GRAND RIVER
+ DISPENSARY

info@cggrc.org

MEMBERSHIP APPLICATION FORM

Applicant Name: ____ (please print)

Address: ____

City: _________________________ Province: _______ Postal Code: ______________

Phone Number: (___)______________ Email: __________________________________

Date of Birth: ____

MMAR Number (if applicable): _______________________________________

Medical Conditions and Symptoms: ____

____

Physician's Name: ____

Address: ____

City: _________________________ Province: ________ Postal Code: ______________

Phone Number: (___)______________ Email: ___________________________________

Optional:

Are you presently taking any prescription pharmaceuticals? Yes ☐ No ☐

If "yes" please list your drug regimen as well as any side effects: ___________________________

____

How long have you been using cannabis as medicine? ___________________________________

How does cannabis affect your symptoms? ____

How much/how often do you use cannabis? ____

Does this dosage alleviate your symptoms? ____

How did you hear about Medicanna? ____

I, applicant hereby declare that the above information is factual.

Applicant Signature: ________________________________ Date Signed: ______________