Aphria Inc.
P.O. Box 20009
269 Erie St S
Leamington, ON N8H 3C4
Phone: 1-844-427-4742
Fax: 1-844-427-4796
Email: info@aphria.com
www.aphria.ca

MEDICAL DOCUMENT

To be completed by the Health Care Practitioner

1 PATIENT INFORMATION

☐ Male ☐ Female

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

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 (Not required)

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 consent to Aphria's collection, use and disclosure of the personal information contained in it, in accordance with Aphria's External Privacy Policy available at: www.aphria.ca. 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 Consent may be withdrawn at any time but such withdrawal will: not have retroactive effect; may have implications to you and/or the subject individual and will not affect the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: Initial if this Medical Document is being submitted via fax to Aphria Inc.**
I acknowledge that the faxed Medical Document is now the original document and that I have retained a copy for office records only. I also confirm that I am a licensed practitioner not named under Section 59 of the Narcotic Control Regulations that has not been retracted under Section 60.

☐ **HEALTH CARE PRACTITIONER: Initial if you agree that all the information on the Medical Document is true and correct.**
I, the patient's Health Care Practitioner certify that the information on this document is correct and complete.

PATIENT REGISTRATION FORM

To be completed by the patient

Any questions?
Call us: 1-844-427-4742

1 PATIENT INFORMATION

Preferred Language
☐ English ☐ Français

Primary Condition (Optional)

Primary Symptom (Optional)

☐ I am a NEW patient with Aphria

☐ I am a RENEWING patient with Aphria

☐ Male ☐ Female

Are you a Canadian Veteran?
☐ Yes ☐ No

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 Aphria 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

Can we leave detailed voicemails? ☐ Primary Phone ☐ Secondary Phone

Fax (If applicable):

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

☐ *Shleter/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

5 SIGNATURE

Patient/Caregiver Signature:

Date (MM/DD/YYYY):

By signing this Registration Document you consent to Aphria'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 Aphria's External Privacy Policy available at: www.aphria.ca. This includes, without limitation, disclosure of the Patient Registration and related documents to the health care practitioner named in the patient's 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 Patient Registration 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.

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

OR

Mail original document to:
Aphria Inc. PO Box 20009 269 Erie St South
Leamington ON Canada N8H 3C4

Aphria Inc.
P.O. Box 20009
269 Erie St S
Leamington, ON N8H 3C4
Phone: 1-844-427-4742
Fax: 1-844-427-4796
Email: info@aphria.com
www.aphria.ca

CONSENT FORM

To be completed by the patient

PLEASE READ CAREFULLY

By signing this document you state that you understand, agree, and consent to each of the following statements:

1. You ordinarily reside in Canada.

2. The information in this application and the accompanying Medical Document is correct and complete.

3. This Medical Document is not being used to seek or obtain dried marijuana or cannabis oil from another source.

4. The use of dried marijuana and cannabis oil are for your own medical purposes ONLY.

5. The original of the medical document is provided in support of the application.

6. Medical marijuana is not currently approved for use as a pharmaceutical drug in Canada. You are using medical product obtained from Aphria at your own risk. You hereby release Aphria 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 medical marijuana obtained from Aphria.

Please check this box if:

☐ You would like to receive email communication *(order receipts, prescription reminders, and monthly promotions)* from Aphria through the contact information you have provided in your registration package.

If you wish to leave the box blank and not include your email within your registration forms, you may request via mail select correspondence by calling Aphria's Patient Care Team.

By signing this Consent Form you consent to Aphria's collection, use and disclosure of the personal information contained in it, in accordance with Aphria's External Privacy Policy available at: www.aphria.ca. This includes, without limitation, disclosure of this Consent Form and related documents to the health care practitioner named in the patient's 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 Patient Registration 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. NOTE: This 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.

Patient/Caregiver Signature:

Date (MM/DD/YYYY):

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CAREGIVER FORM

To be completed by the patient and the caregiver responsible for the patient

1 CAREGIVER INFORMATION

☐ Male ☐ Female

Patient's ID Number: _____

Caregiver's First Name _____

Caregiver's Last Name _____

Caregiver's D.O.B (MM/DD/YYYY) _____

Primary Phone Number _____

Email _____

Can we leave detailed voicemails? ☐ Yes ☐ No

2 SIGNATURE

I, _____ (Full Name of Caregiver) _____ (Relationship to Patient (as required)), am the responsible caregiver for _____ (Name of Patient)

By signing this Caregiver Form:

1. You consent to Aphria's collection, use and disclosure of the personal information contained in it, in accordance with Aphria's External Privacy Policy available at: www.aphria.ca. This includes, without limitation, disclosure of any and all patient personal information collected by Aphria to the patient's Caregiver and disclosure of any and all caregiver personal information to the patient. Hard copies of the External Privacy Policy are available upon request. If the personal information in the Caregiver Form 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. NOTE: This 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.

2. As the patient, you authorize the responsible individual/caregiver to act on your behalf with respect to anything you could do on your behalf with Aphria and you authorize Aphria to accept such authority.

Patient Signature: _____

Caregiver Signature: _____

Date (MM/DD/YYYY): _____