



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

## 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,	<b>consent to receive dried marihuana on behalf of</b>
<b>Signature</b>	Health Care Practitioner's Name	Patient's Name
	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.