MedsEngage
YOUR PRIVATE PHARMACY

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Unit 208, 4656 Westwinds Drive, NE, Calgary, AB Canada T3J 3Z5

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☐ **PERSONAL CHECK**
I will email a signed, void check to
OCM Processing Inc.
Unit 208, 4656 Westwinds Drive,
NE, Calgary, AB Canada T3J 3Z5

☐ **Electronic Funds Transfer**
Routing # (9 Digits) : _____
Account #: _____

☐ **Call 1-800-986-4714**
For other convenient payment methods.

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hLJűᴧ2y' мY Email Prescriptions to (scan or take picture)
l-ŘYˆᴧy'X YˆŜŘăŜyƎl-ƎŜΦÔ2Y

☐

hLJűᴧ2y'н: Fax Prescription with this form to
1-800-986-4751

hLJűᴧ2yo: Mail Prescription with this form to
OCM Processing Inc.
Unit 208, 4656 Westwinds Drive,
NE, Calgary, AB Canada T3J 3Z5

hLJűᴧ2y' пY ***Contact My Doctor***

Dr. Name	Phone #	Fax #

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MedsEngage.com (the "Pharmacy") is an online platform working with verified pharmacy partners from US, UK, Canada, Turkey & India, 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 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.

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☐ "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)