



AURORA[®]

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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 Cannabis Act 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 Cannabis Act, 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 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

_____|_____|_____|_____|_____|_____|
YEAR MONTH DAY