medical cannabis
by SHOPPERS DRUG MART

Medical Cannabis by Shoppers Drug Mart Inc.
6941 Kennedy Road, Unit 100
Mississauga, ON L5T 2R6

www.shoppersdrugmart.ca/cannabis
Fax: 1-866-220-2627
Tel: 1-844-633-2627

Patient Registration Form *(please make sure you complete both sides)*

Note: If you are the caregiver, please complete this form along with the patient. In addition, please make sure you also complete the Caregiver Form. **The patient's first and last names must be identical to what is written on the Medical Document.**

First name | Last name | Date of birth *(mm/dd/yyyy)* | ☐ Male ☐ Female

☐ New client ☐ Renewing ☐ Transferring from a Licensed Producer _____ *(print LP name)*

Residing address | City | Province

Postal code | Primary phone | Secondary phone | Email

Preferred means of communication: ☐ Primary phone ☐ Secondary phone ☐ Email

Patient residence type

☐ Private *(e.g., house, apartment, condo, etc.)* ☐ Establishment *(e.g., long-term care facility, shelter, hostel, etc.)*

If you have selected "establishment", the manager must complete this section:

Name of establishment | Type of establishment | Manager's name

Phone | Fax | Email *(optional)*

Manager's signature | Date *(mm/dd/yyyy)*

Mailing address

☐ Same as residing address above

Address | City | Province | Postal code

Shipping address

Where would you like your product shipped? ☐ Residing address ☐ Mailing address ☐ Healthcare professional office *(Consent must be given on the Medical Document)*

SEE REVERSE. THIS APPLICATION IS NOT COMPLETE UNTIL THE PATIENT CONSENT FORM ON PAGE 3 IS ALSO SIGNED BY THE PATIENT (AND CAREGIVER IF APPLICABLE).

Insurance information

Are you a Canadian veteran?

☐ Yes ☐ No

If so, please provide K number:

Do you have private insurance coverage for medications?

☐ Yes ☐ No

If so, please provide insurer name and policy number

Consent

The patient acknowledges and agrees to the following:

1. the patient consents to Medical Cannabis by Shoppers Drug Mart Inc.'s ("Shoppers") collection, use and disclosure of personal information contained in this Patient Registration Form, in accordance with Shoppers Drug Mart Inc.'s Privacy Policy and applicable laws, in order to complete the registration and communicate with the patient's healthcare professionals, licensing authorities, the licensed producer(s) that may be responsible for production of medical cannabis and service providers that are responsible for purchasing, distribution and verification purposes;

2. the patient permits Shoppers to (a) ship medical cannabis product and information to the physical address identified in the Patient Registration Form and (b) communicate with the patient (and caregiver if applicable) via telephone or email about registration status, order status, product availability, and additional matters in accordance with Shoppers Drug Mart Inc.'s Privacy Policy. The patient understands that electronic communications are not secure and can be forwarded, intercepted, circulated, stored or even changed without their knowledge or permission and agrees to accept that risk. Electronic communication is at the patient's option and the option to communicate electronically may be withdrawn at any time by providing written notice to Shoppers;

3. If the patient has specified a K number or policy number on the Patient Registration Form, the patient consents to Shoppers' sharing of personal details and information contained in the Patient Registration Form with Veterans Affairs Canada or the patient's insurance provider.

Signature of patient

Date *(mm/dd/yyyy)*

Please indicate if you consent to receiving electronic communications from Shoppers containing promotional offers related to medical cannabis. You may unsubscribe at any time. ☐ Yes ☐ No *(select one)*

If yes, please confirm how you would like to receive these electronic communications:

☐ Email ☐ Primary phone ☐ Secondary phone

Standard text messaging and data rates may apply.

Please drop off this completed document at your local Shoppers Drug Mart OR fax this completed document to 1-866-220-2627 OR mail this document to Medical Cannabis by Shoppers Drug Mart Inc., 6941 Kennedy Road, Unit 100, Mississauga, ON L5T 2R6

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Patient Consent Form

The patient (and caregiver if applicable) acknowledges and agrees to the following:

1. the information contained in the Patient Registration Form, Caregiver Form, and Medical Document or Registration Certificate (if applicable) is correct and complete;
2. the patient ordinarily resides in Canada;
3. the original Medical Document or Registration Certificate provided to Medical Cannabis by Shoppers Drug Mart Inc. ("Shoppers") has not been modified;
4. the Medical Document has not been used to obtain medical cannabis products from another source;
5. the use of medical cannabis is for the patient's own medical purposes;
6. the patient (and caregiver if applicable) understands that the safety and risks associated with the use of medical cannabis have not be sufficiently studied and that using medical cannabis product obtained from Shoppers is done at their own risk. The patient (and caregiver if applicable) release Shoppers, its related entities, affiliates, subsidiaries, directors, officers, partners, providers, and employees from any and all actions, claims, complaints, and demands for damages, loss or injury arising as a consequence of the use of medical cannabis products obtained from Shoppers;
7. the patient (and caregiver if applicable) consent to Shoppers' collection, use and disclosure of personal information contained in the Patient Registration Form, Caregiver Form, and Medical Document or Registration Certificate (if applicable), in order to complete the registration and communicate with the healthcare professional who has completed the Medical Document, licensing authorities, any supplier that may be responsible for production of medical cannabis, and service providers responsible for purchasing, distribution, and verification, in accordance with Shoppers Drug Mart Inc.'s Privacy Policy and applicable laws; and
8. the patient (and caregiver if applicable) consent to the disclosure of personal information by the health care professional named in the Medical Document to Shoppers for the purposes of compliance with applicable laws. The patient (and caregiver if applicable) understand and agree that a copy of the Patient Registration Form, Caregiver Form, Medical Document or Registration Certificate (if applicable), this Consent Form, as well as information about status of registration and usage patterns of medical cannabis may be provided to the healthcare professional named in the Medical Document.

Signature of patient	Date *(mm/dd/yyyy)*

Both patient and caregiver are required to sign if there is a caregiver, unless the caregiver is the patient's substitute decision maker (or equivalent to a substitute decision maker) under applicable laws (in which case only the caregiver shall be required to sign). If the patient does not sign, the caregiver, by signing below, confirms, acknowledges, and covenants that they are the patient's substitute decision maker.

Signature of caregiver/individual responsible for patient *(if applicable)*	Date *(mm/dd/yyyy)*

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