



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

# 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)

I,

Name of Individual or Caregiver Responsible

am responsible for

Patient's Name

Signature

Signature of Individual Responsible for Patient

Year

Month

Day