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)

Note: Duration Cannot Exceed One Year

Daily Usage

g/day

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 Practioner 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.

Patient Name

First Name | Last Name

Date of Birth

Year | Month | Day

Gender

☐ Male ☐ Female

Email

Required for Online Shopping with Tilray

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)

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.

***If patient is applying with a registration certificate issued by the Minister under Part 2, patient hereby agrees that this application is made for the purpose of obtaining an interim supply of dried marihuana or cannabis oil.

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, or registration certificate as applicable, is correct and complete;
- The applicant (patient) is ordinarily resident in Canada;
- The medical document, or registration certificate as applicable, used for this application is not being used to seek or obtain dried marijuana 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 *Access to Cannabis 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 *Access to Cannabis 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

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Veterans Affairs Canada

We just need a bit more information to properly submit your request for authorization.

For veteran patients: Would you like Tilray to seek approval from Veterans Affairs Canada (VAC) for medical cannabis reimbursement coverage on your behalf?

☐ Yes ☐ No

Has the patient registered as a VAC patient with another Licensed Producer?

☐ Yes ☐ No

Condition/Ailment

VAC requires Tilray to report the specific condition on which your coverage is based.

VAC K Number

Provide your VAC K number if you know it.

☐ I have selected Tilray to seek approval from Veterans Affairs Canada (VAC) for reimbursement, and authorize them to send the VAC a complete copy of the application and to bill the VAC directly for the cost of the patient's medical cannabis.

IMPORTANT: Tilray does not guarantee VAC approval. Once your Tilray application is approved, and until VAC approves your account, you will be able to make purchases with your own credit card. Once VAC approves your account they will cover the costs of your medicinal cannabis, up to the amount covered. Products other than medicinal cannabis are not eligible for VAC reimbursement and you will be responsible for payment for such items.

Signature

Patient Signature | Year | Month | Day

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Caregiver Information

Caregivers **must** fill out this section.

Caregiver Name

First Name | Last Name

Date of Birth

Year | Month | Day

Gender

☐ Male ☐ Female

Contact Information

Telephone | Email address (Required for Online Shopping with Tilray)

Address

City | Province | Postal Code

Contact Preference

☐ Email ☐ Phone ☐ Mail

I,

Name of Individual or Caregiver Responsible

am responsible for

Patient's Name

Signature

Signature of Individual Responsible for Patient | Year | Month | Day

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Health Care Practitioner Information

Must be completed by Health Care Practitioner who provided the medical document if they consent to receiving dried marihuana on behalf of the patient.

Health Care Practitioner's Title / Name

Title | First Name | Last Name

Shipping Address

Where you would like your product to arrive, if different from business address or consultation address provided on medical document.

- ☐ Same as Business Address provided on medical document
- ☐ Same as Consultation Address provided on medical document
- ☐ Other, please provide below:

Address

City | Province | Postal Code

I, _____ (Health Care Practitioner's Name) consent to receive dried marihuana on behalf of _____ (Patient's Name)

Signature

Signature of Health Care Practitioner | Year | Month | Day

Notice to the Health Care Practitioner:

Withdrawal of consent by the Health Care Practitioner:

If the health care practitioner ceases to consent and receive dried marihuana for the patient, the practitioner must send a written notice to that effect to the patient and the licensed producer.