REGISTRATION APPLICATION

Thank you for selecting Aqualitas as your Licensed provider.

At Aqualitas our medicinal cannabis is organically grown, in compliance with Health Canada standards. Many of our products are small batch and hand-trimmed. Every Aqualitas product is laboratory tested to ensure patients have access to consistent and safe products.

INSTRUCTIONS:

To become an Aqualitas client, you must complete and sign this Registration Application and send it to our Client Services Centre via secure fax, email, or mail to:

AQUALITAS INC - Client Care Team
PO Box 310, Brooklyn, Nova Scotia B0J 1H0

clientsupport@aqualitas.ca | Toll-Free: 1-833-300-AQUA (2782)
Secure eFax: 1-855-750-1884

Aqualitas is required to collect the following information of the Applicant pursuant to the *Cannabis Act* as may be amended from time to time. Aqualitas collects, uses and discloses personal information only in accordance with the provisions of the Personal Information Protection and Electronic Documents Act, the *Cannabis Act*, and our 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 Aqualitas records and correct such information if necessary by submitting an Amendment Application to Aqualitas. By submitting this form, you consent to our lawful collection and disclosure of information.

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 Support Team, toll-free, at 1-833-300-AQUA (2782), if you require any assistance while completing this application.

Applicant Name:

Legal First Name | Middle Name | Surname

Date of Birth*: (YYYY/MM/DD)

Gender:

If applicant is under 18 years of age, please have a Responsible Individual fill out this information on page 3.

Contact Info:

Phone | Email | Fax

Are you enrolled in the Veterans Affairs Canada Program? Yes ☐ No ☐

If YES, please provide the following: K Number:

Residential Address:

Address

Unit Number (if applicable)

City

Province

Postal Code

☐ If your residential address is not a private residence, please check the box and **fill out section "A"** at the bottom of this page.

☐ If registration application is made on the basis of a Registration Certificate with the Minister made under Part 14, Division 2 of the *Cannabis Act,* please check the box and **fill out section "C"** on page 3.

MAILING ADDRESS OF THE RESIDENCE:

Please provide the mailing address associated with the residence listed above.

☐ Same as residential address above.

Mailing Address: *if different from above address

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 residential address, the mailing address of the residence, or the business address of the Healthcare Practitioner who completed the Medical Document and has consented to receive medical cannabis on your behalf **(please note: Applicants without a residential address must have their product shipped to the Healthcare Practitioner who completed their Medical Document.)**

☐ Same as residential address

☐ Same as mailing address

☐ Healthcare 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

Residence Type:

Example: Nursing or Care Home

Name:

Name of Establishment

Contact Info:

Phone

Email

Fax

Signature of Manager:

Manager's Name:

☐ 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.

Date: YYYY/MM/DD

SECTION B: HEALTHCARE PRACTITIONER DELIVERY

* Required if shipping product to Healthcare Practitioner.

Have your Healthcare Practitioner complete this section if they have agreed to receive medical cannabis 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 cannabis on behalf of _____

Name of Healthcare Practitioner | Name of Applicant

Signature of Healthcare Practitioner

Date: YYYY/MM/DD

Note to Healthcare Practitioner: If, at any time, you cease to consent to receive medical cannabis on behalf of the Applicant, you must send a written notice to that effect to both the Client and licensed producer.

INDIVIDUAL(S) RESPONSIBLE FOR THE APPLICANT

* To be completed by the individual responsible for the Applicant (if applicable).

Name:

Given Name | Surname

Date of Birth

(YYYY/MM/DD)

Gender:

Contact Info:

Phone | Email | Fax

I, _____ agree to receive medical cannabis on behalf of _____

Name of Responsible Individual | Name of Applicant

Signature of Responsible Individual

Date: YYYY/MM/DD

SECTION C: *CANNABIS ACT* REGISTRATION CERTIFICATE

* Required if being supported by a copy of a **Registration Certificate** issued by the Minister made under Part 14, Division 2 of the *Cannabis Act*. If you are applying with a copy of the Registration Certificate, please indicate by checkbox if the application is being made for the purpose of obtaining:

- ☐ An interim supply of fresh or dried cannabis or cannabis oil
- ☐ Cannabis plants or seeds

Please check the shipping address to be used for the purpose of obtaining cannabis plants or seeds:

- ☐ Production Site Address
- ☐ Storage Address

DESIGNATED PERSON (if applicable)

Please note that the personal information provided on this form must match the information that appears on your **Medical Document**.

Designated Person's Name: _____ (Given Name) _____ (Surname)

Date of Birth: _____ (YYYY/MM/DD) Gender: _____

Contact Info: _____ (Phone) _____ (Email) _____ (Fax)

PRODUCTION SITE ADDRESS (if applicable)

☐ Use Residential Address OR

Production Site Address: _____ (Address) _____ Unit Number (if applicable)

_____ (City) _____ (Province) _____ Postal Code

STORAGE SITE ADDRESS (if applicable)

☐ Use Residential Address OR

Storage Site Address: _____ (Address) _____ Unit Number (if applicable)

_____ (City) _____ (Province) _____ Postal Code

ACKNOWLEDGMENT OF APPLICANT OR RESPONSIBLE INDIVIDUAL (applies to all applicants)

- The Applicant ordinarily resides in Canada.
- The information in the Application and the Medical Document is correct and complete.
- The Medical Document is not being used to seek or obtain fresh or dried cannabis or cannabis oil or plants or seeds. from another source. The original of the Medical Document is provided in support of the application.
- The Applicant will use fresh or dried cannabis or cannabis oil for their own purposes.

Signature:

Signature of Applicant

Date: YYYY/MM/DD

Or:

Signature of the Responsible Individual (if applicable)

Date: YYYY/MM/DD

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

Thank you.
Our client support team will be in touch.

aqualitas

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