



## REGISTRATION APPLICATION

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 marijuana 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**

<input type="text"/>	<input type="text"/>	<input type="text"/>
Given Name	Middle Name	Surname

**Date of Birth**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<b>Gender</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Year	Month	Day			

**Contact Info**  
(Complete one or more)

<input type="text"/>	<input type="text"/>	<input type="text"/>
Phone	Email	Fax or secondary phone

**Residing Address**

<input type="text"/>		<input type="text"/>
Residing Address		Unit Number <small>(if applicable)</small>
<input type="text"/>	<input type="text"/>	<input type="text"/>
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)

<input type="text"/>		<input type="text"/>
Mailing Address		Unit Number <small>(if applicable)</small>
<input type="text"/>	<input type="text"/>	<input type="text"/>
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**  **Name**   
(example: nursing or care home) 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 receive medical marijuana 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 marijuana on behalf of   
Name of Health Care Practitioner 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 marijuana 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**    **Gender**  Male  Female  
Year Month Day

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

I, , attest that I am responsible for   
Name of Responsible Individual 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
<b>OR</b>
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.

Aurora Cannabis Enterprises Inc., P.O. Box 209, Cremona, AB., T0M 0R0. [www.auroramj.com](http://www.auroramj.com)