

Application to be an Aqualitas Client

Register by:

This online submission form,

1-833-300-AQUA (2782),

1-855-750-1884,

Aqualitas Inc.

Client Care PO Box 310

Brooklyn, NS

B0J 1H0

or clientsupport@aqualitas.ca



Client Information

First Name

Last Name

Date of Birth

The client must be over the legal age to purchase cannabis or have approval from a responsible adult to become a medical client.

Email

Gender

Are you a new Aqualitas client, or are you seeking a renewal?

Are you a Veteran seeking VAC coverage?

Yes.

No.

Residential Address

Residential Address

City

State/Province

Zip/Postal

Country

Phone Number

Fax Number (If Applicable)

Name of Establishment

Type of Establishment

Mailing Address

Mailing Address

City

State/Province

Zip/Postal

Country

Signed Agreement

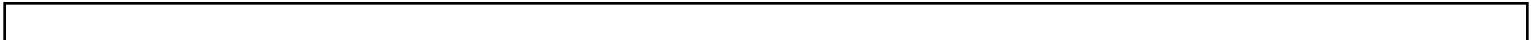
The client and the Responsible Adult for the client (if applicable) must agree to the following: Important, please read and sign below.

- The information contained in this registration application and the medical document, or registration certificate as applicable, is correct and complete;
 - The applicant (client) is ordinarily a resident in Canada;
 - The medical document, or registration certificate as applicable, used for this application is not being used to seek or obtain cannabis from another source;
 - The original of the medical document is provided in support of this application;
 - The applicant (client) will use dried cannabis 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.
- Client and caregiver (if applicable) acknowledge(s) that any medical cannabis product obtained from Aqualitas is used so at their own risk and release(s) Aqualitas, 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 medical cannabis products;
- Client and Responsible Adult (if applicable) consent(s) to the health care practitioner named in their document disclosing required personal information to Aqualitas for the purposes of complying with the requirements of the Cannabis Act and 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 health care practitioner named in their medical document;
 - Client and Responsible Adult (if applicable) consent (s)to Aqualitas' collection, use and disclosure of necessary personal information in order to process this registration, to provide products or services, to comply with the Cannabis Act and Regulations (including disclosure of personal information to provincial licensing authorities upon request), and otherwise in accordance with Aqualitas' Privacy Policy (<https://aqualitas.ca/en/privacy-policy-3/>).
 - By signing this registration form, client and Responsible Adult (if applicable) allow(s) Aqualitas 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 Aqualitas' Privacy Policy (<https://aqualitas.ca/en/privacypolicy-3/>).

Signature of Client



Date of Client Signature



Signature of Responsible Adult (If Applicable)

Date of Responsible Adult Signature

For more information, contact the Office of the Vice President for Research and Economic Development at 319-273-2500 or research@uiowa.edu.

Discounts (if applicable)

First-time patients will receive a 25% welcome discount* on their first order.

(*Welcome discount not stackable with some pricing programs.)

Persons over the age of 60 qualify for a 10% Seniors discount.

Please speak with our Patient Care team about other discounts and programs.

How did you hear about Aqualitas?

For more information, contact the Office of the Vice President for Research and Economic Development at 401-863-2400 or opred@brown.edu.

If referred by an Aqualitas patient, please provide their name.

For more information, contact the Office of the Vice President for Research and Economic Development at 515-294-6450 or research@iastate.edu.

Were you referred by an Aqualitas patient? If so, include their name in the box below and they will receive a 25% referral discount on their next order (stackable with other eligible discounts).

Veterans Affairs Canada (if applicable)

For veteran clients: Would you like Aqualitas to seek approval from Veterans Affairs Canada (VAC) for medical cannabis reimbursement coverage on your behalf?

- Yes
- No

Has the client registered as a VAC patient with another Licensed Producer?

- Yes
- No

Condition/Ailment

VAC K Number

Veteran Client Signature

Date of Veteran Client Signature

Responsible Adult Information (if applicable)

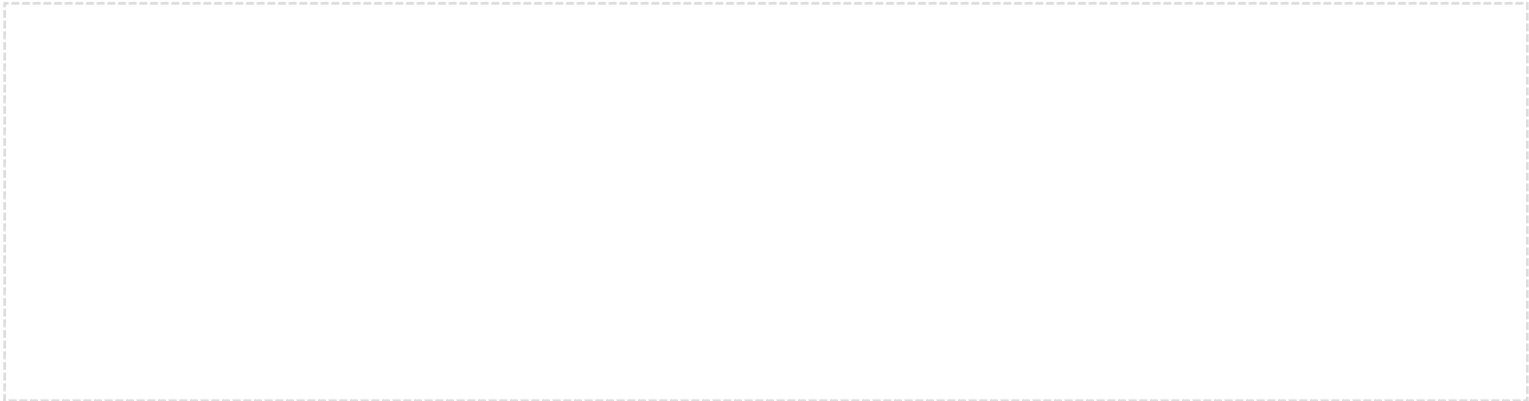
Responsible Adult First Name

Last Name

Date of Birth

Agreement

Signature

A horizontal line for a signature, consisting of a solid top line and a dashed bottom line, with a small vertical tick mark on the left side.

Date

Health Care Practitioner Information (if applicable)

Title

First Name

Last Name

Shipping Address - Where you would like your product to arrive, if different from business address or consultation address provided on medical document.

- Same as Business Address provided on medical document.
- Same as Consultation Address provided on medical document.
- Other, please provide below:

Alternative Shipping Address (If Applicable)

City

State/Province

Zip/Postal

Country

Agreement

Signature

Date

Acknowledge Notice to the Health Care Practitioner - Withdrawal of consent by the Health Care Practitioner:

- If the health care practitioner ceases to consent and receive cannabis for the client, the practitioner must send a written notice to that effect to the client and to Aqualitas.

Compassionate Pricing (if applicable)

Aqualitas Inc. is proud to offer Compassionate Pricing to our clients who need financial assistance to obtain their medicine. Aqualitas Inc. offers a Compassionate Pricing Program for those living with an income under \$40,000 per year. Under the Compassionate Pricing Program, eligible clients receive a 30% discount on Aqualitas cannabis products.

To qualify, all you need to do is submit one of the following with your registration:

- a) proof of receipt of financial assistance from either a federal or provincial program, or
- b) a copy of your 'Notice of Assessment' from the Canada Revenue Agency indicating your income falls below \$40,000.

Once received, Aqualitas will review your request for inclusion in the Aqualitas Compassionate Pricing Program. Clients must confirm their eligibility on an annual basis when new Medical Documents are submitted and Client Registration is either confirmed or denied. Aqualitas reserves the right to request documentation of eligibility. If such proof cannot be provided on request then Aqualitas has the right to cancel your participation in our Compassionate Pricing Program.

All information obtained will remain confidential and only the Client Care and Accounting department will have access to it. Aqualitas retains the right to verify this information periodically and reassess the situation accordingly.

For more information on this program, please contact our Client Services Team by toll-free telephone, at 1-833-300-AQUA (2782),
or by email at clientsupport@aqualitas.ca

Please select one or more of the following:

- I am a recipient of a federal income assistance program
- I am a recipient of a provincial income assistance program
- My total annual income on my most recent Revenue Canada 'Notice of Assessment' was less than \$40,000.
- Other (please provide details below)

(Please note that supporting documents can not be submitted with this online form. Please send an email to clientsupport@aqualitas.ca using the same email address as is stated on your contact information, with copies of these documents attached.)

Please identify or provide details on the specific program for which you receive financial assistance:

First Name

Last Name

Phone Number

Date