CANNABIS
TREATMENT
CLINIC

CANCELLATION OF REGISTRATION

Date: _____

Attn: Licensed Producer,

To whom it may concern, please be advised;

I,_____(First & Last Name) , born on _____ (DD/MM/YYYY),

living at _____ (Full Address) am hereby requesting

cancellation of my registration with your company, effective immediately.

Thank-You,

Patient Signature: _____

Forms can be sent via email or fax

info@ctclinic.ca 1-888-731-6269

Any Questions

416-297-7762 www.ctclinic.ca