The Vancouver Island Compassion Society

Application for Registration

Applicant's name: _____

Address: _____ City: _____ Prov:_____

Postal Code: _____ Phone number(s): _____

Date of birth: _____ E-mail: _____

Medical condition(s) and symptoms: _____

_____

_____

_____

Physician's name: _____

Address: _____ **City:** _____ **Prov:**_____

Postal Code: _____ **Phone number(s):** _____

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

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

_____

_____

_____

How long have you been using cannabis? _____

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

How does cannabis affect your symptoms? _____

_____

How much/how often do you use cannabis? _____

Does this dosage alleviate your symptoms? _____

I hereby declare that the information stated above is factual:

Applicant's signature: _____ Date signed: _____

Printed name: _____

* The Vancouver Island Compassion Society reserves the right to limit the amount of medication supplied to any of its members.