Kelz

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MEMBERSHIP APPLICATION

Applicant Name: _____ Date of Birth: _____ _____ _____
FIRST LAST M D Y

Address: _____
STREET CITY PROVINCE POSTAL CODE

Phone number(s): _____ MMAR# (if applicable): _____

Email: _____

Medical Condition(s) and Symptoms: _____

_____

_____

Physician's Name: _____ Physician Type:

Address: _____ ❑ Medical Doctor

City: _____ Prov: _____ PC: _____ ❑ Naturopath

Phone Number(s): _____ ❑ Doctor of Traditional Chinese Medicine

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Optional Information:

Are you presently taking any prescription pharmaceuticals? ❑YES ❑NO

If you answered "YES", please list your drug regimen as well as any side effects:

_____

_____

_____

_____

_____

How long have you been using cannabis? _____

How long have you been using cannabis as a medicine? _____

How much do you use cannabis? (GRAMS/DAY) _____

Does this dosage alleviate your symptoms? ❑YES ❑NO

How does cannabis affect your symptoms?

_____

_____

_____

_____

I hereby declare that the information stated above is factual:

DATE: _____ APPLICANT'S SIGNATURE: _____

**Kelz reserves the right to limit medication quantity.*