Questions?
We're here to help!
Email: AskUs@MedReleaf.com
Phone: 1.855.4.RELEAF (473.5323)

www.MedReleaf.com

MedReleaf™
THE MEDICAL GRADE STANDARD™

SECTION 1a - PATIENT INFORMATION

Patient's Name

Given First Name(s) | Surname (Last Name) | DOB (DD/MM/YY)

Gender | Email Address

Are you a veteran? ☐ Yes If so, please provide your 'K' number

By indicating you are a veteran, you give permission for MedReleaf to share your details with VAC.

SECTION 1b - INTERIM SUPPLY

Have you obtained a registration certificate from Health Canada to grow your own cannabis? ☐ Yes ☐ No

Registration Certificate #

If you selected yes above: are you registering with MedReleaf to obtain an interim supply of cannabis? ☐ Yes ☐ No

If you selected yes above: are you currently obtaining an interim supply from another Licensed Producer? ☐ Yes ☐ No

SECTION 2 - CONTACT & SHIPPING INFORMATION

Primary Residence, must be In Canada ☐ Use primary address as my shipping address.

Primary Residence

Unit # | Street Address

City | Province | Postal Code

Residence Type ☐ Private Residence ☐ Nursing/Care Home ☐ Shelter ☐ Hostel ☐ Group Home ☐ Other

If Other, Please Specify | Name of Establishment (if not private residence)

Contact Info

Phone Number | Fax Number

More establishment info (if necessary)

ALTERNATE ADDRESS

Applicable **ONLY** if your primary residence has no postal service.

Shipping Address:

Unit # | Street Address

City | Province | Postal Code

This form may be filled out electronically or printed and completed by hand.

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SECTION 3 - CAREGIVER INFORMATION

Not Applicable ☐

Caregiver Name

Given First Name(s) | Surname (Last Name) | DOB (DD/MM/YY)

Gender | Caregiver Phone #

Email Address | Confirm Email Address

Caregiver / Person Responsible Declaration:

I _____ am responsible for _____

Caregiver / Person responsible Full Name | Patient's Full Name

Date Signed (DD/MM/YY) _____ Caregiver Signature _____

Other Person(s) Responsible For the Applicant (multiple caregivers)

Not Applicable ☐

Caregiver Name

Given First Name(s) | Surname (Last Name) | DOB (DD/MM/YY)

Gender | Caregiver Phone #

Email Address | Confirm Email Address

Caregiver / Person Responsible Declaration:

I _____ am responsible for _____

Caregiver / Person responsible Full Name | Patient's Full Name

Date Signed (DD/MM/YY) _____ Caregiver Signature _____

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SECTION 4 - AUTHORIZATION OF APPLICANT

In the case of a prospective patient, the user acknowledges that he or she is interested in learning more about MedReleaf and is considering becoming a patient in the future. medreleaf.com/privacy

If the applicant has registered as a patient, caregiver or doctor the following applies:
By signing, the applicant and/or caregiver responsible for the applicant acknowledges that they have read, understood and agree that:

- The Applicant ordinarily resides in Canada.
- The information in this application and in the Medical Document to be sent is correct and complete.
- The Medical Document is not being used to seek or obtain dried cannabis from another source.
- The original Medical Document or one of the original Personal Use Production License (PUPL) or Designated Person Production License (DPPL) MUST be received by MedReleaf Corp. in order for MedReleaf Corp. to complete the patient registration.
- The Applicant will use dried cannabis only for his/her own medical purposes.
- The Applicant understands and acknowledges that medical cannabis is not currently approved for use as a pharmaceutical drug in Canada.
- The Applicant acknowledges and agrees that he/she is using any medical cannabis product obtained from MedReleaf Corp. at his/her own risk, and releases MedReleaf Corp. (and its partners, providers, officers, directors and staff) from any and all actions, claims, complaints and demands for damages, loss or injury whatsoever arising directly or indirectly from the use of medical cannabis obtained from MedReleaf Corp.

The Applicant agrees that MedReleaf Corp. may collect, use, disclose and store his/her personal information and personal health information provided by the Applicant, his/her caregiver or his/her healthcare professional(s) (collectively, the Applicant's "Information") to determine his/her eligibility for, and registration as, a client of MedReleaf Corp and for the purpose of filling orders and providing information about MedReleaf and its products and services and for the purpose of obtaining and processing payments by, or on behalf of, the Applicant as applicable.

The Applicant authorizes MedReleaf Corp. to disclose information to, and obtain further information from his/her caregiver and his/her healthcare professional(s) to ensure the accuracy and completeness of this application and to register the Applicant as a client of MedReleaf Corp and to facilitate ongoing medical oversight. The Applicant understands and agrees that a copy of this consent & registration application may be provided to the health care practitioner.

The Applicant understands that MedReleaf Corp. will collect, use and disclose his/her Information in connection with the following MedReleaf Corp. services:
- Registration as a client of MedReleaf Corp.;
- Fill orders made online, distribute medical cannabis, and provide other information as requested by the Applicant;
- Provide the Applicant with information about its products and services, including: the latest news on MedReleaf Corp. activities and initiatives, information about new products and services, product updates, technical support issues, events and special offers, and recommending products, services or programs;
- Obtaining and processing payments for medical cannabis dispensed to the Applicant and seeking reimbursement from the Applicant's employer or insurer (as applicable); and
- Enabling MedReleaf Corp., to comply with applicable laws, and specifically the requirements of the Access to Cannabis for Medical Purposes Regulations (ACMPR).

By signing below the applicant acknowledges that they have read, understood and agree that: MedReleaf Corp. will collect, use, disclose and store his/her personal information as outlined above and as set out in MedReleaf's Privacy Statement, and that MedReleaf Corp. may from time to time de-identify the Applicant's Information for research, medical educational, business analytics and other commercial purposes, including by combining the Information with other data for such analyses.

I agree to receiving electronic messages containing news, updates and promotions from MedReleaf regarding its products and activities. Note you can withdraw your consent at any time.

Date Signed (DD/MM/YY)

Applicant's or Caregiver's Signature

How did you hear about MedReleaf? (optional)

Please send both this completed document AND your ORIGINAL Medical Document, or copy of Health Canada Registration Certificate, to us at:

MedReleaf
P.O. Box 3040
Markham Industrial Park
Markham ON, Canada L3R 6G4

This form may be filled out electronically or printed and completed by hand.