

*Note: To register an applicant, HEXO requires this signed original Medical Document and the signed Registration form.*

<b>REQUIRED</b>	<p>This document must be fully completed by the applicant's authorized health care practitioner as defined by Health Canada in the <i>Access to Cannabis for Medical Purposes Regulations</i>. An authorized health care practitioner includes physicians in all provinces and territories, and nurse practitioners in provinces and territories where prescribing dried marijuana for medical purposes is permitted under their scope of practice.</p> <p>Patient's Name: _____ SURNAME, GIVEN NAME</p> <p>Patient's Date of Birth: _____ YYYY/MM/DD</p>
<b>REQUIRED</b>	<p><b>Health Care Practitioner</b>    <input type="checkbox"/> Physician    <input type="checkbox"/> Nurse Practitioner</p> <p>Practitioner Name: _____ SURNAME, GIVEN NAME</p> <p>Profession: _____</p> <p>Province(s) authorized to practice in: _____</p> <p>Licence Number(s): _____</p> <p><b>Health Care Practitioner's Business Address</b></p> <p>Address: _____ Suite Number: _____</p> <p>City: _____ Province: _____ Postal Code: _____</p> <p>Phone Number: _____ Fax Number: _____</p> <p>Email Address: _____</p>
<b>REQUIRED</b>	<p><b>Place of Business Where the Patient Consulted the Health Care Practitioner</b></p> <p><b>*** LEAVE BLANK IF SAME AS ABOVE ***</b></p> <p>Address: _____ Suite Number: _____</p> <p>City: _____ Province: _____ Postal Code: _____</p>

I agree to receive HEXO's newsletter containing news, updates and promotions regarding HEXO's products. You can withdraw your consent at any time.



**Please keep a copy of this document** for your records as HEXO is legally obliged to verify the accuracy of the information contained in the document upon receipt.

**SecureFax #**  
1 (888) 965-4623

REQUIRED	<p>Patient's Name: _____ SURNAME, GIVEN NAME</p> <p>Patient's Date of Birth: _____ YYYY/MM/DD</p> <p><b>Period of Use</b></p> <p>Daily quantity of dried marijuana to be used by the patient: _____ g/day <i>This can not be a range.</i></p> <p>The period of use is _____ day(s) _____ week(s) _____ month(s). <b>cannot exceed one year</b></p>
OPTIONAL	<p>Medical Condition*: _____ OPTIONAL</p> <p><i>*Mandatory if you wish to submit direct billing to Veterans Affairs Canada</i></p> <p>Maximum THC percentage: _____ OPTIONAL %</p> <p>Maximum CBD percentage: _____ OPTIONAL %</p> <p>Consent to receive dried marijuana from HEXO on behalf of your patient (Only if applicable)</p> <p>Address: _____ Suite Number: _____</p> <p>City: _____ Province: _____ Postal Code: _____</p> <p>Telephone Number: _____</p> <p>I _____ FULL NAME, POSITION, BUSINESS NAME</p> <p>consent to receive dried marijuana on behalf of _____ PATIENT'S NAME</p> <p>Health Care Practitioner's Signature: _____</p>
REQUIRED	<p>By signing this document, you confirm you are a licensed health care practitioner not named in a notice issued under section 59 of the <i>Narcotic Control Regulations</i> that has not been retracted under section 60 of those Regulations; you consulted with the applicant and you attest that the information contained in this document is correct and complete.</p> <p><input type="checkbox"/> <b>Check here if you are submitting the Medical Document to HEXO by Fax attesting to the following:</b> <i>I have chosen to submit the original Medical Document to HEXO via it's Secure Concierge s/fax Service. I acknowledge that the faxed Medical Document is now the original Medical Document and that any retained copy of this document is for my records only.</i></p> <p>_____ YYYY/MM/DD</p> <p><i>Print Name Health Care Practitioner's Signature Date</i></p>

