The Canadian Safe Cannabis Society
Box 1113 STN Main
Kamloops, British Columbia
Canada V2C-6H2

Phone: 250-819-9755
Fax:
Website: www.ilikecannabis.ca

Application for Membership

Applicant's Name: _____

Applicant's Date of Birth: _____

Street Address: _____ City: _____

Province: _____ Postal Code: _____

Phone: _____ Email Address: _____

MMAR Number:_____

How would you like us to contact you? e-mail [ ] phone[ ]

How were you referred to us? website [ ] word of mouth [ ] other[ ]

Medical Information

Medical Condition(s): _____

_____

_____

_____

_____

Physician's Name: _____

Physician's Street Address:_____City: _____

Province: _____Postal Code: _____

Physician's Phone Number: _____

Usage Information

How long have you been using cannabis? _____

How long have you been using Cannabis as a medication? _____

What effect does cannabis have on your medical symptoms_____

_____

How much cannabis do you use daily?: _____

I, _____ hereby declare that all information provided in the above membership application is true and factual.

Applicant's Signature: _____

Date: _____._____