medical cannabis by SHOPPERS

Medical Cannabis by Shoppers™
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 note: This form consists of 3 pages)*

Language Selection: ☑ English ☐ French

*Note: If you are the patient's caregiver, please complete this form with the patient and sign the caregiver acknowledgment and confirmation.
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)* | Gender

Fields marked with ▸ are required.

Type of registration

☑ New patient ☐ Transferring from a Licensed Producer _____

Residential address

Street address | Apt | City | Province

Postal code | Primary phone | Secondary phone | Email

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

Mailing address

Complete this section only if it is different from above. Mailing address must be a residence, P.O. Box, or healthcare professional's office.

Street address | City | Province | Postal code

☐ I have requested that medical cannabis products be delivered to my healthcare practitioner's office, with their consent as noted on medical document

Residence Type ☑ Private residence ☐ Shelter/hostel ☐ Nursing home ☐ Other

*Attestation of residence required if shelter/hostel selected. Establishment manager must complete this section.

I, *(Manager's name)* _____ confirm that *(Name of establishment)* _____

provides food, lodging, or other social services to *(Patient's name)* _____

Signature of manager | Contact email | Date *(mm/dd/yyyy)*

THIS APPLICATION IS NOT COMPLETE UNTIL THE PATIENT CONSENT IS ALSO SIGNED BY THE PATIENT (AND CAREGIVER IF APPLICABLE).

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Insurance information (if applicable)

Are you a Canadian veteran?

☐ Yes ☐ No

If so, please provide Blue Cross number:

Please provide a copy of your Blue Cross card with your completed Registration form.

Do you have private insurance coverage for medications?

☐ Yes ☐ No

If so, please provide insurer name:

Policy number:

Caregiver information (if applicable)

A caregiver is a designated adult who is responsible for the patient.

Caregiver first name

Caregiver last name

Date of birth *(mm/dd/yyyy)*

Gender

Relationship to patient

Primary phone

Secondary phone

Email

Caregiver acknowledgment and confirmation

I, *(Print caregiver name)* _____ acknowledge that I am the caregiver for *(Print patient name)* _____

and take responsibility for the ordering, safe storage, and administration of medical cannabis products.

Signature of caregiver

Date *(mm/dd/yyyy)*

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Consent

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

1. Medical Cannabis by Shoppers Drug Mart Inc. ("Shoppers") may collect, use and disclose personal information contained in this application, and any related medical document that is provided to Shoppers (the "Medical Document"), in accordance with Shoppers Drug Mart Inc.'s Privacy Policy (the "Privacy Policy") and applicable laws. The purposes for which Shoppers may collect, use and disclose personal information include: for shipment and fulfillment purposes, to complete the registration of the patient and to communicate with the patient's healthcare professionals, medical clinics, licensing authorities, or suppliers that may be responsible for production of medical cannabis and service providers that are responsible for purchase fulfillment and verification purposes.

2. The patient permits Shoppers to communicate with the patient via telephone or email regarding registration or order status, product availability, and additional matters in accordance with Shoppers' 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 insurance policy number on this application, the patient consents to Shoppers' sharing of personal details and information contained in this application with Veterans Affairs Canada or the patient's insurance provider.

4. The patient understands that the safety and risks associated with the use of medical cannabis have not been sufficiently studied and that using medical cannabis products obtained from Shoppers is done at their own risk. The patient releases Shoppers, its related entities, affiliates, subsidiaries, directors, officers, partners, providers, and employees from any and all actions, claims, complaints, and demands for damage, loss or injury arising as a consequence of the use of medical cannabis products obtained from Shoppers.

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

6. The patient ordinarily resides in Canada.

7. The Medical Document is original and has not been modified.

8. The Medical Document is not being used to obtain medical cannabis from another source.

9. The use of medical cannabis is for the patient's own medical purposes.

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

Please indicate if you consent to receiving email communications from Shoppers containing offers and updates related to medical cannabis. You may unsubscribe at any time. ☑ Yes ☐ No

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™, 6941 Kennedy Road, Unit 100, Mississauga, ON L5T 2R6

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