PATIENT REGISTRATION FORM

PATIENT INFORMATION

Please note that the personal information provided on this Registration Form must match the information that appears on the Medical Document or Registration Certificate. For anyone completing this Registration Form on behalf of the Applicant, please complete the required sections and sign under "Caregiver/Manager of Institution/Healthcare Practitioner". If you require assistance, contact our Client Care Team at 1-844-546-3633.

First Name:	Last Name:	
Gender:	Date of Birth: (YYYY/MM/DD)	
☐ Male ☐ Female ☐ Other		
Email:	Phone:	Fax: (OPTIONAL)
Are you an existing Emblem patient who is renewing?	Are you a veteran?	
☐ No ☐ Yes - Patient ID:	☐ No ☐ Yes - K Number:	

Only fill out this section if applying using a registration certificate issued by the Minister of Health:

I am registering for the purpose of obtaining: (check all that apply) ☐ Interim supply of Dried Cannabis ☐ Cannabis Oil

SHIPPING/MAILING INFORMATION

Please provide the primary residence of the Applicant. Primary residence must be within Canada.

PRIMARY ADDRESS

☐ Private Residence ☐ Institution

Address:		
City:	Province:	Postal Code:

SHIPPING/MAILING ADDRESS

☐ Use Primary Address as Shipping Address

Or shipping/mailing address of Caregiver or Healthcare Practitioner where you would like your product shipped.		
Address:		
City:	Province:	Postal Code:

☐ Shipping/Mailing Address of Caregiver responsible for the Applicant

☐ Shipping/Mailing Address of Healthcare Practitioner consenting to receive cannabis on behalf of the Applicant

Continue on next page...

CAREGIVER/MANAGER OF INSTITUTION/HEALTHCARE PRACTITIONER

To be completed by the "Caregiver/Manager of Institution/Healthcare Practitioner". In providing a shipping address, you must be a "Caregiver/Manager of Institution/Healthcare Practitioner" according to the Access to Cannabis for Medical Purposes Regulations (ACMPR). The "Caregiver" may assist the Applicant in all areas of their registration with Emblem and is responsible for the Applicant.

Non-Primary Residence Type:

- ☐ Caregiver: I am responsible for the Applicant.
- ☐ Manager of Institution: I attest that the institution provides food, lodging, or other social services to the Applicant.
- ☐ Healthcare Practitioner: I consent to receive medication on behalf of the Applicant.
- ☐ Other, please describe:

Name and Type of Establishment (if applicable):

Relationship to Applicant:

First Name:

Last Name:

Caregiver Gender:

☐ Male ☐ Female ☐ Other

Caregiver Date of Birth: (YYYY/MM/DD)

Phone:

Fax:

Email:

Signature:*

Date: (YYYY/MM/DD)

*Signature to be provided by ONLY the Manager of Institution or Healthcare Practitioner accepting medication on behalf of the Applicant.

AUTHORIZATION

By signing below, the Applicant or Caregiver for the Applicant acknowledges that they have read, understood and agree that the Applicant ordinarily resides in Canada. The information in this application and the accompanying Medical Document or registration certificate is correct and complete. The Medical Document or registration certificate is not being used to seek or obtain medical cannabis from another source. The original Medical Document MUST be received by Emblem in order for Emblem to complete the patient registration. The Applicant will use medical cannabis only for their 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 or she is using any medical cannabis product obtained from Emblem at his or her own risk, and releases Emblem (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 Emblem. The Applicant consents to Emblem collecting and disclosing necessary personal information in order to process this registration and to fulfill orders for medical cannabis in accordance with the Emblem privacy policy (www.emblemcannabis.com/clientprivacypolicy). By signing below, the Applicant or Caregiver acknowledges that they have read, understood and agree that: Emblem may from time to time use personal health information (i.e. your condition(s), product selection) on an anonymous and aggregate basis for research and/or medical educational purposes. We may also ask you to complete surveys that we use for research purposes, although you do not have to respond to these. The Applicant consents to their health care practitioner named in the Medical Document disclosing required personal health information to Emblem for the purposes of complying with the requirements of the Access to Cannabis for Medical Purposes Regulations (ACMPR). The Applicant or Caregiver understands and agrees that a copy of this consent and registration application may be provided to the health care practitioner. By indicating the Applicant is a veteran, the Applicant or Caregiver hereby gives permission for Emblem to share personal and order information with Veterans Affairs Canada. The Applicant consents to Emblem sending email, text message and other electronic messaging from Emblem and their respective subsidiaries, affiliates, business brands and marketing partners. The Applicant understands that they may withdraw their consent at any time. Patient hereby acknowledges and agrees that Emblem does not make any representations or warranties with respect to the quality and fitness of any promotional or ancillary product(s) provided and/or sold by Emblem, and shall not be liable for any damages direct or indirect that may occur as a result of its use. Please note that the Confirmation of Registration Form is proof of legal possession and the Patient Card that you may receive from Emblem is not proof of legal possession. You may be required to provide either your patient label on your original packaging and/or the Confirmation of Registration to prove legal possession within Canada only.

☐ Authorization of Applicant ☐ Authorization of Caregiver responsible for the Applicant

First Name:

Last Name:

Signature:

Date: (YYYY/MM/DD)

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