Breathing Green Solutions Registration Application

Thank you for choosing Breathing Green Solutions as your trusted source for medical cannabis. As the province's first licensed producer, and with our proprietary PurePlant™ method, you can trust that we have the experience and expertise to deliver the most pristine, reliable and trustworthy cannabis products for the well-being of customers everywhere.

INSTRUCTIONS:
To become a Breathing Green Solutions Client, you must complete and sign this Registration Application and send it to out Client Services Centre via secure fax, email, or mail to:

FAX:
EMAIL: orders@breathinggreen.com
MAIL: ATTN: Breathing Green Client Services Center
15693 Highway 4 Wentworth, NS B0M 1Z0

Our Breathing Green Solutions team is 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 breathinggreen.com

You must also have your Healthcare Practitioner complete and sign your Medical Document. Our Client Services centre only accepts this document by secure fax 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.

If you need any assistance, our Client Service team is happy to help you.

The Breathing Green Team.

REGISTRATION APPLICATION

Breathing Green Solutions 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. Breathing Green Solutions collects, uses and discloses personal information only in accordance with the applicable provisions of the *Personal Information Protection and Electronic Documents Act*, the Nova Scotia *Personal Health Information Act*, the ACMPR, and BGS's Privacy Policy and only for the purpose of providing medical marihuana and related services to Applicants. In the pursuit of such purposes, we may provide your personal information to a third-party partner/service provider for the purposes of [processing, shipping, etc.], but will do so only in accordance with the aforementioned legislation and Breathing Green Solutions Privacy Policy. At any time, Applicants may access their personal information contained in Breathing Green Solutions records and correct such information if necessary by submitting an Amendment Application to Breathing Green Solutions.

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 Client Services Team, toll-free, at 1.833.259.3200 if you require any assistance while completing this application.

Applicant Name | GivenName | Middle Name | Surname

Date of Birth | Year | Month | Day

Gender ☐ Male ☐ Female

Contact Info (Complete one or more) | Phone | Email | Fax

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

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 medical marihuana 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 of establishment

Contact Info (Complete one or more) _____ _____ _____
Phone — Email — Fax

Address _____ _____
Unit Number (If applicable)

_____ _____ _____
City — Province — Postal Code

Signature of Manager _____ 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, _____ agree to receive medical marihuana on behalf of _____
Name of Healthcare Practitioner — Name of Applicant

Signature _____ Date _____ _____ _____
Year — Month — Day

Signature of Healthcare Practitioner

Note to Healthcare Practitioner: If, at anytime, you cease to consent to receive dried marihuana 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,

Name of Responsible Individual

Name of Applicant

Signature

Signature of Responsible Individual

Date

Year Month Day

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 dried marihuana from another source.
- The original of the Medical Document is provided in support of the application.
- The Applicant will use dried marihuana for their own purposes.

Signature

Signature of Applicant

OR Signature of the Responsible Individual (if applicable)

Date

Year Month Day

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

Breathing Green Solutions
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Toll Free Fax: