PHONE: 1-844-928-7672 | EMAIL: CLIENTCARE@AURORAMJ.COM | FAX: 403-637-3121

REGISTRATION APPLICATION

ALL FIELDS ARE MANDATORY UNLESS SPECIFIED WITH AN ◆ AND RELATIVE NOTES. USE A PEN AND PRINT AS CLEARLY AS POSSIBLE.

1. APPLICANT INFORMATION (THE "APPLICANT")

◆ ALL INFORMATION IN SECTION 1 MUST MATCH YOUR GOVERNMENT ISSUED IDENTIFICATION

CLIENT NAME

FIRST NAME _____ LAST NAME _____

DATE OF BIRTH

YEAR ____ MONTH __ DAY __

VETERANS K-NUMBER ◆ IF APPLICABLE

_____

2. CONTACT INFO

EMAIL _____ PHONE ___ ___ ___ ___ ___ ___ ___ SECONDARY PHONE ___ ___ ___ ___ ___ ___ ___

3. RESIDING ADDRESS

UNIT NUMBER _____ ADDRESS LINE 1 _____

ADDRESS LINE 2 _____

CITY, TOWN OR VILLAGE _____ PROVINCE OR TERRITORY _____ POSTAL CODE ___ ___ ___ ___

☐ **SHIP TO MAILING ADDRESS** FILL OUT SECTION BELOW
◆ MUST BE REGISTERED TO RESIDING ADDRESS (I.E., P.O. BOX)

☐ **YOUR RESIDING ADDRESS IS AN INSTITUTION/ESTABLISHMENT**
(I.E., CARE FACILITY, SHELTER ETC.) FILL OUT SECTION 5

4. MAILING ADDRESS

◆ IF DIFFERENT FROM RESIDING ADDRESS

MAILING ADDRESS

P.O. BOX NUMBER _____ ADDRESS LINE 1 _____

ADDRESS LINE 2 _____

CITY, TOWN OR VILLAGE _____ PROVINCE OR TERRITORY _____ POSTAL CODE ___ ___ ___ ___

5. INSTITUTION INFORMATION

◆ ONLY COMPLETE THIS SECTION IF YOUR RESIDING ADDRESS IS AN INSTITUTION / ESTABLISHMENT

INSTITUTION

INSTITUTION TYPE (I.E., A LONG TERM CARE FACILITY, SHELTER ETC.) _____ INSTITUTION NAME _____

ADDRESS OF INSTITUTION _____

INSTITUTION MANAGER CONTACT INFO

EMAIL _____ PHONE ___ ___ ___ ___ ___ ___ ___ SECONDARY PHONE ___ ___ ___ ___ ___ ___ ___

INSTITUTION MANAGER'S SIGNATURE

BY SIGNING 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.

FIRST AND LAST NAME _____ X SIGNATURE OF THE MANAGER _____

6. HEALTH CARE PRACTITIONER DELIVERY

◆ REQUIRED IF SHIPPING PRODUCT TO HEALTH CARE PRACTITIONER

PRACTITIONER TITLE AND NAME

TITLE _____ FIRST NAME _____ LAST NAME _____

☐ I agree to receive medical cannabis on behalf of _____.
FULL NAME OF APPLICANT

SIGNATURE

X _____
SIGNATURE OF PRACTITIONER

DATE

____|____|____|____ YEAR ____|____ MONTH ____|____ DAY

7. INDIVIDUAL RESPONSIBLE FOR APPLICANT

◆ TO BE COMPLETED BY THE INDIVIDUAL RESPONSIBLE FOR THE APPLICANT (IF APPLICABLE)

CAREGIVER NAME

FIRST NAME _____ LAST NAME _____

DATE OF BIRTH

____|____|____|____ YEAR ____|____ MONTH ____|____ DAY

CONTACT INFO

EMAIL _____ PHONE ____|____ ____|____|____ ____|____|____|____

SECONDARY PHONE ____|____|____ ____|____|____ ____|____|____|____

☐ I attest that I am responsible for _____.
FULL NAME OF APPLICANT

SIGNATURE

X _____
SIGNATURE OF RESPONSIBLE INDIVIDUAL

DATE

____|____|____|____ YEAR ____|____ MONTH ____|____ DAY

ACKNOWLEDGEMENT OF APPLICANT OR RESPONSIBLE INDIVIDUAL

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

- The Applicant acknowledges that medical cannabis is not approved for use as a drug in Canada and that its risks and appropriate dosages have not been determined. The Applicant acknowledges that he/she is using medical cannabis at his/her own risk and that Aurora is not liable for any damages, loss, or injury whatsoever that results, either directly or indirectly, from the use of medical cannabis.
- The Applicant acknowledges that some of the information provided in this document may be shared with our service providers for shipping purposes only.
- The Applicant understands and acknowledges that any Medical Documents sent with this form can not be returned once registration is complete.
- The Applicant ordinarily resides in Canada.
- The Applicant acknowledges that, where the Applicant has been referred to Aurora by a third-party intermediary (i.e. your physician/clinic), Aurora may share some personal information collected by Aurora, including information provided in this document, with the applicable third-party intermediary.
- The information in this application and the Medical Document is correct and complete.
- The original Medical Document submitted to Aurora by yourself or your physician 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 medical cannabis only for their own medical purposes.

☐ I'd like to receive news and updates from Aurora Cannabis.

☐ I'd like Aurora Cannabis to contact me about opportunities to participate in research, including clinical studies, focus groups, and more.

At Aurora we take your privacy seriously. Any information collected by opting in to receive correspondence from Aurora is retained and disclosed in strict accordance to our privacy policy which can be viewed in full here on our website.

SIGNATURE

X _____
SIGNATURE OF APPLICANT OR RESPONSIBLE INDIVIDUAL

DATE

____|____|____|____ YEAR ____|____ MONTH ____|____ DAY

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AURORA®

MEDICAL DOCUMENT

TO BE COMPLETED BY YOUR HEALTH CARE PRACTITIONER

ALL FIELDS ARE MANDATORY UNLESS SPECIFIED WITH AN ◆ AND RELATIVE NOTES. USE A PEN AND PRINT AS CLEARLY AS POSSIBLE.

1. PATIENT INFORMATION

PATIENT NAME

FIRST NAME _____ LAST NAME _____

DATE OF BIRTH

YEAR ____ MONTH ____ DAY ____

CONTACT INFO

EMAIL _____ PHONE ____ ____ ____

2. HEALTH CARE PRACTITIONER INFORMATION

PRACTITIONER TITLE AND NAME

TITLE _____ FIRST NAME _____ LAST NAME _____

GENERAL INFO

PROFESSION _____ LICENCE # (CPSO, CPSBC, CMQ) _____ PROVINCE(S) LICENSED TO PRACTISE IN _____

CONTACT INFO

EMAIL _____ PHONE ____ ____ ____ FAX ____ ____ ____

BUSINESS ADDRESS

UNIT NUMBER _____ ADDRESS LINE 1 _____

ADDRESS LINE 2 _____

CITY, TOWN OR VILLAGE _____ PROVINCE OR TERRITORY _____ POSTAL CODE ____ ____

CONSULTATION ADDRESS

☐ IF DIFFERENT THAN ABOVE

UNIT NUMBER _____ ADDRESS LINE 1 _____

ADDRESS LINE 2 _____

CITY, TOWN OR VILLAGE _____ PROVINCE OR TERRITORY _____ POSTAL CODE ____ ____

3. PRESCRIPTION

QUANTITY/DIAGNOSIS

GRAMS/DAY ____ PERIOD OF USE (MAXIMUM OF 365 DAYS) _____ PRIMARY CONDITION (REQUIRED ONLY IF DOCUMENT WILL BE SUBMITTED TO VETERANS AFFAIRS) _____

SIGNATURE

I ATTEST THAT THE INFORMATION IN THIS DOCUMENT IS CORRECT AND COMPLETE.

X _____

SIGNATURE OF HEALTH CARE PRACTITIONER _____ YEAR ____ MONTH ____ DAY ____

4.SUBMISSION AND SHIPPING ◆ IF APPLICABLE

Your medical document may be submitted to us by mailing the original version or by faxing a copy of the original. It may be sent to the address or fax number in the header of this document depending on your preferred method. If you choose to fax this document it must be faxed by your health care practitioner from their business address.

☐ **HEALTH CARE PRACTITIONER INITIAL IF YOU ARE SUBMITTING THE MEDICAL DOCUMENT TO AURORA BY FAX**
I, the patient's health care practitioner, have chosen to submit the original medical document via Aurora's secure fax eportal. I acknowledge that the faxed medical document is now the original medical document and the document in my possession reverts to a copy retained for record keeping purposes only.

☐ **HEALTH CARE PRACTITIONER INITIAL IF YOU WILL BE RECEIVING THE PATIENT'S MEDICAL CANNABIS TO YOUR BUSINESS ADDRESS**
I, the patient's health care practitioner, consent to receive medical cannabis on behalf of the patient at the business address on this medical document.
Note: If at any time you cease to consent to receive medical cannabis on behalf of the patient, you must send a written notice to that effect to both the patient and the licensed producer.