Springfield Pharmacy

PHONE: 1-833-781-5773 **EMAIL:** info@spfpharmacy.com
FAX: 1-844-803-5627 **WEBSITE:** www.spfpharmacy.com

30 Co-OP Dr
Oakbank, MB
R0E 1J0
Canada

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://spfpharmacy.com/faq/

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Payment Options:

☐ **PERSONALCHECK**
I will email a signed, void check to
30 Co Op Dr
Oakbank, MB
R0E 1J0
Canada

☐ **Electronic Funds Transfer**

Routing # (9 Digits) : _____

Account #: _____

☐ **Call 1-833-781-5773**
For other convenient payment options

Prescription Submission

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

Option2: Fax Prescription with this form to
1-844-803-5627

Option3: Mail Prescription with this form to
30 Co Op Dr
Oakbank, MB
R0E 1J0
Canada

Option 4: ***Contact My Doctor***

_____ _____ _____
Dr. Name Phone # Fax #

Patient Authorization (Please Check One)

Springfield Pharmacy (the "Pharmacy")is a pharmacy based in Winnipeg, Manitoba, Canada, that specializes in assisting patients obtain high quality, affordable prescription and non-prescription medications. (collectively, the "Products") . The following terms and conditions apply between you (the "Patient") and 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 further physical examination.
2. I understand that all Products shall be sold and dispensed by a Pharmacy operating within a unique international jurisdiction (currently Canada) and in a manner consistent with the laws of this 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 the Products and delivering them to me. This authorization shall include, but not be limited to: (a) 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 Products that have been approved for sale in the jurisdiction of the Pharmacy. Title to the Products passes from the Pharmacy to me in the jurisdiction of the Pharmacy when the Products 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, the Patient, and the Pharmacy, its employees, agents, affiliates, officers, directors, legal representatives and assigns.

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)