Tilray Medical
P.O. Box 20009
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Leamington, ON N8H 3C4
Phone: 1-844-427-4742
Fax: 1-844-427-4796
Email: info@tilraymedical.com
www.tilraymedical.ca
Licence Holder: Aphria Inc

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/K Number (VAC)

☐ Mandatory If Checked

5 SIGNATURE

Health Care Practitioner Signature:

Date (MM/DD/YYYY): | **Province Authorized to Practice In:**

By signing this Medical Document you acknowledge that Tilray Medical is a medical marketplace brand of Aphria Inc, which is a federally authorized 'Sale for Medical Purposes' licence holder. As such, you acknowledge that Aphria Inc is responsible for completing all registrations and transactions through Tilray Medical and with whom patients will be registered. You consent to Tilray Medical'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 Tilray Medical's External Privacy Policy available at: www.tilray.com/general-privacy-policy. 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 Consent may be withdrawn at any time but such withdrawal will: not have retroactive effect; may have implications to you and/or the subject individual and will not affect the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.

Please fax this completed document to: 1-844-427-8472

OR

Mail original document to:
Tilray Medical PO Box 20009 269 Erie St South
Leamington ON Canada N8H 3C4