PATIENT REGISTRATION FORM

To be completed by the patient

Any questions?
Call us: 1-844-427-4742
Licence Holder: Aphria Inc.

1 PATIENT INFORMATION

Preferred Language

☐ English ☐ Français

☐ I am a NEW patient

☐ I am a RENEWING patient

☐ Male ☐ Female ☐ Unlisted (i.e., non-binary)

Primary Condition (Optional)

Primary Symptom (Optional)

Are you a Canadian Veteran?

☐ Yes ☐ No

☐ Released ☐ Still Serving

If your benefit plan includes medical cannabis, please indicate your policy Number OR K Number

Policy Number OR K Number

Name of policy provider: _____

By indicating your K Number or Policy Number, you give permission to Tilray Medical to share your details with Veterans Affairs Canada and/or your insurance provider.

Given First Name

Last Name

D.O.B (MM/DD/YYYY)

Primary Phone Number

Secondary Phone Number

Email

2 SHIPPING ADDRESS (Primary Residence)

Organization *(if not private)*

Address

Unit Number

Buzzer Code or PO BOx (If applicable)

City

Province

Postal Code

Residence Type

☐ Private ☐ Nursing Home

☐ *Shelter/Hostel ☐ Group/Other

*Attestation of residence required if Shelter/Hostel is selected:

Phone

Fax

Manager's Email

Manager's Signature

Date (MM/DD/YYYY)

3 MAILING ADDRESS

☐ Same as residential address above

Address

Unit Number

Buzzer code or PO Box (If applicable)

City

Province

Postal Code

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Licence Holder: Aphria Inc.

4 CAREGIVER

COMPLETE ONLY IF APPLICABLE. MANDATORY IF PATIENT IS UNDER 19 YEARS OF AGE.

As the patient, you authorize the responsible individual/caregiver to act on your behalf with Tilray Medical and you authorize Tilray Medical to accept such authority.

Caregiver's First Name	Caregiver's Last Name	Caregiver's D.O.B (MM/DD/YYYY)

Primary Phone Number	Email	Relationship to Patient (as required)

5 CONSENT

By signing below, the applicant, or the individual responsible for the applicant, confirms and agrees to the following:

1. General and Privacy Consent

1.1 You ordinarily reside in Canada.

1.2 The information in this application and the Medical Document you submit in support of this application is correct and complete.

1.3 The Medical Document or Registration Certificate you submit in support of this application is not being used to seek or obtain a cannabis product from another source.

1.4 The use of cannabis products is for your own medical purposes only.

1.5 The original Medical Document is being provided in support of the application.

1.6 The medical document that forms the basis for the application has not, to your knowledge, been altered.

1.7 If your application is being submitted on the basis of a registration certificate, you attest that the copy of the registration certificate is an accurate reproduction of the original.

1.8 The Licensed Producer may use the applicant's personal health information, including but not limited to medical conditions and product selection, on an anonymous and aggregate basis for research purposes or medical education purposes.

1.9 Cannabis products are not currently approved for use as pharmaceutical drugs in Canada. You are using cannabis products for medical purposes obtained from Tilray Medical . ("Tilray", "Aphria Inc." "us" or "we") at your own risk. You understand that there are no guarantees regarding the effectiveness of cannabis products to manage your condition and no way to predict the incidence of side effects. You acknowledge that your health care practitioner has discussed with you the risks of using cannabis products for your treatment, that the use of cannabis products has been fully explained to you by your health care practitioner and that all of your questions have been answered. To the extent permitted by applicable law, on your own behalf, and on behalf of your heirs, executors, administrators, successors and assigns, you hereby release Tilray Medical and its related entities from any and all actions, claims, complaints, demands for damages, personal losses, and/or injuries arising directly and indirectly from the use of cannabis products obtained from Aphria Inc.

1.10 By signing this Registration Document you acknowledge that Tilray Medical is a medical marketplace brand of Aphria Inc., which is a federally authorized 'Sale for Medical Purposes' license holder. As such, you acknowledge that Aphria Inc is responsible for completing all registrations and transactions through Tilray Medical and with whom patients will be registered. You consent to Tilray's collection, use and disclosure of the personal information contained in it, in accordance with Tilray's External Privacy Policy available at: https://www.tilray.com/general-privacy-policy. This includes, without limitation, disclosure of this Consent Form and related documents to the health care practitioner named in your Medical Document and to any clinic or employer with which the health care practitioner works. Hard copies of the External Privacy Policy are available upon request. If the personal information in the application pertains to someone other than you, you represent and warrant that you have obtained their consent to submit this information and/or have authority to consent on their behalf. Consent may be withdrawn at any time by contacting info@tilraymedical.com but such withdrawal will not have retroactive effect. NOTE: This may have implications for you and/or the individual for whom the application is submitted (if not you). Withdrawal will not affect the collection, use and disclosure of personal information where such collection, use and disclosure is permitted or required by law without consent. I have read, acknowledged, understood and formally agree to the statements above and such statements are accurate and complete.

☐ I have read, acknowledged, understood and formally agree to the statements above and such statements are accurate and complete.

2. Marketing Emails and Promotional Materials Consent

☐ I agree to receive electronic communications, including emails, from Tilray Medical about news, updates, medical and adult-use cannabis products, offers, promotions and educational information.

Patient/Caregiver Signature:

Date (MM/DD/YYYY):

By signing this consent form, you acknowledge that Tilray Medical is a medical marketplace brand of Aphria Inc., which is a federally authorized 'Sale for Medical Purposes' license holder. As such, you acknowledge that Aphria Inc is responsible for completing all registrations and transactions through Tilray Medical and with whom patients will be registered. You consent to Tilray Medical's collection, use and disclosure of the personal information contained in it and in all related documents, such as any medical document or registration certificate, in accordance with Tilray Medical's External Privacy Policy available at: www.tilray.com/general-privacy-policy. Hard copies of the External Privacy policy are available upon request. If the personal information in the Medical Document pertains to someone other than you, you represent and warrant that you have obtained their consent and/or have authority to consent on their behalf. Consent may be withdrawn at any time but such withdrawal will: not have retroactive effect; may have implications to you and/or the subject individual and will not affect the collection, use, and disclosure of personal information where such collection, use, and disclosure is permitted or required by law without consent.

MEDICAL DOCUMENT

To be completed by the Health Care Practitioner

Tilray Medical
265 Talbot St. W.,
Leamington, ON N8H 4H3
Phone: 1-844-427-4742
Fax: 1-844-427-4796
Email: info@tilraymedical.com
www.tilraymedical.ca

1 PATIENT INFORMATION

Given First Name | Last Name | D.O.B (MM/DD/YYYY)

Patient Email | Patient Phone Number

☐ Male ☐ Female ☐ Unlisted (i.e., non-binary)

2 HEALTH CARE PRACTITIONER INFORMATION

Title | Given First Name

Last Name | Profession

Physician License # | Phone

Fax | Email

Business Address

Unit # (If applicable) | City

Province | Postal Code

☐ **HEALTH CARE PRACTITIONER: Initial if you agree to receive the patient's medical cannabis to your business address listed on this document.** I, the patient's Health Care Practitioner, agree to have the patient's medical cannabis shipped to the business address specified on this Medical Document.

3 CONSULTATION ADDRESS

CONSULTATION ADDRESS

☐ Same as Business Address

Consultation Address

Unit # (If applicable) | City

Province | Postal Code

4 PRESCRIPTION

Grams/Day | Duration in Days (Max. 365 days)

Max. THC (Not required) | Diagnosis/ Medical Condition (Required for VAC)

Notes

☐ Mandatory If Checked

5 SIGNATURE

Health Care Practitioner Signature:

Date (MM/DD/YYYY): | **Province Authorized to Practice In:**

By signing this Medical Document you acknowledge that Tilray Medical is a medical marketplace brand of Aphria Inc, which is a federally authorized 'Sale for Medical Purposes' licence holder. As such, you acknowledge that Aphria Inc is responsible for completing all registrations and transactions through Tilray Medical and with whom patients will be registered. You consent to Tilray Medical's collection, use and disclosure of the personal information contained in it and in all related documents, such as any medical document or registration certificate, in accordance with Tilray Medical's External Privacy Policy available at: www.tilray.com/general-privacy-policy. Hard copies of the External Privacy policy are available upon request. If the personal information in the Medical Document pertains to someone other than you, you represent and warrant that you have obtained their consent and/or have authority to consent on their behalf. Consent may be withdrawn at any time but such withdrawal will: not have retroactive effect; may have implications to you and/or the subject individual and will not affect the collection, use and disclosure of personal information where such collection, use and disclosure is permitted or required by law without consent.

☐ **HEALTH CARE PRACTITIONER INITIALS:**
I confirm that I am legally authorized to prescribe medical cannabis through my regulating college and all information on the Medical Document is correct and complete. I acknowledge that the faxed Medical Document is now the original document and that I have retained a copy for office records only.

Please fax this completed document to: 1-844-427-4796
or scan and email to: info@tilraymedical.com

OR

Mail original document to:
265 Talbot St. W., Leamington, ON N8H 4H3