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

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