitoba; and
2. I grant authority to any International Referral Pharmacy selected by TCP as my attorney for the purpose of signing any documents required by the laws of the jurisdiction of the International Referral Pharmacy to expedite the delivery to me of my medication, as I would sign if I had purchased my medication in the jurisdiction of the International Referral Pharmacy.

E. About the releases

1. I release and discharge TCP and its directors, officers, agents and employees from any and all liability, claims, actions or causes of action with respect to errors or omissions by the carrier responsible for delivering my medication to me.
2. I acknowledge and agree that I am aware that the Providers will be transmitting my personal information by electronic means to their respective partners. I hereby grant my consent to transmit my personal information by electronic means.

F. About any disputes

1. I acknowledge that if my medication(s) are dispensed by TCP, the pharmacy service of TCP was performed in the Province of Manitoba, in the same way as if I had physically went to TCP's location in Winnipeg, Manitoba, Canada; and
 - i. I agree that any dispute, complaint, demand, claim, or cause of action, whether based on alleged breach of contract or alleged negligence arising between TCP and me from TCP filling the prescription for my medication, will be governed by the laws of the Province of Manitoba and only the Province of Manitoba and the regulations of the Manitoba Pharmaceutical Association and any applicable federal laws of Canada; and
 - ii. I attorn to the jurisdiction of the Province of Manitoba in Canada; and
 - iii. If any dispute does arise between TCP and me from the purchase of my medication that cannot be resolved on the basis of both sides acting reasonably, then such dispute shall be referred to arbitration in Winnipeg, Manitoba in accordance with The Arbitration Act of the Province of Manitoba; and any award or determination shall be absolutely final and binding upon TCP and me.
2. I agree that if my medication(s) are dispensed by an International Referral Pharmacy, the pharmacy service of any International Referral Pharmacy was performed in that jurisdiction, in the same way as if I had physically went to the International Referral Pharmacy; and
 - i. I agree that any dispute, complaint, demand, claim, or cause of action, whether based on alleged breach of contract or alleged negligence arising between International Referral Pharmacy and me from International Referral Pharmacy filling the prescription for my medication, will be governed by the laws of that jurisdiction; and
 - ii. I attorn to the jurisdiction of the International Referral Pharmacy; and

BY SIGNING THIS FORM, I CONFIRM THAT I HAVE READ AND UNDERSTAND ALL THE TERMS AND PROVISIONS OUTLINED IN IT AND CONFIRM THAT THE INFORMATION ABOUT ME AND MY MEDICATION IS TRUE AND CORRECT, AND I AGREE THAT SAID TERMS AND PROVISIONS ARE BINDING ON ME AND MY HEIRS, SUCCESSORS, ASSIGNS AND PERSONAL REPRESENTATIVES.

Patient Signature: X _____ **Date:** _____

Patient Name (Please Print) _____