



Mail/Fax this form to: **Tilray**  
 1100 Maughan Rd  
 Nanaimo, BC  
 V9X 1J2  
 Telephone: 844-845-7291  
 Fax: 888-783-1323

# Medical Document

To be completed by a Health Care Practitioner. All fields required under regulation unless otherwise noted.

## Patient Information

Information must match information on patient registration.

### Patient Name

First Name

Last Name

### Date of Birth

Year

Month

Day

Telephone

### Period of Use

Month(s)

### Daily Usage

g/day

Note: Duration Cannot Exceed One Year

Quantity of Dried Marihuana

NOTE: Range not permitted (e.g. 1-2 g/day)

### Usage Purpose

Primary Condition (Optional)

Primary Symptom (Optional)

## Health Care Practitioner Information

Please print clearly in full (no abbreviations).

### Title / Name

Title

Given Name

Surname

### Profession

### Business Address

Address

City

Province

Postal Code

### Consultation Address

Address of Consultation Location with Patient (If Different Than Above)

City

Province

Postal Code

### Phone / Fax / Email

Telephone (Required)

Fax (If Applicable)

Email (If Applicable)

### Province of Practice

Province in which Practitioner is Authorized to Practice

### Licence Number

Licence number issued by Provincial College

Note: Do not enter billing number (e.g. MSP no.)

### Signature

By signing, the Practitioner attests that the information in this document is correct and complete

Year

Month

Day

### Practitioner Initials

(use only when faxing document)

By initialling, Practitioner acknowledges that the Medical Document faxed to Tilray constitutes the original Medical Document and that he/she has retained a copy of the Medical Document for his/her records. Practitioner also attests that the Medical Document will not be faxed or provided to any party other than Tilray.



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# Application to be a Tilray Patient

## Patient Information

All fields required unless otherwise noted. This form must be filled out by the patient (if patient is applying on his/her own behalf) or a caregiver (i.e. an individual responsible for the patient) applying on behalf of the patient. Caregivers must also complete the Caregiver Information form.

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### Patient Name

First Name

Last Name

### Date of Birth

Year

Month

Day

### Gender

Male

Female

### Email

Required for Online Shopping with Tilray

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### Residence Address\*

Address

City

Province

Postal Code

\*If the residence address above is not for a private residence, please indicate the following:

Name of Establishment

Type of Establishment

### Phone / Fax

Telephone

Fax (If Applicable)

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### Mailing Address

(If different from above residence address)

Address

City

Province

Postal Code

If you would like Tilray to ship product to an address other than the Residence Address provided above, please check the option that applies:

Ship to Mailing Address above

Ship to health care practitioner's address\*

\*Health Care Practitioner must consent to receive product by filling out Health Care Practitioner Information form.

# The patient and the individual responsible for the patient (if applicable) must agree to the following:

Important, please read and sign below.

- The information contained in this registration application and the medical document is correct and complete;
- The applicant (patient) is ordinarily resides in Canada;
- The medical document used for this application is not being used to seek or obtain fresh or dried marijuana or cannabis oil from another source;
- The original of the medical document is provided in support of the application;
- The applicant (patient) will use fresh or dried marijuana or cannabis oil only for their own medical purposes;
- The indications, safety and risks of dried marijuana use have not been adequately studied and the appropriate dosage is unclear. Patient and caregiver (if applicable) acknowledge(s) that any medical marijuana product obtained from Tilray is done so at their own risk and release(s) Tilray, along with its affiliates, partners, providers, directors, officers and employees from any and all actions, claims, complaints, and demands for damages, loss or injury whatsoever arising directly or indirectly as a consequence of the use of medical marijuana products;
- Patient and caregiver (if applicable) consent(s) to the health care practitioner named in his/her document disclosing required personal information to Tilray for the purposes of complying with the requirements of the *Marihuana for Medical Purposes Regulations*. Patient and caregiver (if applicable) understand(s) and agree(s) that a copy of this consent and registration application, as well as information about the patient's registration status and usage patterns may be provided to the health care practitioner named in their medical document;
- Patient and caregiver (if applicable) consent to Tilray's collection, use and disclosure of necessary personal information in order to process this registration, to provide products or services, to comply with the *Marihuana for Medical Purposes Regulations* (including disclosure of personal information to provincial licensing authorities upon request), and otherwise in accordance with Tilray's Privacy Policy (<https://www.tilray.ca/en/policy-and-terms/privacy-policy/>).
- By signing this registration form, patient and caregiver (if applicable) allow Tilray to (a) send product and registration information to the physical and email addresses provided therein, and (b) communicate with them via email regarding registration status, product availability, order status, and other matters in accordance with Tilray's Privacy Policy (<https://www.tilray.ca/en/policy-and-terms/privacy-policy/>).

Signature

Signature of Patient

Year

Month

Day

If there is a caregiver, both patient and caregiver must sign this form unless the caregiver is the patient's substitute decision maker (or equivalent) under applicable provincial law. **If the patient does not sign, the caregiver, by signing below, attests that he or she is the patient's substitute decision maker (or equivalent) under applicable provincial law.**

Signature

Signature of Individual Responsible (if applicable)

Year

Month

Day