World Health Link.com

Email: info@worldhealthlink.com
Web: www.worldhealthlink.com

CODE: MKT: AFF:

Phone: 1-844-494-5465 International: 1-204-789-4153
Fax: 1-855-594-5465 International Fax: 1-204-272-0268

Personal Information:

Full Name (Please print clearly) ☐ Male ☐ Female

Street Address

City State/Province Country Zip/Postal Code

( ) ( )
Phone (Home) Phone (Other)

Email Birth Date (MM/DD/YY)

Please check if you are placing this order for a pet.

☐ Cat ☐ Dog ☐ Other (Please specify) _____

First Time Patient Information (Authorized Contact):

Please fill out this section if you are a first time patient, or to update your information on file.

Authorized Contact:

Full Name of Secondary Contact (Please print clearly)

( )
Relationship to you Phone

Your Physician:

Primary Physician's Full Name (Please print clearly)

Clinic Name/Street Address

City State/Province Country Zip/Postal Code

( ) ( )
Phone Ext. Fax

Allergies:

Do you have any severe allergies? ☐ YES ☐ NO If yes, please describe below:

Medication:

For medication(s) that you wish to order, please enter the quantity (max 3 month supply), and listed price, as obtained through our website or customer service center. We will accept a copy of your prescription by Upload, Email, or Fax. Please follow up by mailing in the original prescription, to comply with Canadian International Pharmacy Association standards. (Pricing in $US).

Remember! Couples need to fill out and submit separate order forms!

Generic OK?	Medication	Strength	Qty	Price
			SHIPPING:	$9.95
			TOTAL:	

Take advantage of a ONE TIME Lifetime Shipping fee of $49.95 for your household! Sign up today instead of paying $9.95 for each order!

Medication (Continued):

Please list any additional medications, vitamins, minerals, and herbs you are taking (you will not be purchasing) , to comply with Canadian International Pharmacy Association standards.

Medication	Dosage	Frequency

Referral Program:

Please complete to earn credits for yourself and the person who referred you!

( )
Full Name of person who referred you Phone

/
Patient's Signature Date (MM/DD/YY)

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Please list the medications you would like us to contact your Doctor for, or to transfer from another Pharmacy:

Medication Name	Strength	Directions	Rx Number
We are able to contact your Doctor and/or transfer your prescription (only available to residents of the United States and Canada).			

CUSTOMER ORDER & AUTHORIZATION AGREEMENT (Please check one):

☐ WorldHealthLink.com™, which includes its officers, directors, affiliated entities, representatives, agents, contractors and sub-contractors (collectively, "WHL") is an international prescription referral service that is committed to helping ensure that I, the undersigned customer ("I" or "Me"), am able to obtain medication, products and /or services (collectively, the "Product") from licensed pharmacies and/or government approved dispensaries. This Customer Order & Authorization Agreement ("Agreement") shall govern all sales of Product facilitated by WHL between me and any of WHL's authorized pharmacies and/or government approved dispensaries located in Canada, the United Kingdom, Singapore, Turkey, New Zealand, Australia and Mauritius (collectively, the "Pharmacy"). I acknowledge and agree that:

1. I am the age of majority, am fully competent to make my own health care decisions and have obtained any prescription(s) for the Product in a lawful manner.

2. I initiated contact with and understand that WHL is not located in the United States.

3. I have fully and accurately disclosed my personal information and personal health information and consent to its use by the Pharmacy, have had a physical examination by a physician within the last 12 months, and do not require a physical examination.

4. If I suffer any adverse effects while taking the Product that I will immediately contact my prescribing physician ("My Own Physician") and in the event that I come under the care of another physician, I will inform him or her of any and all Product that I have been prescribed.

5. I will be solely responsible for any adverse effects that I may suffer from taking or continuing to take the Product in the event that I have failed to fully furnish my complete and accurate medical history to WHL and/or if I fail to notify My Own Physician and WHL of any change in my physical or medical condition.

6. WHL will only verify and facilitate the delivery of Product that My Own Physician has already prescribed to me. No controlled medications, narcotics, tranquilizers, or other medications that WHL and/or the Pharmacy deem inappropriate will be provided.

7. I authorize and appoint WHL and the Pharmacy, as my attorneys and agents, 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 Product and delivering it to me. This authorization shall include, but not be limited to: collecting and using my personal and personal health information as reasonably necessary for the fulfillment of my order, including disclosure to a licensed physician for the issuance of a valid prescription in the jurisdiction of the Pharmacy, if required. Any review of my medical information by such a licensed physician is in no way intended as a means to diagnose any medical condition and does not substitute the requirement for me to obtain my own professional medical advice from My Own Physician. This authorization may be revoked at any time and shall continue until I revoke it.

8. 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 Product that has been approved for sale in the jurisdiction of the Pharmacy. Title to the Product passes from the Pharmacy to me when the Product leaves the Pharmacy. The Pharmacy delivers the medication to my agent in the Pharmacy's jurisdiction. Typically this agent is a delivery service, in which case I give the Pharmacy or its agent authority to select the agent on my behalf.

9. Any and all agreements reached or contracts formed and transactions undertaken with or involving the Pharmacy are and shall be deemed to be made in the jurisdiction of the Pharmacy and shall be governed by the laws of the jurisdiction of the Pharmacy applicable to such contracts, agreements and transactions (unless WHL elects otherwise in its sole discretion). The Courts of that jurisdiction shall have sole and exclusive jurisdiction over any dispute that may arise between me and the Pharmacy and I agree to attorn to the Courts of that jurisdiction for any and all such dispute or disputes (unless WHL elects otherwise in its sole discretion).

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 customer 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 customer's behalf."

Patient's Signature Date (MM/DD/YY) /

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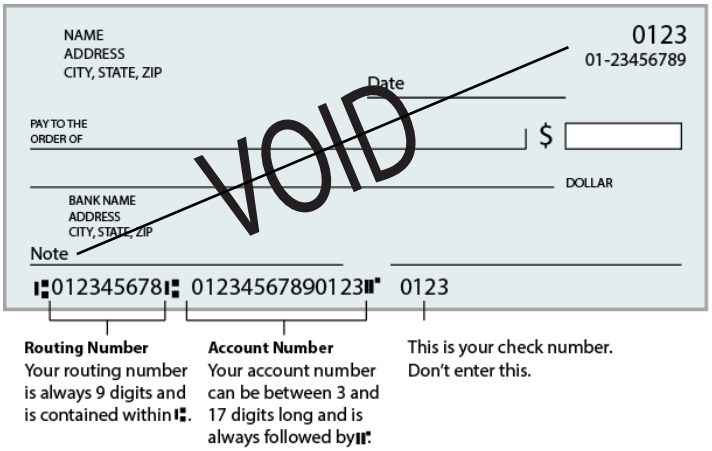
Payment Option 1:

eCheck21 (Please provide your banking Check information):

Your Routing Number

Your Account Number

Please include a copy of a voided check for verification purposes:



Payment Option 2:

Personal Check, Cashier's Check or International Money Order:

Please make Personal Check or International Money Order paid to:

WorldHealthLink.com

- ◯ I will send a PERSONAL check.
- ◯ I will send a CASHIER'S check.
- ◯ I will send an International Money Order. (Included with forms)

WorldHealthLink.com
WorldHealthLink
PO Box 42 Station Main
Winnipeg, MB R3C 2G1
Canada

Mailing/Information Contact:

◯ Option 1:

Please mail your prescription and these forms to the address above:

◯ Option 2:

Contact My Doctor Please mail these forms to the address above and make sure that your Doctor's information is accurately filled out on page 1.

◯ Option 3:

Please mail these forms to the address above and transfer my prescription from another Pharmacy .

Rx Number of prescription

Pharmacy Name (Please print clearly)

Street Address

City State/Province Country Zip/Postal Code

( ) ( )
Phone Ext. Fax

Please use this form to submit your prescription(s), and send it back to us to complete your order.

/
Patient's Signature Date (MM/DD/YY)