



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.

Caregiver Required? Yes* No *If yes, please complete in full the Caregiver form attached to this medical document.

Patient Name
First Name Last Name

Date of Birth **Telephone**
Year Month Day

Period of Use Months(s) **Daily Usage** g/day
Note: Duration Cannot Exceed One Year

Usage Purpose
Primary Condition (Optional) Primary Symptom (Optional)

Dried Only Extract Only
 If neither option is selected, the patient will be able to order any combination of extracts or dried cannabis products

Additional Potency Guidance % THC max (for flower) mg/mL THC max (for extracts)

Health Care Practitioner Information

Please print clearly in full (no abbreviations).

Title / Name
Title Given Name Surname

Profession

Business / Clinic Name

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 **Licence Number**
Province in which Practitioner is Authorized to Practice 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

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

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, | consent to receive dried marihuana on behalf of |
| Signature | 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.