WIISAG
REGISTRATION

Thank you for selecting Wiisag as your new holistic health home of choice! Here at Wiisag, our medicinal cannabis products are produced in compliance with industry standards.

All of our products are laboratory tested to ensure patients have access to safe and consistent products.

INSTRUCTIONS:
To become a Wiisag client, you must complete and sign this Registration Form and send it to our Health Services Bureau Centre via secure email or mail to:

EMAIL: INFO@WIISAG.CA
MAIL: Wiisag Health Services Bureau Centre
348 PORT ELGIN ROAD NEYAASHIINIGMIING, ON
N0H 2T0

Our Wiisag team is always available to answer any questions; we are here to assist you each step of the way.

To expedite the registration process, we advise registering online at www.wiisag.ca.

You must also have your Healthcare Practitioner complete and sign your Medical Document. Our Medical Services Bureau Centre **only** accepts this document by secure e-mail sent directly from your Healthcare Practitioner's office. If not, the original paper version of your Medical Document must be mailed by either you or your doctor.

We are here to assist you each step of the way during your healthcare journey.

The Wiisag Team

Email: info@wiisag.ca

REGISTRATION FORM

Wiisag is required to collect the following information of the Applicant pursuant to the Access to Cannabis for Medical Purposes Regulations (the "ACMPR") as may be amended from time to time. Wiisag collects, uses and discloses personal information only in accordance with the provisions of the Personal Information Protection and Electronic Documents Act, the Ontario Personal Information Protection Act, the ACMPR, and Wiisag's Privacy Policy and only for the purpose of providing medicinal cannabis and related services to Applicants. At any time, Applicants may access their personal information contained in Wissag's records and correct such information if necessary, by submitting an Amendment Form to Wiisag.

All fields are mandatory unless specified with an * and relative notes. Clarification to those fields may be provided.

APPLICANT INFORMATION (THE "APPLICANT")

Please note that the personal information provided on this form must match the information that appears on your Medical Document. Please contact our Medical Services Bureau Team, toll-free, at 1-000-000-0000 if you require any assistance while completing this application.

Applicant Name

Client's Legal First Name | Middle Name | Surname

Date of Birth *if under 18 years of age, please have Responsible Individual fill out this information.

Year | Month | Day

Gender Male ☐ Female ☐

Contact Info (Complete one or more)

Phone | Email | Band Number

Are you enrolled in the Veterans Affairs Canada Program? ☐ Yes ☐ No

If YES, please provide the following: K Number

Residential Address

Residential Address | Unit Number (If applicable)

City | Province | Postal Code

☐ If your residential address is not a private residence, please check the box and fill out section "A" on the following page.

☐ If registration application is made on the basis of a Registration Certificate with the Minister made under Part 2, please check the box and fill out section "C" on page 3.

MAILING ADDRESS OF THE RESIDENCE

Please provide the mailing address associated with the residence listed above. ☐ Same as residential address above.

Mailing Address

*If different from above

Mailing Address | Unit Number (If applicable)

City | Province | Postal Code

SHIPPING ADDRESS

NOTE: This is the address we will ship your product to.
This address must be either your residential address, the mailing address of the residence, or the business address of the Healthcare Practitioner who completed the Medical Document and has consented to receive medicinal cannabis on your behalf (please note: Applicants without a residential address must have their product shipped to the Healthcare Practitioner who completed their Medical Document.)

☐ Same as residential address

☐ Same as mailing address

☐ Healthcare Practitioner's business address as specified in the Medical Document (please fill out section "B" on the following page)

SECTION A: NON-PRIVATE RESIDENCE

* Required if address is non-private

Residence Type _____ Example: Nursing or Care Home

Name _____ Name of Establishment

Contact Info (Complete one or more)

Phone _____ Email _____ Fax _____

Signature _____ Signature of Manager

Manager's Name _____

Date _____ Year _____ Month _____ Day _____

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 Applicant listed above.

SECTION B: HEALTHCARE PRACTITIONER DELIVERY

*Required if shipping product to Healthcare Practitioner.
Have your Healthcare Practitioner complete this section if they have agreed to receive medical marihuana on your behalf. Product will ship to the business address specified on the Medical Document.

Practitioner Title and Name

Title _____ Given Name _____ Surname _____

I, _____ Name of Healthcare Practitioner agree to receive medical marihuana on behalf of _____ Name of Applicant

Signature _____ Signature of Healthcare Practitioner

Date _____ Year _____ Month _____ Day _____

Note to Healthcare Practitioner: If, at any time, you cease to consent to receive dried marijuana on behalf of the Client, you must send a written notice to that effect to both the Client and licensed producer.

INDIVIDUAL(S) RESPONSIBLE FOR THE APPLICANT

* To be completed by the individual responsible for the Applicant (if applicable).

Name

Given Name _____ Surname _____

Date of Birth _____ Year _____ Month _____ Day _____

Gender ☐ Male ☐ Female

Contact Info
(Complete one or more)

Phone | Email | Fax

I, _____ agree to receive medical marihuana on behalf of _____

Name of Responsible Individual | Name of Applicant

Signature _____ Date _____ (Year / Month / Day)

Signature of Responsible Individual

SECTION C: ACMPR REGISTRATION CERTIFICATE

* Required if being supported by a copy of a Registration Certificate issued by the Minister made under Part 2.

If you are applying with a copy of the Registration Certificate, please indicate by checkbox if the application is being made for the purpose of obtaining:

- ☐ An interim supply of fresh or dried marihuana or cannabis oil
- ☐ Marihuana plants or seeds

Please check the shipping address to be used for the purpose of obtaining cannabis plants or seeds:

- ☐ Production Site Address
- ☐ Storage Address

DESIGNATED PERSON

Please note that the personal information provided on this form must match the information that appears on your Medical Document.

Designated Person's Name _____ _____

Given Name | Surname

Date of Birth _____ (Year / Month / Day) Gender ☐ Male ☐ Female

Contact Info
(Complete one or more)

Phone | Email | Fax

PRODUCTION SITE ADDRESS

☐ Use Primary Address

Production Site Address

_____ _____

Mailing Address | Unit Number (If applicable)

_____ _____ _____

City | Province | Postal Code

STORAGE SITE ADDRESS

☐ Use Primary Address ☐ Use Production Site Address

Mailing Address

*If different from above

Mailing Address | Unit Number (If applicable)

City | Province | Postal Code

ACKNOWLEDGMENT OF APPLICANT OR RESPONSIBLE INDIVIDUAL

- The Applicant ordinarily resides in Canada.
- The information in the Application and the Medical Document is correct and complete.
- The Medical Document is not being used to seek or obtain fresh or dried marihuana or cannabis oil from another source.
- The original of the Medical Document is provided in support of the application.
- The Applicant will use fresh or dried marihuana or cannabis oil for their own purposes.

Signature

Signature of Applicant

OR Signature of the Responsible Individual (if applicable)

Date

Year | Month | Day

☐ I agree to receive Wiisag's newsletter and other electronic messages containing news, updates and promotions regarding Wiisag's products and activities. You may withdraw your consent at any time.