SpectrumTherapeutics™
A CANOPY GROWTH COMPANY

Registration Form

Complete this form to register as a customer for the purchase of medical cannabis.

Please send BOTH pages to us.

Instructions

A. Complete Registration Form

To register as a customer for the purchase of medical cannabis, complete and sign this Registration Form and send it to us by one of the following:

1. **Secure ePortal fax line**
   1-888-977-2595
2. **Email**
   Care@SpectrumTherapeutics.com
3. **Online**
   SpectrumTherapeutics.com
4. **Regular mail**
   ATTN: Customer Care
   1 Hershey Drive
   Smiths Falls, ON
   K7A 0A8

Your healthcare professional can also send us your Registration Form by secure fax along with your Medical Document.

B. Complete a Medical Document with your Healthcare Professional

We will also need the original version of your Medical Document, completed by your healthcare professional. We can accept this document by fax only directly from your healthcare professional's office. Otherwise, you or your doctor will need to mail us the original paper version. If you need assistance with this, we'll be pleased to arrange for the collection of your forms and/or to provide you with a self-addressed, prepaid envelope upon request.

Once we receive your Registration Form and Medical Document, we will verify the documents. We will send you a confirmation email, at which point you can place your first order.

Have questions?

To reach our care team, and/or for help filling out this registration form, contact us by telephone at 1-855-558-9333 or by email at Care@SpectrumTherapeutics.com.

1. Customer information

First name _____ Last name _____ Date of birth _____ (DD/MM/YY)

Email _____ Telephone _____

Gender ◯ Male ◯ Female ◯ Prefer not to say ◯ Custom _____

2. Residence address

Address _____

City _____ Province _____ Postal code _____

Please indicate if the address above is ◯ A private residence (*i.e., a house, apartment, condo, retirement home etc.*) ◯ An establishment *(i.e., a long-term care facility, a shelter, etc.*)

This section to be completed ONLY if you selected establishment. *This section to be completed by the establishment manager.*

Name of establishment _____

Type of establishment _____

Certification by establishment *I hereby certify that I am a manager of the above-listed establishment and that we provide food, lodging or other social services to the patient listed above.*

Signature _____ Name _____ (Printed) Title _____

Email _____ Telephone _____ Date _____

3. Where will we be shipping your medical cannabis?

◯ To residence address ◯ To mailing address (*can only be selected if this is your primary address for Canada Post*) ◯ To my healthcare professional (*Note: you will need your healthcare professional's permission*)

ONLY complete this section if you selected 'To mailing address' or 'To my healthcare professional'.

Address _____ Care of (*if applicable*) _____

City _____ Province _____ Postal code _____

Healthcare professional's information (*if applicable*)

Name of healthcare professional _____

Telephone _____ Fax _____

Certification by healthcare professional: *I hereby consent to receive cannabis products on behalf of the patient listed above.*

Signature _____ Name _____ (Printed) Date _____ (DD/MM/YY)

4. Individual responsible for the applicant

Only complete this section below if you are an Individual Responsible for the Applicant applying on behalf of the patient.
Please provide your information.

Primary individual responsible for the applicant:

First name _____ Last name _____ Date of birth _____ (DD/MM/YY)

Relationship _____ Email _____ Telephone _____

Secondary individual responsible for the applicant (*if applicable*):

First name _____ Last name _____ Date of birth _____ (DD/MM/YY)

Relationship _____ Email _____ Telephone _____

5. Authorization

We need you to sign here certifying that:
(a) the applicant ordinarily resides in Canada,
(b) the information in the application is correct and complete,
(c) the medical document that forms the basis for the application has not, to the knowledge of the individual signing the statement, been altered,
(d) the medical document is not being used to seek or obtain cannabis products from another source,
(e) in the case where the applicant is signing the statement, they intend to use any cannabis product that is supplied to them on the basis of the application only for their own medical purposes, and
(f) in the case where an adult who is named under section 4 is signing the statement, they are responsible for the applicant.

Signature _____ Name _____ (Printed) Date _____ (DD/MM/YY)

You acknowledge you will be a registered customer of Tweed Inc., a Licensed Producer under the *Cannabis Act* and its accompanying Regulations (the "Act"). You also acknowledge that you have read and agree to the Spectrum Therapeutics Terms of Service and Privacy Policy, available at SpectrumTherapeutics.com. You further acknowledge that medical cannabis is not approved for use as a drug in Canada, that its indications, safety and risks have not been adequately studied and the appropriate dosage is unclear. You acknowledge and agree that you are using any medical cannabis product obtained from Spectrum Therapeutics at your own risk, and release Spectrum Therapeutics from any and all actions, claims, complaints and demands for damages, loss, liability or injury whatsoever arising directly or indirectly as a consequence of the use of medical cannabis obtained from Spectrum Therapeutics. Spectrum Therapeutics makes no representations and gives no warranties or conditions, whether express, implied, statutory, or otherwise, including, without limitation, any warranties or conditions of merchantability, merchantable quality, durability, or fitness for a particular purpose, all of which are hereby disclaimed. That said, Spectrum Therapeutics takes its product quality very seriously, as well as its obligations under the *Cannabis Act* to investigate all customer complaints. If at any time you have an issue with your Spectrum Therapeutics medicine, we encourage you to get in touch with us.

By signing this Registration Form, you give us permission to send medical cannabis and your registration information to the shipping address provided. You also give us permission to communicate with you at your listed email address so that we can provide you with information related to your account and purchases. If you do not provide an email address, please indicate your preferred method of contact below.

Please indicate if we may also contact you:

◯ By phone
◯ By mail at your residential address
◯ By mail at your mailing address (if applicable)

Indicate if we may also email you regarding product availability or to provide other updates containing information and exclusive offers with respect to products and services, special events and store promotions:

◯ Yes ◯ No

6. Compassionate pricing promise

We offer customers a Compassionate Pricing Promise to help ensure that those in need can better afford their medicine. Eligibility terms can be found on our website. If you would like to apply for this Program, please check the box below and make sure to provide supporting documentation. You must include proof that you receive income support from an eligible provincial or federal program or meet the low-income threshold for compassionate pricing.

◯ I have included proof that I receive income support from an eligible provincial or federal program or meet the low-income threshold for compassionate pricing.

7. Direct billing for Canadian Forces Veterans

In order for us to bill Veterans Affairs Canada directly for the cost of your medicine, we require the following information*:
(a) Your doctor MUST provide a diagnosis on your Medical Document;
(b) Your Veterans Affairs Canada Health Benefit Card number _____;
(c) A completed Veterans Affairs Canada Consent to Disclose form (available on our website).

I hereby acknowledge and agree, that in connection with my acceptance of the Veterans' pre-approval coverage, I have not previously registered for coverage with another licensed producer, and that Spectrum Therapeutics will submit the payment request to Veterans Affairs Canada on my behalf.

Initial here ☐

* Direct billing is subject to approval by Veterans Affairs Canada.