

## Registration Form

Thank you for choosing Organigram as your licensed producer of medical cannabis. Before we can place your first order, you will need to complete your application.

To register as a client, you must:

a) Complete and sign TWO COPIES of this form, leaving one original copy at your doctor's office so we have your consent to verify your information.

b) Mail the second copy along with your medical document to the following address:

35 English Drive  
Moncton, NB E1E 3X3

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Check box if Certificate of Registration from the minister was submitted in lieu of Medical Document.  
- I understand that It is prohibited to seek or obtain fresh or dried cannabis as well as cannabis oil, plants or seeds from more than one source at a time on the basis of the same medical document.

c) If you require the use of a caregiver or a health-care practitioner receiving your medicine on your behalf, please complete our supplementary forms available on our website.

Important, please read and sign below:

- The information contained in the registration document and medical document is correct and complete.
- The applicant is ordinarily a resident of Canada.
- The medical document is not being used to seek or obtain medical cannabis from another source.
- The original of the medical document accompanies the application.
- The applicant will use fresh or dried cannabis or cannabis oil for their own medical purposes.
- The applicant consents to their health-care practitioner named in the Medical Document disclosing required personal health information to Organigram Inc for the purposes of complying with the requirements of the Access to Cannabis for Medical Purposes Regulations (ACMPR) and receiving personal health information from Organigram Inc in accordance with Organigram's Privacy Policy ([www.organigram.ca/privacy-policy](http://www.organigram.ca/privacy-policy)).

First Name:

Phone:

Last Name:

Date of Birth: DD/ MM/ YYYY/

Email:

Gender:

Mailing Address:

Shipping Address:  
(If different from mailing address)

Signature: \_\_\_\_\_  
(Patient's Name)

Date: \_\_\_\_\_