

GlobalPharmacyProgram.com

Your Prescription For Savings

Our Mission is to be your one and only connection to the best pharmacies worldwide. We are a "Patient Advocate" helping Americans obtain affordable prescription drugs.

Visit Website @ <http://www.GlobalPharmacyProgram.com>

Rx Order Package

P. O. Box 125
Doniphan, Mo.
Postal Code 63935

Low Cost Prescription Program Telephone: 1.573.996.3333

24/7 Hour Fax : 1.573.996.5566

Hours Of Operation:
Monday to Friday 8:00 am - 5:00 pm CST
24 Hour Messaging Service

About Our Organization

Our Mission is to be your one and only connection to the best pharmacies in the world. GlobalPharmacyProgram.com will save American's up to 85% on name brand prescription drugs through licensed GlobalPharmacyProgram.com networked pharmacies and have them mailed directly to your home without sacrificing safety, quality or service.

When you order from us, there are **NO HIDDEN FEES**. You pay the cost of the medication plus a shipping fee of \$10.99 [per order](#), per country, (not per drug). Our average customers have reduced their prescription costs by 55% with some prescribed drugs offering savings of up to 85%!

You can receive your first order within 14 days of placement and all refills will be sent at your request before you run out! Each days thousands of new customers receive their order from Global network licensed and regulated pharmacies. All of our orders are reviewed by a licensed Global Network physician then filled by a licensed pharmacist.

How To Order? Follow Our 5 Simple & Easy Steps ...

1. Obtain the medication from our price list.

If you haven't already selected from GlobalPharmacyProgram.com the medications you wish to order, please visit our website at www.GlobalPharmacyProgram.com. We also have a printable version available for your convenience and reference. Please visit our [about us](#) page for info on how and why you can save hundreds, even thousands of dollars.

If you prefer to speak to a dedicated staff member to obtain a price quote, please call us **at 1.573.996.3333**. Our hours of operation are Monday to Friday from 8:00am to 5:00pm central standard time.

2. Complete and sign the 3 forms attached.

Included in the Rx ordering package is a ***Prescription Medication Order Form, Customer Details Form, Medial History, Customer Agreement Form and Fax Cover Sheet to fax your prescription.***

3. Fax or mail us your forms along with a copy of the original prescription from your doctor.

Our **24/7/365 fax line is 1.573.996.5566**

Our mailing address is:
GlobalPharmacyProgram.com
P. O. Box 125
Doniphan, Mo.
Postal Code 63935

4. Our contracted pharmacy technicians will review and process your order promptly.

Should we have any questions about your prescription order, a technician will contact you. If you provide your e-mail on the order form, we'll send you a tracking number for which you can use to track your shipment via expedited Canada Post online. (www.CanadaPost.ca)

5. Delivery to your home.

Your prescription package will be sent to the address provided on your order form. Shipping costs are \$10.99 US funds for per order per country (not per drug) and may take up to 2-6 weeks for delivery.

Thank you for choosing Global Pharmacy Program and visiting GlobalPharmacyProgram.com

physician info

Occasionally, we are required to contact your physician to verify particulars of your prescriptions. Please fill out the following form with your current physician information for our records.

Primary Physician Name _____

Address _____

City _____ State/Province _____

Country _____ Zip/Postal Code _____

Telephone (____) _____ Fax (____) _____

License Number _____

Date Last Consulted (mm-dd-yyyy)

Reason _____

Canadian only: please fill out the following information.

Provincial Health Care Number _____

Secondary Insurance Plan Number _____

Type of Plan _____

Other (Please specify) _____

Prescription Details

Please enter details of the medications you are ordering

Drug Name	Strength	Quantity	Price (US)
			Shipping
			Total

medical history

Please answer ALL the questions below, if answer 'Yes' please circle applicable condition and give details:

- 1a. HEART & BLOOD, e.g. High Blood Pressure, High Cholesterol, Coronary Artery Disease, Heart Attack, Murmur, Congestive Heart Failure, Angina, Swelling of Ankles, Irregular or Rapid Pulse, Hemophilia, Leukemia, Sickle Cell Anemia, Blood Clotting etc.?

yes no if "YES", please provide details:

- 1b. NOSE, THROAT & LUNGS, e.g. Asthma, Bronchitis, Persistent Cough, COPD, Pleurisy, Emphysema, etc.?

yes no if "YES", please provide details:

- 1c. LIVER, STOMACH, INTESTINES, KIDNEYS, BLADDER & GENITAL ORGANS, e.g. Hepatitis, Ulcers, Acid reflux, Frequent Indigestion, Ulcerative Colitis, Crohns Disease, Inflammation, kidney dialysis, enlarged prostate, Stones, Pus or trouble urinating, sexually transmitted diseases etc.?

yes no if "YES", please provide details:

- 1d. NERVOUS SYSTEM & PSYCHIATRIC CONDITIONS, e.g., Neurological Disorders, Epilepsy, Seizure, Parkinsons, Migraines, Convulsions, Stroke, Alzheimer's disease, Glaucoma, Cataracts, Nervous Breakdown, Anxiety, Depression, Bipolar, Schizophrenia etc.?

yes no if "YES", please provide details:

- 1e. GLANDULAR SYSTEM, e.g. Thyroid, Endocrine disorder, Anemia, Diabetes, Gout, Enlarged Lymph Nodes, etc.?

yes no if "YES", please provide details:

- 1f. SKIN, MUSCLES, BONES & JOINTS, e.g. Arthritis, Osteoporosis, Frequent Fractures, Paralysis, Unusual Skin Lesions, Psoriasis, Eczema, etc.?

yes no if "YES", please provide details:

- 1g. IMMUNE SYSTEM, e.g. Immune Deficiencies, Tested Positive to Aids/HIV, etc.?

yes no if "YES", please provide details:

2. Have you undergone Diagnostic tests or Surgery within the last 12 months or been treated for a Tumor or Cancer?

yes no if "YES", please provide details:

3. Do you have severe Allergies?

yes no if "YES", please provide details:

4. Do you currently take Nutraceuticals, e.g. Vitamins, Minerals, Herbs, etc.?

yes no if "YES", please provide details:

5. Do you exercise regularly?

yes no if "YES", please provide details:

6. Is there any significant family (mother, father, brother, sister) history of illness, e.g. Huntingtons Chorea, Diabetes, Seizure Disorders, Heart or Kidney Disease, etc.?

yes no if "YES", please provide details:

7. Is there any other medical condition or history not mentioned above the Physician should be aware of?

yes no if "YES", please provide details:

8. Are there any other medications you are currently taking? If so please list ALL these medications.

yes no if "YES", please provide details:

My Information

- 24. The collection, retention, disclosure and use of my personal health information by CanAm shall be governed by the privacy policy of CanAm in effect, and as amended, from time to time, in the reasonable exercise of CanAm's discretion.
- 25. I authorize CanAm to collect from me, my Primary Physician, an NSP or my pharmacist, and share with any NSPs and pharmacists which fill my Prescription(s) or any physician who co-signs or re-writes my Prescription(s), my personal health information, for the purposes of facilitating the filling of my Prescription(s). NSPs may also share my information with each other in order to fill my Prescription(s) and promote safety.

Dispensing

- 26. CanAm and the NSPs which fill my Prescription(s) are relying on the health information and documentation that is provided by me. This includes, but is not limited to, my Member Questionnaire and all other related information I forward to CanAm.
- 27. In all cases, CanAm must receive a valid Prescription for fulfillment, and in some cases, a Prescription must be re-written or co-signed by a physician licensed to practise medicine in the jurisdiction in which the NSP filling my Prescription(s) operates. In the event my Prescription must be so re-written or co-signed, the co-signing physician will evaluate my medical profile and may approve my Prescription, but is in no position to modify the Product(s) which I order. This relationship does not replace the relationship I have with my Primary Physician.
- 28. When possible, any Prescription Medication which I order will be in original manufacturer's packaging that may or may not be in child resistant packaging, and I must indicate if I choose or choose not to have child resistant packaging supplied.
- 29. An NSP may substitute a generic Prescription Medication for a brand name Prescription Medication, where available, unless my Primary Physician has indicated there be no such substitution.
- 30. Habit forming, narcotic, or any other controlled Prescription Medication are only available where permitted to be delivered or picked up at the location of the NSP filling my Prescription(s).
- 31. The sale to me takes place in the jurisdiction in which the fulfilling NSP operates, and I become the owner of the Product(s) when the NSP places the Product(s) in a container or otherwise completes the steps necessary to prepare it for my use. I am then responsible for personally importing the Product(s) to my address in the jurisdiction in which I reside. Any steps connected with transportation are carried out by me or by someone acting as agent on my behalf.
- 32. The pharmacists, contracted physicians

and NSPs are located and licensed to practise pharmacy or medicine, as the case may be, in various jurisdictions. All treatment I receive from each of the said pharmacists, physicians and NSPs is being received in the jurisdiction in which each such pharmacist, physician or NSP is licensed and/or operates.

Release & Disputes

- 33. I agree that any and all agreements reached, or contracts formed, throughout the course of my relationship with CanAm shall be deemed to be made in the Commonwealth of the Bahamas (the "Bahamas"), and accordingly shall be governed by the laws of the Bahamas applicable to such agreements and contracts, and I acknowledge that I am benefiting from such laws by engaging CanAm to arrange for my order(s) to be filled.
- 34. Any dispute that arises between myself and CanAm, its affiliates, related companies, subsidiaries, officers, directors, shareholders, employees or agents, shall be governed by the laws of the Bahamas applicable to contracts formed in the Bahamas, provided that the courts of the Bahamas shall have sole and exclusive jurisdiction over any such dispute, including but not limited to, claims of negligence or malpractice. If I am a consumer located in the United States at the time of the order, I may choose instead to refer the dispute for binding settlement to the American Arbitration Association, and the supplementary rules for consumer-related disputes shall apply. One arbitrator will then decide the matter in accordance with the substantive law of the Bahamas. The arbitration shall be governed by the substantive law of the Bahamas, and evidentiary privileges under the law of the Bahamas (such as solicitor-client) will apply as well. No action or claim may be brought more than a year after I receive the Product(s) which I order.
- 35. The dispute settlement provisions contained in these Terms and Conditions shall survive regardless of the invalidity of these Terms and Conditions in whole or in part.
- 36. Where either CanAm or I am liable to compensate the other, the amount is restricted to recovering those actual losses recoverable by the law of the Province of Manitoba, and not any punitive or exemplary damages.
- 37. Any provision in these Terms and Conditions that is invalid or unenforceable shall be deemed to be severable from the other provisions contained in these Terms and Conditions.
- 38. CanAm, and the NSPs, disclaim any and all representations and warranties, whether express or implied, with respect to the Program and my participation in it.
- 39. I release, discharge, indemnify and hold harmless each of CanAm, the NSPs, the

MSRs, each of their respective subsidiaries, affiliates, and suppliers, and each of their respective officers, directors, shareholders, agents and employees from any and all liability, claims, causes of actions or damages of any kind, whether direct, indirect, consequential, incidental, punitive or otherwise, however caused and regardless of the theory of liability, arising from or due to:

- (a) any act, error or omission on the part of any third party who is appointed as my agent pursuant to these Terms and Conditions;
 - (b) termination of the Program and/or my participation in it;
 - (c) errors made by prescribing physicians;
 - (d) any problems that arise from my failure to provide full and accurate information in accordance with these Terms and Conditions;
 - (e) side-effects I experience from the Product(s) which I order;
 - (f) the failure of the Product(s) which I order to produce a particular effect that I or my physician expect or desire;
 - (g) any errors or omissions by the NSP that fills my Prescription(s); and
 - (h) these Terms and Conditions or my participation in the Program except where my loss is caused by CanAm's own actions (and not those of other persons such as NSPs, pharmacist, prescribing physicians, me or my agent, etc) and CanAm is liable for the loss under the law of the Province of Manitoba, Canada, taking into account all limitations or defences, including those stated in these Terms and Conditions.
40. These Terms and Conditions constitute the entire agreement between CanAm and myself, and CanAm and I have no additional obligations or liabilities to one another due to any other statements we may have made prior to my agreeing to be bound by these Terms and Conditions.

BY MY SIGNATURE BELOW, (1) I CONFIRM THAT I HAVE READ AND UNDERSTOOD THESE TERMS AND CONDITIONS, (2) I CONFIRM THAT THE REPRESENTATIONS MADE BY ME IN THESE TERMS AND CONDITIONS ARE TRUE AND CORRECT, AND (3) I AGREE THAT THESE TERMS AND CONDITIONS ARE BINDING ON ME AND MY HEIRS, EXECUTORS, LEGAL PERSONAL REPRESENTATIVES AND ASSIGNS.

(Signature)

(Print Name)

(Date of Execution)



NEW PRESCRIPTION ORDER FACSIMILE TRANSMITTAL SHEET
FAX ORDER TO 1.573.996.5566

THE FINAL STEP IS TO FILL OUT THE INFORMATION BELOW, FAX IT TO US AS A COVER PAGE TO COMPLETE YOUR ORDER:

Your Name: (as written on prescription)	
Address:	
Shipping Address:	
City, State, Postal Code:	
Home Phone:	
Birth Date:	
Number of Prescriptions In This Order:	
Please Attach Prescription(s) to the Box Below Before Faxing:	



Attach Here!



REFILL ORDER FORM

If prescriptions filled for you were written with refills, we can have them filled them as they come due at your request. You may inform us of your request in the following ways:

By Mail: P.O. Box 125
Doniphan, Mo.
Postal Code 63935

By Phone: 1.573.996.3333

By Email: Refill@GlobalPharmacyProgram.com

By Fax: 1.573.996.5566

You may also Order a Prescription and a New Prescription at the same time. A copy of the New Prescription must be sent by fax, mail or electronically to CanadianMeds.com prior to filling the new order.

Name: _____

Phone: (_____) _____

Email: _____@_____

Please refill the following medication(s): (Information is found on prescription label)
(If you are transferring a prescription – please complete the transfer sheet.)

Prescription Number(s)	Name of Medication(s)	Strength	Quantity

Have there been any changes in your Health Profile? Please indicate: No _____ Yes ____ If yes, please indicate: _____

Have there been any changes in your delivery address? No _____ Yes ____ If yes, please indicate: _____

Have there been any changes in your credit card information? Please check the date of expiration on the card. Any changes? Yes _____ No _____ If yes, indicate changes below: _____
