CALL USA/CANADA TOLLFREE +1-800-626-1035

(7 days a week: 8:00 AM - 8:00 PM EST)

Patient Order Form

Email Completely filled scanned copy of the ORDER FORM at
orders@completemedonline.com

Personal Information

Patients First Name: _____

Patients Last Name: _____

Gender: _____

Address Information

Street Address: _____

City: _____

Zip Postal Code: _____

Patients State / Province: _____

Country : _____

Contact Information

Phone No. : _____

Best Time to be contacted: _____

Fax number: _____

Medical Information

S.No	Medication Name	Strength	Quantity	Price

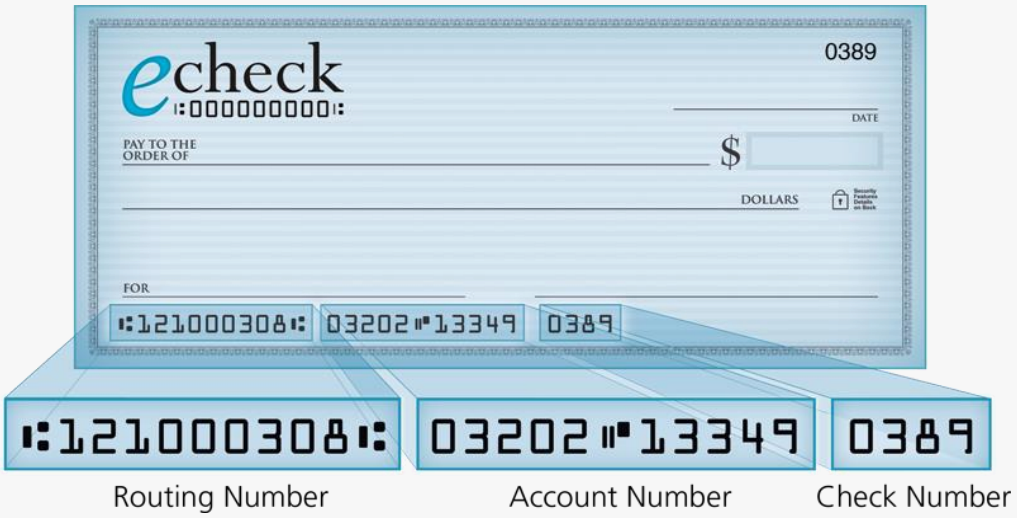
Cont....2

Payment Information for US customers (We take payments via eCheck):

9 digit routing number: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Account number: _____

Check number: _____



NO PRESCRIPTION(S) CAN BE FILLED BEFORE AND DATED COPIES OF THIS ORDER FORM AND PATIENT APPLICATION HAVE BEEN ISSUED BY *COMPLETEMEDONLINE.COM.*

Patient authorization:

The foregoing terms and conditions regulate sales as between ***completemedonline.com*** (the "Pharmacy") and the customer **(the "Patient"**) in respect of the goods and services **(the "Products")** provided by the Pharmacy for sale.

1- I also completely and properly recorded my relevant details and health information and consent to the Pharmacy's usage of it. I have undergone a medical test from a specialist in the last 12 months, so will not need a physical exam.

2- I agree that a pharmacy located within a particular foreign jurisdiction and in a manner compliant with the laws of that jurisdiction shall market and dispense all Goods.

Cont....3

3- I approve and assign the pharmacy as my solicitor and representative to follow all action, sign all paperwork and work on my behalf as though I were present and working for the specific purposes of (a) receiving a legitimate prescription for every medication I have submitted to the pharmacy; and (b) packing and distributing my medications to me. Such authorisation shall involve, but not limited to: gathering and utilizing my identity and mental health records as fairly required for the execution of my request, including submission to a licensed practitioner if appropriate to obtain a legitimate prescription in the Pharmacy's jurisdiction. This authorisation will at any point be withdrawn and will proceed until I revoke it.

4- I believe that the Pharmacy is lawfully established and fully allowed to do business. Within the Pharmacy's jurisdiction, and that I purchase medicines which have been approved

For sale in Pharmacy jurisdiction.

The description of my medicines moves from the Pharmacy to me in the Pharmacy authority as my medicines leave the Pharmacy. All deals or arrangements signed with the Pharmacy shall be considered to have been made under the Pharmacy's jurisdiction, sales shall be regulated by regulations of Pharmacy jurisdiction, and I attorn to the courts of the jurisdiction of the Pharmacy, That shall have sole and exclusive jurisdiction over any conflict between me and the Pharmacy, its affiliates, officers and directors.

I have read and accepted the terms and conditions set out in this Document and consent to be bound by certain terms and conditions on my own behalf by my successors, descendants, administrators and assigns.

I am the Patient's parent / legal guardian / procurator listed herein, am over the age of majority, and have absolute power to register on behalf of the patient and to make the following statements to the Pharmacy.

Patients Signature: _____

Patients Name: _____

Date (DD/MM/YY): _____

For Queries – orders@completemedonline.com