Canada PharmaHub

Medication Order Form

Please fill out the following form to place your medication order. Ensure all information is accurate to avoid delays in processing.

Patient Information

First Name:

Last Name:

Date of birth:

Gender: ◯ **Male** ◯ **Female**

Phone Number:

Email Address:

Shipping Address

Country:

State/ Province:

City:

Zip/Postal Code:

Street Address:

Please make sure to include your house number and any other necessary details to ensure successful delivery.

Medication Information

Medication Name #1:

Dosage:

Quantity:

Prescription Required: ◯ **Yes** ◯ **No**

Upload Prescription: **Attach a scanned copy or photo for online/fax submissions**

Medication Name #2:

Dosage:

Quantity:

Prescription Required: ◯ **Yes** ◯ **No**

Upload Prescription: **Attach a scanned copy or photo for online/fax submissions**

Payment Information

Payment Method: ◯ **Credit** ◯ **Other**

Cardholder Name:

Card Number:

Expiration Date:

CVV:

Billing Address

Same as Shipping Address: ◯ **Yes** ◯ **No**

Country:

State/Province:

City:

Zip/Postal Code:

Street Address:

Additional Information

Preferred Shipping Method: ◯ **Standard Shipping** ◯ **Expedited Shipping** ◯ **Overnight Shipping**

Special Instructions or Comments:

Consent and Verification

Agreement: ◯ **I confirm that the information provided is accurate.** ◯ **I understand that prescription medications require a valid prescription.**
◯ **I consent to the use of my personal data for the purpose of processing this order.**

Signature:

Date: