Membership Form

Date : ______________
Member # : ______________

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

☐ M.D. (Specialist : ________________________)

Medical diagnosis and/or symptoms :

____
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____
____

Do you suffer from psychological problems? ☐ **No** ☐ **Yes (Specify) :** __________________

____

Do you suffer from cardiac or respiratory problems? ☐ **No** ☐ **Yes (Specify) :** ___________

____

Do you have any allergies? ☐ **No** ☐ **Yes (Specify) :** ______________________________

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

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____

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? : ___________________________

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I declare all information provided to be true.

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Member signature **Date**