NEW ACCOUNT FORM

Please fill out the form below to sign up for a new account with AVARI Medical®
Return your completed form to customerservice@avarimedical.com

ACCOUNT INFORMATION

ACCOUNT NAME Dr. Warren Roberts

Primary Contact Name Carly Olynyk
EMAIL: carly@ptifa.com
Phone: 778-883-1503
Type of Practice: Dental
Instagram Handle: ptifa1

Billing Address

Attention: Accounts Payable - James Bell
Street 1 1228 Pacific Drive
Street 2
City Delta
Province BC Postal Code V4M 2K6

Shipping Address Check if same as billing ☐

Street 1 5550 12 Ave
Street 2
City Delta
Province BC Postal Code V4M 4C2

CREDIT CARD INFORMATION

VISA ☐ MASTERCARD ☐
Cardholder Name Please invoice us
Card number
Expiry Date
CVV

I _____ (full name) authorize AVARI Medical to charge the credit card above (or such other card as I authorize from time to time) for all shipped order balances upon order shipment.

Print name:_____
Signature:_____
Date: _____

☑ I would like to receive promotions and the latest news from AVARI

LICENSED MEDICAL PRACTITIONER CERTIFICATION AND AGREEMENT

Account Name Dr. Warren Roberts

I, the undersigned, hereby certify that I am authorized under law to practice medicine in the jurisdiction(s) and under the valid medical license(s)/registration(s) numbers identified below and that I am authorized under applicable law to order, dispense and authorize the use of prescription drugs and prescription dermal fillers in those jurisdictions (Practitioner Authorization). I certify that the primary address of my medical practice is:

5550 12 Ave, Delta BC V4M 4C2

(Practitioner's Primary Practice Address)

I certify and agree that: (i) I am the medical practitioner of record responsible for the possession and administration of any drug, medical device or cosmetic distributed under this account ("Product (ii) only I, or an individual under my direct supervision who is authorized under applicable laws to administer such Products will be permitted to administer Products under this account, and (iii) I have provided to AVARI Medical Ltd (AVARI) the names and qualifications of all individuals associated with this account who may be administering any such Products ("Qualified Injectors")

I further certify and agree that: (i) if the status of my Practitioner Authorization, of the Qualified Injectors or of my Primary Practice Address changes, I will notify AVARI immediately and undertake to perform any procedures required by AVARI Canada to recertify my status in connection with this account (including, but not limited to, submitting a New Account Application and a Licensed Medical Practitioner Certification and Agreement), and (ii) I will not sell and will not permit to be sold by this account or my medical practice (if different), any Products. I acknowledge that shipment of Products to this account and to my medical practice may be suspended in the event that (i) or (ii) is contravened.

Practitioner's name (Print): Warren Roberts

Signature _____

Date _____

License # _____

Injector Certification# (if applicable) _____

Program _____

Date of Certification _____

Please return your completed form to customerservice@avarimedical.com