Appendix A

Medical Document

To be completed by a healthcare practitioner

INDIVA™
OUR ROOTS RUN DEEP

Medical document

Authorizing the use of cannabis for medical purposes.

This form is to be completed only by a healthcare practitioner.

SECURE EPORTAL FAX:
1-888-681-5801

Note: *Initialled medical documents are void unless faxed to INDIVA from practitioner's office.*

24/7 CLIENT CARE
1-888-649-6686

MAIL FORM TO:
INDIVA Inc.
Unit 10
1050 Hargrieve Road
London, ON N6E 1P5

INSTRUCTIONS TO THE HEALTHCARE PRACTITIONER

Thank you for taking the time to assess whether cannabis for medical purposes is appropriate for your client.

THERE ARE TWO WAYS TO SEND US THIS DOCUMENT

1. Original paper copy: INDIVA requires the original version of this medical document, completed and signed by the healthcare practitioner.

2. Fax alternative: We can accept this document by fax only directly from your office, and only with acknowledgement that the faxed medical document is the original medical document.

If you wish to send the original paper version, we can assist with the collection of forms by providing self-addressed stamped envelopes upon request.

INSTRUCTIONS FOR THE INDIVA CLIENT

To be fully registered, the client must submit a separate registration form to accompany this document.

To speed up the process, we advise registering online at www.indiva.com/register. Alternatively, the INDIVA client may submit a paper copy of the registration form, either printed from our website, or by request from our client centre.

Please contact us to obtain access to these materials or to answer any questions you may have.

The medical outreach team can be reached at care@indiva.com, or by phone at 1-888-649-6686

We look forward to hearing from you.

To be completed by a health carepractitioner.
All fields required under regulation unless otherwise noted.

Medical document

CLIENT INFORMATION

Information must match information on INDIVA client registration

Client's first name | **Last name** | **Gender**

Date of birth (Month / Day / Year) | **Phone number**

Period of use ☐ Day(s) ☐ Week(s) ☐ Month(s)

Note: *Duration cannot exceed one year*

Daily usage g/day

Quantity of dried cannabis

Note: *Range not permitted (e.g. 1-2 g/day)*

Usage purpose

Primary condition (optional)

Primary condition (optional)

Are you a veteran? If so, please provide your 'K' number
By indicating you are a veteran, you give permission for INDIVA to share your details with VAC.

HEALTHCARE PRACTITIONER INFORMATION

Please print clearly in full (no abbreviations)

Given name | **Last name** | **Profession**

Phone | **Fax** *(if applicable)* | **Email** *(if applicable)*

Consultation location | **City** | **Province** | **Postal code**

(Address of the location at which the person consulted with the healthcare practitioner)

Medical licence number

Licence number issued by provincial college. Note: Do not enter billing number (e.g. MSP no.)

Province of practice

Indicate province if different than above

Signature

By signing, the practitioner attests that the information in this document is correct and complete

Month / **Day** / **Year**

Practitioner initials
Use only when faxing document

By initialling, practitioner acknowledges that the medical document faxed to INDIVA constitutes the original medical document and that he/she has retained a copy of the medical document for his/her records. Practitioner also attests that the medical document will not be faxed or provided to any party other than INDIVA.

Please send all required medical documents and this cover letter to INDIVA secure fax line: 1-888-681-5801

Secure fax cover letter

From _____

Your fax number _____

Date _____

Number of pages _____

Initial _____

I attest that the information in this medical document is correct and complete and I have consulted with the client referenced in the application.

Initial above if you are submitting the medical document to INDIVA using the secure electronic fax system and attest to the following:

The provincial professional licensing authority of the province(s) in which I am authorized to practice approves of the use of electronic medical documents and I have chosen to submit the original medical document to INDIVA via the secure electronic fax system. This document is being sent directly from my medical office, I acknowledge that the faxed medical document is now the original medical document and that I have retained a copy of this document for my records only.

To be completed by client or client's caregiver.
All fields required under regulation unless otherwise noted.

Client registration form

CLIENT INFORMATION

This form must be filled out by the client (if client is applying on his/her own behalf) or a caregiver (i.e. an individual responsible for the client) applying on behalf of the client. Caregivers must also complete the caregiver information form.

Client's first name

Last name

Gender

Date of birth

Month Day Year

Email *(Required for online shopping with INDIVA)*

Are you a veteran? If so, please provide your 'K' number
By indicating you are a veteran, you give permission for INDIVA to share your details with VAC.

Residence address*

City

Province

Postal code

*If the residence address above is not for a private residence, please indicate the info:

Name of establishment

Type of establishment

Phone *(if applicable)*

Fax *(if applicable)*

Email *(if applicable)*

Mailing address *(If different from above address)*

City

Province

Postal code

*If the residence address above is not for a private residence, please indicate the info:

Name of establishment

Type of establishment

Please indicate to which address the client's product should be delivered.

☐ Ship to mailing address above ☐ Ship to healthcare practitioner's address*

**Healthcare practitioner must consent to receive product by filling out healthcare practitioner information form.*

The client and the individual responsible for the client (if applicable) must agree to the following:

Authorization of applicant

IMPORTANT, PLEASE READ AND SIGN BELOW.

By signing below, I confirm:

- The information contained in this registration application and the medical document is correct and complete;
- The applicant (client) is ordinarily a resident in Canada;
- The medical document or registration certificate used for this application is not being used to seek or obtain fresh or dried cannabis or cannabis oil from another source;
- The original medical document or fax of the original medical document, or copy of the original registration document accompanies the application;
- The applicant (client) will use INDIVA medical cannabis products only for their own medical purposes;
- The indications, safety and risks of cannabis use have not been adequately studied and the appropriate dosage is unclear. Cannabis obtained from INDIVA is at client's own risk, the client or caregiver release(s) INDIVA, along with its affiliates, partners, providers, directors, officers and employees from any and all actions, claims, complaints and demands for damages, loss or injury whatsoever arising directly or indirectly as a consequence of the use of cannabis products;
- Client and caregiver (if applicable) consent(s) to the healthcare practitioner named in his/her document disclosing required personal information to INDIVA for the purposes of complying with the requirements of the Cannabis Regulations. Client and caregiver (if applicable) understand(s) and agree(s) that a copy of this consent and registration application, as well as information about
the client's registration status and usage patterns may be provided to the healthcare practitioner named in their medical document;
- Client and caregiver (if applicable) consent to INDIVA's collection, use and disclosure of necessary personal information in order to process this registration, to provide products or services, to comply with the Cannabis Regulations (including disclosure of personal information to provincial licensing authorities upon request), and otherwise in accordance with INDIVA's privacy policy (https://www.indiva.com/privacy-policy/).
- By signing this registration form, client and caregiver (if applicable) allow INDIVA to (a) send product and registration information to the physical and email addresses provided therein, and (b) communicate with them via email regarding registration status, product availability, order status, and other matters in accordance with INDIVA's privacy policy (https://www.indiva.com/privacy-policy/).

Signature

Signature of client *(if applicable)*	**Month**	**Day**	**Year**

If there is a caregiver, both client and caregiver must sign this form unless the caregiver is the client's substitute decision maker (or equivalent) under applicable provincial law. If the patient does not sign, the caregiver, by signing below, attests that he or she is the client's substitute decision maker (or equivalent) under applicable provincial law.

Signature

Signature of individual responsible *(if applicable)*	**Month**	**Day**	**Year**