

Membership Form

Family Name _____ Name _____ Birth date _____ Sex _____

Address _____ City _____ Province _____ Postal Code _____

Telephone (home) _____ Telephone (work/cell) _____ E-mail _____

Physician's name _____ Physician's phone number _____ Physician's fax number _____

Medical diagnosis and/or symptoms :

Do you suffer from psychological problems? No Yes (Specify) : _____

Do you have any allergies? No Yes (Specify) : _____

Do you take any drugs (prescription or non-prescription)? No Yes (Specify) : _____

Emergency contact : _____

Name

Phone number

How long have you been using cannabis? : _____

How much cannabis do you use per week? : _____

How does cannabis help with your symptoms? : _____

I declare all information provided to be true.

Member signature

Date