PHONE: 1-877-9AURORA | EMAIL: REGISTRATION@AURORAMEDICAL.COM | FAX: 403-637-3121

PATIENT REGISTRATION APPLICATION

PLEASE INDICATE IF THIS IS A(N): ☐ NEW / RENEWAL REGISTRATION ☐ AMENDMENT TO AN ACTIVE REGISTRATION

ITEMS MARKED WITH ◆ ARE MANDATORY AND APPLICATIONS CAN NOT BE COMPLETED WITHOUT THIS INFORMATION

SECTION 1 – PATIENT INFORMATION

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

◆ FIRST NAME | MIDDLE NAME OR INITIAL | ◆ LAST NAME

◆ Y Y Y Y M M D D
DATE OF BIRTH (YEAR/MONTH/DAY)

☐ MALE ☐ FEMALE ☐ OTHER ☐ PREFER NOT TO SAY
GENDER

☐ ENGLISH ☐ FRENCH
PREFERRED LANGUAGE

MOBILE PHONE NUMBER | ALTERNATE PHONE NUMBER | ◆ EMAIL ADDRESS (REQUIRED TO ORDER ONLINE)

IF YOU ARE A VETERAN, PLEASE SELECT APPLICABLE OPTION:

☐ STILL SERVING ☐ NON-SERVING

VETERANS K-NUMBER ◆ IF APPLICABLE

K

BY PROVIDING YOUR K-NUMBER, YOU GIVE PERMISSION FOR AURORA® TO SHARE YOUR DETAILS WITH VETERANS AFFAIRS CANADA.

DO YOU HAVE INSURANCE COVERAGE FOR MEDICATIONS (EITHER THROUGH YOUR OWN OR ANOTHER BENEFIT PLAN)?

☐ YES ☐ NO

IF YES, DOES THE INSURANCE PLAN INCLUDE COVERAGE FOR MEDICAL CANNABIS?

☐ YES ☐ NO ☐ UNSURE

YOUR INSURANCE PLAN AND POLICY NUMBER / GROUP NUMBER ◆ IF APPLICABLE

NAME OF INSURANCE PROVIDER | INSURANCE POLICY NUMBER / GROUP NUMBER*

OTHER INSURANCE PLAN AND POLICY NUMBER / GROUP NUMBER ◆ IF APPLICABLE

NAME OF INSURANCE PROVIDER | INSURANCE POLICY NUMBER / GROUP NUMBER*

* WE ARE NOT ABLE TO DIRECTLY BILL YOUR INSURANCE PROVIDER AT THIS TIME, HOWEVER THE INFORMATION YOU PROVIDE HERE MAY HELP YOU PURSUE REIMBURSEMENT.

SECTION 2 - ADDRESS INFORMATION

IF PROVIDING A P.O. BOX # YOU MUST ALSO INCLUDE YOUR PRIMARY ADDRESS. THE ADDRESS MUST BE IN CANADA.

PLEASE INDICATE IF YOUR PRIMARY ADDRESS IS A: ☐ PRIVATE HOME ☐ NURSING / CARE HOME ☐ SHELTER ☐ HOSTEL ☐ GROUP HOME

◆ STREET ADDRESS | UNIT / APARTMENT NUMBER

INSTITUTION NAME (IF APPLICABLE) | ◆ CITY, TOWN OR VILLAGE | ◆ PROVINCE OR TERRITORY | ◆ POSTAL CODE

MAILING ADDRESS IF DIFFERENT FROM PRIMARY ADDRESS ☐ USE PRIMARY ADDRESS AS MY SHIPPING ADDRESS

P.O. BOX NUMBER | STREET ADDRESS | UNIT / APARTMENT NUMBER

INSTITUTION NAME (IF APPLICABLE) | CITY, TOWN OR VILLAGE | PROVINCE OR TERRITORY | POSTAL CODE

INSTITUTION INFORMATION

ONLY COMPLETE IF PRODUCT IS BEING SENT TO A NURSING/CARE HOME OR AUTHORIZING HEALTHCARE PRACTITIONER.

STREET ADDRESS | UNIT / APARTMENT NUMBER

CITY, TOWN OR VILLAGE | PROVINCE OR TERRITORY | POSTAL CODE

EMAIL | PHONE | SECONDARY PHONE

FIRST AND LAST NAME OF THE MANAGER

X
SIGNATURE OF THE MANAGER

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.

◆ REQUIRED IF SHIPPING PRODUCT TO HEALTHCARE PRACTITIONER – SEE MAILING ADDRESS

I agree to receive medical cannabis on behalf of ______________________________.

FULL NAME OF APPLICANT

X ______________________ Y Y Y Y M M D D

SIGNATURE OF HEALTHCARE PRACTITIONER | YEAR | MONTH | DAY

CAREGIVER / PERSON RESPONSIBLE

ONLY COMPLETE THIS SECTION IF YOU ARE A CAREGIVER OR PERSON RESPONSIBLE FOR THE APPLICANT.

FIRST NAME | LAST NAME | Y Y Y Y M M D D DATE OF BIRTH (YEAR/MONTH/DAY)

EMAIL | MOBILE PHONE NUMBER | ALTERNATE PHONE NUMBER

I attest that I am responsible for ______________________________.

FULL NAME OF APPLICANT

X ______________________ Y Y Y Y M M D D

SIGNATURE OF CAREGIVER / PERSON RESPONSIBLE | YEAR | MONTH | DAY

CAREGIVER / PERSON RESPONSIBLE #2 IF APPLICABLE

FIRST NAME | LAST NAME | Y Y Y Y M M D D DATE OF BIRTH (YEAR/MONTH/DAY)

EMAIL | MOBILE PHONE NUMBER | ALTERNATE PHONE NUMBER

I attest that I am responsible for ______________________________.

FULL NAME OF APPLICANT

X ______________________ Y Y Y Y M M D D

SIGNATURE OF CAREGIVER / PERSON RESPONSIBLE | YEAR | MONTH | DAY

ACKNOWLEDGEMENT OF APPLICANT OR CAREGIVER / PERSON RESPONSIBLE

Aurora Cannabis Enterprises Inc. ("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 applicable federal and provincial privacy legislation, the Cannabis Act, and Aurora's Privacy Policy. 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 on our website.

- 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 they are using medical cannabis at their 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 ordinarily resides in Canada.
- The Applicant will use medical cannabis only for their own medical purposes.
- 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 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 or Registration Certificate is correct and complete.
- The original Medical Document or Registration Certificate (for interim supply or starting materials) 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 or Registration Certificate accompanies the application.
- The Applicant agrees that Aurora® may collect, use, disclose and store their personal information and personal health information provided by the Applicant, their caregiver or their health care professional(s) (collectively, the Applicant's "information") to determine their eligibility for, and registration as, a client of Aurora®, and for the purpose of filing orders and providing information about Aurora® and its products and services and for the purpose of obtaining and processing payments by, or on behalf of, the Applicant as applicable.
- The Applicant acknowledges that, when applicable, Aurora® may speak with, and share information with, the Applicant's health insurer, union, or private benefit provider to maximize the available benefit(s) to the Applicant.
- The applicant acknowledges your address change may require us to transfer your registration between our licensed sites. This will not affect you other than your product will be fulfilled from a different site. By submitting this form you consent to such transfer if required.

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

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

SIGNATURE | **DATE**

◆ X ______________________ ◆ Y Y Y Y M M D D

SIGNATURE OF APPLICANT OR CAREGIVER / PERSON RESPONSIBLE | YEAR | MONTH | DAY