

CanUSAmeds.com CUSTOMER AGREEMENT v 2.6 effective 3/1/05

NO PRESCRIPTION(S) WILL BE FILLED UNTIL A SIGNED AND DATED COPY OF THIS DOCUMENT AND A COMPLETED PATIENT PROFILE HAVE BEEN RECEIVED BY CanUSAmeds.com (CUC) and our partnered Canadian Pharmacy

- IN ORDER TO ASSIST YOU IN OBTAINING YOUR PRESCRIBED MEDICATION FROM CANADA AND OTHER COUNTRIES, WE ARE PROVIDING YOU WITH THE OPTION TO CHOOSE THE COUNTRY OR COUNTRIES YOU WOULD LIKE TO PURCHASE YOUR MEDICATIONS FROM.
- BY SIGNING THIS AGREEMENT, YOU AGREE THAT CUC WILL SELECT FROM ANY OF THE FOLLOWING COUNTRIES, BASED ON PRODUCT AVAILABILITY AND/OR PRICE.
- ALL PHARMACIES ARE LICENSED IN THE COUNTRY IN WHICH THEY ARE LOCATED.
- MY MEDICATIONS MAY BE FILLED BY A LICENSED CANADIAN PHARMACY AND/OR FROM A LICENSED PHARMACY FROM ANY OF THE FOLLOWING COUNTRIES AS FOLLOWS:

Canada New Zealand European Union UK India Australia US ALL

I, as the undersigned, being over the age of 21, hereby enter into this agreement (the "Agreement") with **our partnered Canadian Pharmacy**, and **CanUSAmeds.com(CUC)** intending to be legally bound:

PART I – DISPENSING PHARMACY/MY MEDICATIONS

1.01 I acknowledge and agree:

- a. on my order form I have selected, on a product by product basis, which country (the "Selected Country") I want to purchase My Medications from;
- b. for each product I have ordered, CUC will, as my agent, select a licensed pharmacy (the "Dispensing Pharmacy") from the Selected Country I want to purchase My Medications (defined below) from;
- c. the product(s) being dispensed by a Dispensing Pharmacy will be shipped directly to me by (and I am purchasing My Medications from) the Dispensing Pharmacy;
- d. it is only those of My Medications that are being dispensed by a Canadian Pharmacy that I am purchasing from a Canadian Pharmacy; and
- e. If My Medications are being purchased from pharmacies in different countries, they will be shipped separately but should arrive at approximately the same time.

PART II - DISCLOSURE AND REPRESENTATIONS

2.01 I hereby represent and confirm to CUC, and to each of its affiliates, associates, related companies, subsidiaries and parent company and each of their respective directors, officers, shareholders, employees, contractors, subcontractors, successors and assigns and to My Agents (defined below) that:

- a. My Medications were prescribed by a doctor ("My Doctor") licensed to practice medicine in the country, state or other applicable jurisdiction in which I reside, or where I sought treatment;
- b. the prescription for My Medications ("My Prescription") was lawfully obtained by me from My Doctor;
- c. I will use My Medications strictly according to the instructions provided by My Doctor, as the person for whom they were prescribed;
- d. I can make my own medical decisions according to the laws of the place where I reside;
- e. My Prescription has not been altered in any way, nor has it been filled prior to submission to CUC. I agree to immediately destroy all copies of My Prescription once it has been filled;
- f. I am not seeking or relying on any medical information, advice or approval from CUC or My Agents, and I have consulted a qualified physician licensed in the jurisdiction where I obtained My Prescription within the last year;
- g. I will immediately contact My Doctor in the event I suffer any unexpected side effects from any of My Medications;
- h. I understand that it is my responsibility to have regular physical examinations by my primary licensed physician that is responsible for my care, including all suggested testing, to ensure that I have no medical conditions or problems which would contraindicate me taking My Medications; and
- i. I acknowledge that CUC and My Agents have relied and will continue to rely on the information and documentation that I am providing to them (including this Agreement, My Order, My Prescription and the Patient Profile) and I represent and confirm that I have fully and truthfully disclosed all pertinent information and documentation to CUC. I agree to notify CUC of any changes to my physical or medical condition by providing an updated Patient Profile.

PART III – AUTHORIZATIONS AND CONSENT

3.01 The authorizations, powers of representation and consents that I am providing herein to CUC and My Agents commence on the date I sign this Agreement and will continue until I cancel them. I understand that I can cancel the consents and authorizations I have herein granted at any time.

3.02 I hereby authorize and appoint CUC and My Agents as my agents and attorneys for the limited purpose of taking all steps and signing all documents on my behalf necessary to obtain an Equivalent Prescription (defined below) if required by law in a Selected Country from which I am purchasing My Medications, to the same extent as I could do personally if I were present taking those steps and signing those documents myself. In this Agreement, the term "Equivalent Prescription" means a prescription or equivalent authorization or approval that (in accordance

with Section 1.03 above) is a Selected Country equivalent of My Prescription. This authorization shall include, but not be limited to: collecting personal health information about me; collecting similar information from My Doctor or pharmacist; and disclosing that personal health information to CUC employees, agents, contractors, subcontractors, affiliates and service providers, including without limitation any Agent Physician (defined below), any pharmacy and any pharmacist in a Selected Country being engaged on my behalf (collectively, "My Agents"), as required, for the limited purpose of obtaining the Equivalent Prescription for My Order to be filled.

3.03 Without limiting anything else herein, I hereby provide my consent to allow a physician retained by CUC on my behalf (an "Agent Physician"), in each Selected Country where My Medications are being purchased, to obtain my medical history, drug history, contact information and other necessary documentation from My Doctor. This Agent Physician will be a duly licensed physician in the Selected Country where I am purchasing My Medications. For example, if My Medications are being purchased only in Canada, this Agent Physician will be a licensed Canadian physician; if they are being purchased in more than one Selected Country, an Agent Physician will be engaged in each Selected Country in which My Medications are being purchased (if required by the laws of that Selected Country), in connection with those of My Medications that I am purchasing in that Selected Country.

3.04 I further consent to each Agent Physician and My Doctor being able to contact one another to discuss my medical condition, as it pertains to the prescribing of My Medications. I understand that the reason for this consent is to provide each Agent Physician with the full opportunity to conduct an independent analysis of whether My Prescription is appropriate, and discuss any potential medical complications that might arise. I further understand that my medical information will not be used for any other reason, and will be kept in strict confidence. I further agree to regularly visit My Doctor and to promptly advise the Agent Physician and CUC of any changes to my medical condition or prescriptions. It is clearly understood that I am not seeking medical treatment or service of any kind from any Agent Physician, CUC or My Agents with regard to any medical advice, professional advice or treatment of any kind whatsoever. I have relied only on My Doctor in respect of My Prescription.

3.05 I hereby specifically acknowledge that I am aware that CUC will be transmitting my personal health information by electronic means (for example fax, or secure internet) to My Agents. I understand that the use of electronic means will enhance the efficiency and timeliness of processing My Order. I also understand that CUC, as a custodian of my personal health information, will take all appropriate precautions to protect my personal health information from improper disclosure or use. I hereby consent to CUC's transmission of my personal health information by electronic means to My Agents.

3.06 If I was directed to CUC's services through an intermediary (for example Pharmacy Benefit Manager, Health Management Organization or other service provider), I hereby authorize CUC to release the following data to such an intermediary: a numerical identifier indicating that I was referred from that source; and financial information that will permit the processing of any claims on my behalf. It is my understanding that all such intermediaries will provide confidentiality covenants to CUC whereby they agree to hold any such information in strictest confidence and to abide by the privacy policies of CUC relating to the protection of my personal health information. I specifically consent to the transmission of the foregoing information to such intermediaries by electronic means.

3.07 Subject specifically to Section 1.03 above and Sections 5.01 and 5.02 below, I authorize and appoint CUC and My Agents as my agents and attorneys for the purpose of taking all steps and signing all documents on my behalf necessary to package or re-package My Medications and to deliver them to me, to the same extent as I could do if I were personally present taking those steps and signing those documents myself.

3.08 I acknowledge and agree that I initiated a consultation with CUC and that CUC is not located in the United States. I also acknowledge that My Agents are located either in Canada or in a Selected Country other than Canada, and those of My Agents that are physicians or pharmacists are licensed to practice medicine or pharmacy in Canada or in a Selected Country other than Canada, as the case may be, and that all services that I receive from CUC and My Agents are being received (to the extent that My Medications are purchased in Canada) in Canada or (to the extent that My Medications are purchased in a Selected Country other than Canada) in that Selected Country.

PART IV - PURCHASE AND SALE TERMS

4.01 CUC will, as agent for the Dispensing Pharmacy, charge my credit card the medications price and shipping charges (in US dollars, as determined by CUC) as posted on the CUC web site on the day CUC processes My Order and all other documentation (including the Equivalent Prescription) necessary to enable the Dispensing Pharmacy(ies) to fill My Prescription has been received. In the event my payment is not authorized, CUC has the right to cancel My Order and attempt to provide me with notice of such cancellation.

4.02 I acknowledge and agree that:

- a. Any of My Medications being purchased from a Canadian Dispensing Pharmacy will be packaged in child protected packaging, unless I request otherwise on my Patient Profile;
- b. CUC and My Agents shall be entitled to substitute a brand name prescription drug with a generic prescription drug, where available, unless My Doctor indicates that there be "no substitution";
- c. once purchased and shipped, no pharmaceutical product may be returned or exchanged;
- d. CUC and My Agents reserve the right to refuse to assist me in obtaining My Order or any other order in their sole discretion, in which event I will be entitled to a refund for monies paid for such order;
- e. neither CUC nor My Agents provide their agency or attorney services as a substitute for healthcare or the advice of my primary care physician; and
- f. Neither CUC nor My Agents will exchange medications or return any monies paid once an order is filled, unless the medications provided to me by the supplying pharmacy do not correspond with my prescription.

4.03 I SPECIFICALLY ACKNOWLEDGE AND AGREE THAT EACH AND EVERY ONE OF THESE TERMS AND CONDITIONS (INCLUDING, WITHOUT LIMITATION, MY CHOICE OF SELECTED COUNTRY(IES) AND DISPENSING PHARMACY(IES)) WILL AUTOMATICALLY, AND WITHOUT FURTHER ACTION BY ME OR CUC, APPLY TO AND GOVERN ANY FUTURE ORDERS BY ME OF MEDICATIONS FROM CUC, UNLESS I SPECIFICALLY INDICATE OTHERWISE AT THE TIME OF ORDERING SUCH MEDICATIONS. WITHOUT LIMITING THE FOREGOING, EACH AUTHORIZATION AND CONSENT PROVIDED BY ME IN THIS AGREEMENT WILL CONTINUE UNTIL I CANCEL SUCH AUTHORIZATION OR CONSENT (WHICH I CAN DO AT ANY TIME).

PART V - GOVERNING LAW

5.01 I specifically acknowledge and agree that title to My Medications passes from the Dispensing Pharmacy when My Medications leave the Dispensing Pharmacy, and that any and all agreements reached or contracts formed throughout the course of my purchase of My

Medications are and shall be deemed to be made:

- a. in respect of any of My Medications that are purchased in Canada, in the Province of Alberta, Canada and accordingly shall be governed by the laws of the Province of Alberta and the laws of Canada applicable to such contracts and agreements; and
- b. in respect of any of My Medications that are purchased in a Selected Country, in that Selected Country and accordingly shall be governed by the laws of that Selected Country applicable to such contracts and agreements.

5.02 I specifically acknowledge and agree that any dispute that arises between me and CUC, or any of My Agents shall:

- a. insofar as such dispute relates to CUC or any of My Agents located in Canada, be governed by the laws of the Province of Alberta and the laws of Canada applicable to contracts formed in Alberta, and the courts of the Province of Alberta shall have sole and exclusive jurisdiction over any such dispute; and
- b. insofar as such dispute relates to any of My Agents located in a Selected Country other than Canada, be governed by the laws of that Selected Country applicable to contracts formed in that Selected Country, and the courts of that Selected Country shall have sole and exclusive jurisdiction over any such dispute.

I HAVE READ AND UNDERSTOOD THE TERMS AND CONDITIONS SET OUT IN THIS AGREEMENT AND AGREE, ON BEHALF OF MYSELF, MY HEIRS, SUCCESSORS, ADMINISTRATORS AND ASSIGNS, TO BE BOUND BY THESE TERMS AND CONDITIONS.

Signed this _____ day of _____, 2008.

Signature of Witness

Signature

Please print Witness name clearly

Please print name clearly

Date of Birth (MM/DD/YYYY)

PLEASE USE THE SPACE BELOW TO PRINT THE NAME OF ANY COUNTRY YOU DO NOT WISH TO RECEIVE MEDICATIONS FROM:

Attach a copy of your original prescription here!

Or use a separate page for multiple prescriptions!

*Ask your Dr. , Banker or Librarian (who may have a FAX machine)
to FAX completed forms to :*

866-469-7171

This will save at least 2 days of mail time.

***** IMPORTANT *****

Canadian Law requires that the full patient name, address (and telephone number) must be CLEARLY PRINTED on the written prescription in order for this prescription to be filled.

IMPORTANT - This form (including the customer agreement) must be faxed to 866-469-7171 or mailed to CanUSAMeds.com 3108 S. Rt. 59 Suite 124-287 Naperville, IL USA 60564. DON'T FORGET TO ATTACH A COPY OF YOUR ORIGINAL PRESCRIPTION WITH THIS ORDER.

Information requested by your affiliate site

Agent Number: CUC-1000-10000

PATIENT PROFILE

Enter your Contact Information and primary address: (Please Print Clearly)

Form fields for patient profile including: * First Name, Middle Name, * Last Name, * Gender, * Date Of Birth, * Weight (lbs), * Primary Address, * City/Town, * State, * Zip Code, * Country, Email, * Phone (Home), Phone (Work), Fax, Phone (Cell), Shipping Instructions.

Shipping Address (if different than the address above)

NOTE: Your primary address (above), if this is the only address given, or your separately stated shipping address (below) will be used as the "ship to" address for your prescription orders. The address you provide will be used for all future orders unless and until you notify us that your shipping address has changed.

Form fields for shipping address including: Shipping Address, City/Town, State, Zip Code, Country.

Medical Information

Enter information about your Primary Physician:

Form fields for primary physician including: * First Name, * Last Name, * Address, * City/Town, * State, * Zip Code, * Country, * Phone, Fax.

Check all the medical conditions that you "currently" have:

- List of medical conditions with checkboxes: Alzheimers Disease, Anxiety, Arthritis - Rheumatoid, Osteoarthritis & Lupus, Asthma, Cancer (please describe), COPD - Bronchitis & Emphysema, Depression, High Cholesterol, Epilepsy, Glaucoma, Heart disease (please describe), High blood pressure, HIV / AIDS, Hysterectomy, Kidney or renal disease, Liver disease, Osteoporosis, Parkinsons Disease, Schizophrenia, Thyroid disorders, Tobacco use (do you smoke?), Diabetes (please describe).

Please use the space below to add additional comments regarding the medical conditions you have selected on page 7 and/or other medical conditions not listed.

Drug Allergies: Please check the drug group and circle the corresponding medication.

- | | | |
|---|--|---|
| <input type="checkbox"/> A.C.E. Inhibitors (Vasotec, Altace, Zestril, Accupril, Capoten) | <input type="checkbox"/> Glucocorticoids (Prednisone, Cortisone, Dexamethasone) | <input type="checkbox"/> Penicillins (Amoxil, Lederillin VK, Ampicillin, Augmentum) |
| <input type="checkbox"/> Beta Adrenergic Blocking Agents (Inderal, Tenormin, Sectral, Betapace) | <input type="checkbox"/> Histamine H2 Inhibitors (Zantac, Tagamet, Pepcid) | <input type="checkbox"/> Proton Pump Inhibitors (Aciphex, Nexium, Protonix, Prilosec, Prevacid) |
| <input type="checkbox"/> Calcium Channel Blocking Agents (Norvasc, Diltiazem, Verapamil, Plendil, Nifedipine) | <input type="checkbox"/> HMG-COA Reductase Inhibitors (Lescol, Zocor, Pravachol, Lipitor, Mevacor) | <input type="checkbox"/> Quinolones (Cipro, Noroxin, Levaquin) |
| <input type="checkbox"/> Carbamazepine (Tegretol) | <input type="checkbox"/> Hydantoins (Phenytoin, Dilantin) | <input type="checkbox"/> Selective Serotonin Reuptake Inhibitors (Prozac, Zoloft, Luvox, Celexa, Paxil) |
| <input type="checkbox"/> Cephalosporins (Keflex, Ceclor, Cefzil, Ceftin) | <input type="checkbox"/> Macrolides (Biaxin, Erythromycin, Zithromax) | <input type="checkbox"/> Sulfonamides (Bactrim, Septra, Cotrim, Celebrex, Flomax, Glyburide, HCTZ) |
| <input type="checkbox"/> Cox-2 Inhibitor (Vioxx, Celebrex, Bextra, Mobic) | <input type="checkbox"/> NSAID's (Naprosyn, Aspirin, Relafen, Voltaren, Indocid, Motrin) | <input type="checkbox"/> Tetracyclines (Tetracycline, Minocycline, Doxycycline) |

Please use the space below to add additional comments regarding the allergies you have selected above and/or other allergies not listed.

Order and Existing Prescriptions

Please list below any medications you are currently taking, how long you have been taking them and the conditions for which they have been prescribed: (*If applicable)

Drug Name/Strength	Length Used (Example: 5 years)	Medical Condition (Example: high cholesterol)	Order Today? <input type="checkbox"/> Yes <input type="checkbox"/> No
1)			<input type="checkbox"/> Yes <input type="checkbox"/> No
2)			<input type="checkbox"/> Yes <input type="checkbox"/> No
3)			<input type="checkbox"/> Yes <input type="checkbox"/> No
4)			<input type="checkbox"/> Yes <input type="checkbox"/> No
5)			<input type="checkbox"/> Yes <input type="checkbox"/> No
6)			<input type="checkbox"/> Yes <input type="checkbox"/> No
7)			<input type="checkbox"/> Yes <input type="checkbox"/> No
8)			<input type="checkbox"/> Yes <input type="checkbox"/> No
9)			<input type="checkbox"/> Yes <input type="checkbox"/> No
10)			<input type="checkbox"/> Yes <input type="checkbox"/> No

NOTE: We will only send a 90-day supply in the original manufacturers package or less if requested AND available in original manufacturer's package.

**** All sales are final. We cannot accept the return of any medications.**

To minimize waiting time, please ask your physician to write the prescription for a 3-month supply plus 3 refills. Your initial order for each prescription will be delivered between 14 and 21 days in most cases. All refills should be delivered in approximately 10 days.

- * Please use Generics to save more money: Yes No
- * Please use Childproof lids on containers: Yes No
- * How will you get the original Prescription to us?
 - I will fax the Prescription to you
 - The Physician will fax the Prescription
 - I will mail the original Prescription to the Pharmacy

Payment Options

We offer two forms of payment: Credit Card (Visa or Mastercard) and check.
Please check which option you prefer and fill in the required information.

Option 1: CREDIT CARD

Option 2: PAY BY CHECK

* Card holder's name: _____

Certified Check or Money Order Only: _____

* Credit Card Type: Visa / MasterCard (circle one) _____

Made Payable to: NOT AVAILABLE AT THIS TIME

* Credit Card Number: _____

* Expiration Month: _____

NO PERSONAL CHECKS ACCEPTED

* Expiration Year: _____

*
Cardholder's Signature: _____

In respect of your order, billing information will appear on your bank/credit card statements as follows:

1. for any prescriptions purchased from/dispensed by our Canadian pharmacy, a charge will appear on your bank/credit card statement as a charge from the corresponding pharmacy; and
2. for any prescriptions purchased from/dispensed by a non-Canadian pharmacy, a charge will appear on your bank/credit card statement as a charge from the corresponding pharmacy.

Remember – if you order your prescriptions both from our Canadian pharmacy and from a non-Canadian pharmacy or pharmacies, you will have multiple charges on your bank/credit card statement (one for each country you are purchasing your prescriptions from).

Canadian Doctor Declaration

I provide my consent to allow a physician licensed in Canada to obtain my medical history, drug history, contact information and other necessary documentation from my U.S. physician. In this context, I further consent to both the Canadian physician and my U.S. physician being able to contact one another to discuss my medical condition, as it pertains to the prescribing of the medication(s) in question. I understand that the reason for this consent is to provide the Canadian physician with a full opportunity to conduct an independent analysis of whether the medication(s) prescribed by my U.S. physician is appropriate, and discuss any potential medical complications that may arise. I further understand that my medical information will not be used for any other reason, and will be kept in strict confidence.

I further agree to regularly visit my U.S. physician(s) and to promptly advise the Canadian physician of any changes to my medical condition or prescriptions.

Counseling Information

We offer counseling to all of our patients about the prescription medications we provide. We also ensure that these consultations will be conducted in an atmosphere of confidentiality and privacy. A consultation is designed to provide you, our patient, with important information regarding your prescription medications. A consultation will cover the drug name, what the drug does, how and at what time the drug should be taken, drug interventions, the importance of taking the drug as directed (regularly or when needed), what to do if a dose is missed, common side effects, food, drink or other activities to avoid, special storage requirements and refill information. If you would like a pharmacist to contact you regarding any of these issues or any other drug related question please state so when you send us your prescription.

Thank you for your business,

Cris Whitlock
President
877-469-9619