MEMBER REGISTRATION FORM

Patient Name: _____

Email Address: _____ Date of Birth: _____

Address: _____ City: _____ Zip: _____

Phone Number: _____ State Driver's License or ID: _____

Doctor Name: _____

Verification Phone#: _____

Verification Website: _____ Recommendation ID#: _____

Rec. Issue Date: _____ Rec. Expiration Date: _____

I hereby authorize my treating doctor to release medical information regarding my diagnosis and condition to **OCMEDS**.

I understand and agree as follows:
I am a qualified patient protected by California Health and Safety Code 11362.7. et. seg., and Senate Bill 420. My doctor has recommended the use of medical marijuana and provided written documentation of such recommendation. My doctor will review my case on a yearly basis. Per the relevant sections of California law, I am able to legally possess, use, and cultivate cannabis collectively for medical purposes. I designate **OCMEDS** as my care provider. I agree to follow all the rules and guidelines of the collective and pay reasonable compensation and/or volunteer for other services and activities provided by the collective.

Signed: _____ Date: _____

For Office Use Only

Date and Time Verified: _____ **Verified** By: _____

Method of Verification & Special Notes: _____