NEW CLIENT REGISTRATION

Alberta Craft Cannabis Inc. is required to collect the following information of the Applicant pursuant to the Cannabis Act and may be amended from time to time. The personal information provided on this form must match the information that is on the supported Medical Document.

Phone: 1-888-759-2552 **Secure Fax:** 1-877-886-2754

Address: 5705-99 Street NW, Edmonton, AB, T6E3N8

APPLICANT INFORMATION

FIRST NAME

LAST NAME

PHONE NUMBER

EMAIL ADDRESS

DATE OF BIRTH (MM / DD / YYYY)

GENDER

○ MALE ○ FEMALE ○ OTHER

RESIDING ADDRESS

CITY

PROVINCE

POSTAL CODE

IS THE ADDRESS ABOVE A PRIVATE RESIDENCE?
IF NO, PLEASE FILL OUT THE SECTION BELOW

☐ YES ☐ NO

NON-PRIVATE RESIDENCE

TYPE OF ESTABLISHMENT (NURSING HOME, ETC.)

NAME OF ESTABLISHMENT

CONTACT PERSON FULL NAME

PHONE

EMAIL

SHIPPING ADDRESS

This is the address where we will ship your product. Please fill out only if your shipping address is different from the residence address listed above. Please note that we cannot ship to PO boxes.

ADDRESS

CITY

PROVINCE

POSTAL CODE

HEALTH CARE PRACTITIONER DELIVERY

* REQUIRED IF SHIPPING TO HEALTH CARE PRACTITIONER

PRACTITIONER TITLE

PRACTITIONER FIRST NAME

PRACTITIONER LAST NAME

BUSINESS ADDRESS

CITY

PROVINCE

POSTAL CODE

PHONE NUMBER

FAX

EMAIL ADDRESS

NAME OF HEALTH CARE PRACTITIONER

agree to receive medical cannabis on behalf of

APPLICANT'S NAME

SIGNATURE OF HEALTH CARE PRACTITIONER

DATE (MM / DD / YYYY)

INDIVIDUAL RESPONSIBLE FOR APPLICANT

* TO BE COMPLETED BY INDIVIDUAL RESPONSIBLE (IF APPLICABLE)

FIRST NAME

LAST NAME

DATE OF BIRTH (MM / DD / YYYY)

PHONE NUMBER

EMAIL ADDRESS

GENDER

○ **MALE** ○ **FEMALE** ○ **OTHER**

NAME OF RESPONSIBLE INDIVIDUAL

confirm that I am responsible for

APPLICANT'S NAME

SIGNATURE OF RESPONSIBLE INDIVIDUAL

DATE (MM / DD / YYYY)

ACKNOWLEDGMENT OF APPLICANT OR INDIVIDUAL RESPONSIBLE FOR APPLICANT

- 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 information in this application and the Medical Document is correct and complete.
- The Medical Document is not being used to seek or obtain dried 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.
- In the case where the individual signing is not the Applicant, they acknowledge they are responsible for the Applicant.

I attest that the information contained in this document is correct & complete.

SIGNATURE OF APPLICANT

DATE (MM / DD / YYYY)

SIGNATURE OF RESPONSIBLE INDIVIDUAL (IF APPLICABLE)