AURORA
MEDICAL DOCUMENT

To be completed by your Health Care Practitioner

All fields are mandatory unless specified with an * and relative notes. Clarification to those fields may be provided.

Aurora Cannabis Enterprises Inc.
Email: clientcare@auroramj.com
P.O. Box 209
Cremona, AB. T0M 0R0
Phone: 1-844-928-7672
Fax: 403-637-3121

Patient Information

Please contact our client care team at 1-844-928-7672 if you have any questions regarding this form.

Patient Name
Given Name | Surname

Date of Birth
Year | Month | Day

Gender ☐ Male ☐ Female

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

Health Care Practitioner Information

Practitioner Title and Name
Title | Given Name | Surname

General Info
Profession | License # (CPSO, CPSBC, CMQ) | Province(s) Authorized to Practice in

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

Business Address
Business Address | Unit Number (If applicable)
City | Province | Postal Code

***Consultation Address**
☐ **Same as above**
Consultation Address | Unit Number (If applicable)
City | Province | Postal Code

Prescription

Quantity/Diagnosis
Grams/Day | ◯Days ◯Weeks ◯Months **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
Signature of Health Care Practitioner

Date
Year | Month | Day

Submission and Shipping (If Applicable)

*Required 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 on the top right corner of this document depending upon 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 RECIEVING THE PATIENT'S MEDICAL MARIJUANA TO YOUR BUSINESS ADDRESS.**
I, the patient's Health Care Practitioner, consent to recieve medical marijuana on behalf of the patient at the business address on this *Medical Document.*
Note: If at anytime you cease to consent to recieve medical marijuana on behalf of the patient, you must send a written notice to that effect to both the patient and the licensed producer.

AURORA®

REGISTRATION APPLICATION

Aurora Cannabis Enterprises Inc.
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Cremona, AB. T0M 0R0
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Aurora 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. 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 marihuana 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.

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 care team at 1-844-928-7672 if you require any assistance while completing this application.

Client Name

Given Name | Middle Name | Surname

Date of Birth

Year | Month | Day

Gender ☐ Male ☐ Female

Contact Info
(Complete one or more)

Phone | Email | Fax or secondary phone

Residing Address

Residing Address | Unit Number (If applicable)

City | Province | Postal Code

If your residing address is not a private residence, please check the box and fill out section A on the following page ☐

Mailing Address of 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 residing address, the mailing address of the residence, or the business address of the Health Care Practitioner who completed the Medical Document and has consented to receive marijuana on your behalf (please note: Applicants without a residential address must have their product shipped to the Health Care Practitioner who completed their Medical Document.)

☐ Same as residing address

☐ Same as mailing address

☐ Health care 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

Type (example: nursing or care home)

Name Name of Establishment

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

Signature

Date
Signature of Manager | 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: Health Care Practitioner Delivery

*Required if shipping product to Health Care Practitioner

Have your health care practitioner complete this section if they have agreed to recieve 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, Name of Health Care Practitioner, agree to recieve medical marihuana on behalf of Name of Applicant

Signature

Date
Signature of Health Care Practitioner | Year | Month | Day

Note to health care practitioners: If at any time 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 the licensed producer.

Individual Responsible for 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 or secondary phone

I, Name of Responsible Individual, attest that I am responsible for Name of Applicant

Signature

Date
Signature of Responsible Individual | Year | Month | Day

Acknowledgement of Applicant or Responsible Individual

- The Applicant acknowledges that medical marihuana 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 marijuana 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 marihuana.
- 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 acknowledges that, where the Applicant has been referred to Aurora by a third-party intermediary, Aurora may share some personal information collected by Aurora, including information provided in this document, with the applicable third-party intermediary.
- The Applicant ordinarily resides in Canada.
- The information in this 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 accompanies the application.
- The Applicant will use dried marihuana only for their own medical purposes.

Signature

Signature of Applicant

OR

Signature of Responsible Individual (if applicable)

Date

Year Month Day

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

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