



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 (T → ALL INFORMATION IN SECTION 1 MUST MA	THE "APPLICANT") TCH YOUR GOVERNMENT ISSUED IDENTIFICATION	
CLIENT NAME		
FIRST NAME	LAST NAME	
DATE OF BIRTH	VETERANS K-NUMBER ◆ IF APPLICABLE	
YEAR MONTH DAY		
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 S	VOUR REGIR	DING ADDRESS IS AN INSTITUTION/ESTABLISHMENT
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 RE	ESIDING ADDRESS IS AN INSTITUTION / ESTABLISHMI	ENT
INSTITUTION		
INSTITUTION TYPE (I.E., A LONG TERM CARE FACILI	TY, SHELTER ETC.) INSTITUTION NAME	
ADDRESS OF INSTITUTION		
INSTITUTION MANAGER CONTACT INFO		
EMAIL		SECONDARY PHONE
INSTITUTION MANAGER'S SIGNATURE	BY SIGNING I HEREBY CERTIFY THAT I AM A MANAG WE PROVIDE FOOD, LODGING, OR OTHER SOCIAL SE X	GER OF THE ABOVE LISTED ESTABLISHMENT AND THAT ERVICES TO THE APPLICANT LISTED ABOVE.
FIRST AND LAST NAME	A SIGNATURE OF THE M	IANACED

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 b	ehalf of	NT
SIGNATURE	DATE	
Х		1
SIGNATURE OF PRACTITIONER	YEAR MONTH	DAY
7. INDIVIDUAL RESPONSIBLE FOR A TO BE COMPLETED BY THE INDIVIDUAL RESPON		
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	DATE	
X SIGNATURE OF RESPONSIBLE INDIVIDUAL		L DAY
		DAT
ACKNOWLEDGEMENT OF APPLICAN		
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	n Aurora Cannabis.	
I'd like Aurora Cannabis to contact me a	bout opportunities to participate in research, inc	luding clinical studies, focus groups, and more
At Aurora we take your privacy seriously. Any informatic privacy policy which can be viewed in full here on our we	on collected by opting in to receive correspondence from Au bsite.	rora is retained and disclosed in strict accordance to ou
SIGNATURE	DATE	
X	_	

SIGNATURE OF APPLICANT OR RESPONSIBLE INDIVIDUAL

MONTH DAY

YEAR



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

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 DATE OF BIRTH	LAST NAME CONTACT INFO	
YEAR MONTH DAY	EMAIL	PHONE
2. HEALTH CARE PRACTITIONER IN	FORMATION	
PRACTITIONER TITLE AND NAME		
TITLE FIRST NAME	LAST NAME	
GENERAL INFO		
PROFESSION	LICENCE # (CPSO, CPSBC, CMQ)	PROVINCE(S) LICENSED TO PRACTISE IN
CONTACT INFO		
BUSINESS ADDRESS	PHONE	FAX
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	RE SURMITTED TO VETERANS AFFAIRS)
SIGNATURE I ATTEST THAT THE INFORMATION IN THIS DOCUMEN		SE SOBMITTED TO VETERANIO ALLANIO,
X	1 10 00 m 20 m 22 m	
SIGNATURE OF HEALTH CARE PRACTITIONER	YEAR MONTH	DAY
4.SUBMISSION AND SHIPPING + IF I	APPLICABLE	
	ng the original version or by faxing a copy of the original. It n ou choose to fax this document it must be faxed by your he	
I, the patient's health care practitioner, have o	YOU ARE SUBMITTING THE MEDICAL DOCUMENT TO chosen to submit the original medical document via Aurora' I document and the document in my possession reverts to a	s secure fax eportal. I acknowledge that the faxed
HEALTH CARE PRACTITIONER INITIAL IF No. 1, the patient's health care practitioner, conse	YOU WILL BE RECEIVING THE PATIENT'S MEDICAL CAN ent to receive medical cannabis on behalf of the patient at the pecive medical cannabis on behalf of the patient, you must see the patient of the patient.	NNABIS TO YOUR BUSINESS ADDRESS ne business address on this medical document.