MEMBERSHIP REGISTRATION PACKAGE

WHAT IS INCLUDED IN THE PACKAGE

1. INSTRUCTIONS
2. REGISTRATION CHECKLIST
3. MMS APPLICATION FORMS
4. PARENTAL CONSENT FORM IF UNDER 25 YEARS OF AGE.

CHOOSE 1 LICENSED PRODUCER AND FILL OUT THEIR FORMS

APHRIA

TWEED/BEDROCAN

MED RELEAF

METTRUM

ORGANIGRAM

MMS
Medical Marijuana Services

SIGN UP IN 5 EASY STEPS

1. **Download** our membership registration forms found at www.medicalmarijuanaservices.ca/sign-up

2. **Choose** a Licensed Commercial Producer (LCP) from our Gold Members OR from the Health Canada's List of Licensed Producers. You will find our Gold Member Registration Forms ready to download on the sign up page.

   These are our Gold Member Licensed Producers:

   Aphria Medical Marijuana · Tweed bedrocan canada · ORGANIGRAM · MEDRELEAF · mettrum

3. **Complete** registration/application form for Licensed Commercial Producer (LCP) and ATTACH it to your Membership Registration Package. Mail the complete Patient Registration Package to MMS.

4. **Consultation** with the Doctor via Telemedicine or in person to discuss your medical condition. The Doctor's office will mail your medical document directly to your LCP after your consultation. 90% of our Patients see a Doctor within 7 Days.

5. **Order** your medicine from your Licensed Commercial Producer. The Licensed Commercial Producer will contact you within 7 – 14 business days after verification. 80% of our patients are verified by Gold Member LP's within 7 days!

   Please note that the licensed producer may require time to verify your application. This varies depending on the Licensed Producer.

We accept Visa, MC, Amex, Certified Cheques and money orders payable to MMS, Interac e-transfers are also welcome.

VISA · MasterCard · American Express · Interac

Contact us if you have any further questions.

Call Toll Free 1-866-355-4751
9am-1pm 2pm-6pm Mon-Saturday

Closed Sunday

PATIENT REGISTRATION INSTRUCTIONS

PLEASE READ CAREFULLY

MMS
Medical Marijuana Services

WHAT IS INCLUDED IN A MMS MEMBERSHIP?

- CONSULTATION WITH A TOP DOCTOR IN THE FIELD OF MEDICAL MARIJUANA.
- PREFERRED STATUS WITH MMS GOLD STANDARD LICENSED PRODUCERS.
- AT COST VAPORIZERS AND OTHER ACCESSORIES.
- HELPFUL CUSTOMER SERVICE TO ANSWER ALL OF YOUR QUESTIONS.
- ADVICE ON THE BEST LICENSED PRODUCERS AND MOST EFFECTIVE TREATMENTS.
- 24 HOUR EMERGENCY ASSISTANCE (IF VERIFICATION IS REQUIRED BY AUTHORITIES).
- AUTOMATIC RENEWAL NOTICE.
- MEDICAL MARIJUANA RESOURCES TO HELP NAVIGATE YOUR TREATMENT EFFECTIVELY.

WHAT IS THE MEMBERSHIP PROCESS?

STEP 1:

COMPLETE DOCUMENTATION. FILL IN ALL RELEVANT FORMS AS DESCRIBED IN THE INSTRUCTIONS.

STEP 2:

SUBMIT MEMBERSHIP APPLICATION TO MMS. SEE 'HOW TO SUBMIT MY FILES TO MMS.

STEP 3:

CONSULTATION WITH OUR DOCTOR-THE DOCTOR SENDS YOUR PRESCRIPTION TO THE LICENSED PRODUCER

STEP 4:

ORDER YOUR MEDICINE FROM THE LICENSED PRODUCER-THEY WILL CALL ONCE PRESCRIPTION VERIFIED

STEP 5:

ATTEND ANY FOLLOW UP CONSULTATIONS RECOMMENDED BY THE DOCTOR. INCLUDED IN MEMBERSHIP

STEP 6:

RENEW YOUR PRESCRIPTION IN 12 MONTHS. MMS WILL CONTACT YOU IN TIME FOR RENEWAL.

WHAT IS THE CHECKLIST?

THE CHECKLIST IS YOUR GUIDE TO COMPLETING THE MEMBERSHIP REGISTRATION COMPLETELY AND ACCURATELY. PLEASE ENCLOSE THE COMPLETED CHECKLIST WITH YOUR APPLICATION.

WHAT IS THE PATIENT ASSESSMENT FORM?

THIS IS YOUR MEDICAL HISTORY. FILL THIS FORM OUT YOURSELF. YOU DO NOT NEED YOUR DOCTOR TO FILL OUT THIS FORM. PLEASE SUPPLY AS MUCH DETAIL AS POSSIBLE. THE MORE INFORMATION WE HAVE THE BETTER THE DOCTOR CAN TREAT YOU.

WHAT IS THE TREATMENT AGREEMENT?

THIS IS A CONTRACT BETWEEN YOURSELF AND THE DOCTOR. IT EXPLAINS THE EFFECTS OF MARIJUANA AND THE RISKS INVOLVED IN USING MARIJUANA AS MEDICINE. THIS AGREEMENT ALSO DESCRIBES THE ACCEPTABLE PRACTICES FOR LEGALLY USING MARIJUANA AS MEDICINE. THIS FORM IS MANDATORY.

WHAT IS THE MEMBERSHIP CONTRACT?

THIS IS AN AGREEMENT BETWEEN YOURSELF AND MEDICAL MARIJUANA SERVICES. IT EXPLAINS WHAT YOUR MEMBERSHIP INCLUDES AND YOUR RIGHTS AS A MEMBER. THIS FORM IS MANDATORY.

WHAT IS A SUPPORTING MEDICAL DOCUMENT?

- A SUPPORTING DOCUMENT CAN BE ANY ONE (OR MORE) OF THE FOLLOWING:
- A DIAGNOSIS OF YOUR ILLNESS OR
- A CAT SCAN, MRI OR X-RAY INDICATING YOUR INJURY(S)
- A LETTER FROM YOUR FAMILY DOCTOR EXPLAINING YOUR ILLNESS(S)
- PROOF OF GOVERNMENT ASSISTED DISABILITY
- A STATEMENT OF DISABILITY FROM HEALTH CANADA
- OBVIOUS PHYSICAL DISABILITY (QUADRIPLEGIC, PARAPLEGIC, MS)

WHAT IS THE ANXIETY/DEPRESSION FORM?

YOU FILL THIS FORM OUT IF YOUR PRIMARY REASON FOR USING MEDICAL MARIJUANA IS DUE TO ANXIETY OR DEPRESSION. YOU WILL ALSO NEED TO COMPLETE THE MEMBERSHIP REGISTRATION.

WHAT IS THE SLEEP DISTURBANCE FORM?

YOU FILL THIS FORM OUT ONLY IF YOUR PRIMARY REASON FOR USING MEDICAL MARIJUANA IS DUE TO A FORM OF SLEEP DISTURBANCE. YOU WILL ALSO NEED TO COMPLETE THE MEMBERSHIP REGISTRATION.

WHAT IS THE PATIENT REFERRAL FORM?

USE THIS FORM IF YOUR DOCTOR IS COMFORTABLE WITH YOU USING MARIJUANA AS MEDICINE, BUT IS UNWILLING TO SIGN THE MEDICAL DOCUMENT HIM/HERSELF. ASK YOUR DOCTOR TO FILL IN THE FORM AND SEND IT TO MMS OR YOUR RESIDENCE. ATTACH THIS TO YOUR PACKAGE.

WHAT IS THE CONSENT TO DISCLOSE FORM?

THIS ALLOWS MMS TO ASK YOUR FAMILY DOCTOR OR MEDICAL CLINIC FOR YOUR MEDICAL FILE AS IT RELATES TO YOUR ILLNESS. YOU CAN SPECIFY WHAT DOCUMENTS WE CAN ACCESS. YOU WILL HAVE TO PUT YOUR DOCTOR'S NAME ON THE FIRST LINE AND HAVE A WITNESS (FRIEND OR FAMILY) SIGN THE DOCUMENT WITH YOU.

THE EASIEST WAY TO ACCESS YOUR FILE IS TO VISIT OR CALL YOUR DOCTOR'S OFFICE AND ASK FOR A COPY OF YOUR FILE. IT IS YOUR RIGHT TO HAVE ACCESS TO YOUR MEDICAL RECORDS. YOU ARE NOT REQUIRED TO EXPLAIN WHY YOU NEED THE RECORDS. IF YOU CHOOSE TO USE THIS FORM PLEASE SEND IT DIRECTLY TO YOUR DOCTOR'S OFFICE, NOT TO MMS.

NB* YOU DO NOT NEED TO FILL OUT THE PATIENT REFERRAL FORM OR CONSENT TO DISCLOSE FORM IF YOU HAVE A SUPPORTING MEDICAL DOCUMENT.

WHAT IS THE CREDIT CARD PAYMENT FORM?

USE THIS FORM IF YOU WISH TO PAY BY CREDIT CARD. (FOR AMEX USERS PLEASE WRITE THE 4 DIGIT CVV CODE IN THE SPACE WHERE IT ASKS FOR THE 3 DIGIT CVV CODE).

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HOW MUCH DOES THE MEMBERSHIP COST?

INITIAL CONSULTATION AND MMS MEMBERSHIP (INCLUDES DOCTOR CONSULTATION)

MEMBERSHIP ONTARIO ONTARIO OUT OF PROVINCET199.00-ALBERTA 249.00-QUEBEC 199.00	149.00
UNDER 25 (WITH PARENTAL CONSENT)TH PARENTAL CONSENT (MANDATORY)	$249.00
MEMBERSHIP RENEWAL (INCLUDES CONSULTATION)	$99.00
ADDITIONAL MEDICAL DOCUMENT (MAXIMUM 1)	$100.00
COPY OF ORIGINAL MEDICAL DOCUMENT (MAXIMUM 1)	$50.00
CHANGE LICENSED COMMERCIAL PRODUCERS	$100.00
MISSED OR RESCHEDULED APPOINTMENT	$100.00

*ALL PRICES ARE SUBJECT TO 13% HST- PRICES ARE SUBJECT TO CHANGE WITHOUT NOTICE.
REFUND POLICY. SHOULD THE DOCTOR DECIDE THAT MARIJUANA IS NOT THE CORRECT TREATMENT FOR YOU A REFUND OF 80% OF THE CONSULTATION WILL BE ISSUED WITHIN 5 BUSINESS DAYS.

HOW DO I SUBMIT MY FILES TO MMS?

PRINT AND FAX (RECOMMENDED)

(FASTEST PROCESSING TIME – 1-5 BUSINESS DAYS)

- PRINT AND FILL OUT THE REGISTRATION FORMS.
- EVERY PAGE THAT YOU FAX MUST BE COMPLETED APPROPRIATELY AND EACH PAGE MUST BE INITIALED ON THE BOTTOM RIGHT CORNER.
- THE FAXED REGISTRATION PACKAGE FAX MUST BE SENT AS ONE COMPLETE PACKAGE.
- FAX (TOLL FREE) TO: 1 866 355 5159

PRINT, SCAN AND EMAIL

MAXIMUM 15 MB FILE SIZE (PLEASE SCAN AT 100 DPI – LOW RESOLUTION.)
(FASTEST PROCESSING TIME – 1-5 BUSINESS DAYS)

- PRINT AND FILL OUT THE REGISTRATION FORMS.
- EVERY PAGE THAT YOU PRINT, SCAN AND EMAIL MUST BE SIGNED APPROPRIATELY AND EACH PAGE MUST BE INITIALED ON THE BOTTOM RIGHT CORNER.
- THE BEST FORMAT TO SEND THE FILE IN IS PDF. (ADOBE CORPORATION)
- THE REGISTRATION PACKAGE MUST BE COMBINED INTO 1 FILE.
- MAKE SURE TO INCLUDE YOUR SUPPORTING MEDICAL DOCUMENTS IN THE PACKAGE.
- THE FILE MUST BE NAMED: YOURNAME-MMS-REGISTRATION.
- EMAIL THE FILE TO: REGISTRATION@MEDICALMARIJUANASERVICES.CA

BY EMAIL

(FASTEST PROCESSING TIME – 1-5 BUSINESS DAYS)

- YOU MUST DOWNLOAD THE REGISTRATION PACKAGE (DO NOT FILL OUT ONLINE)
- USE THE FILLABLE FIELDS IN THE REGISTRATION PACKAGE TO COMPLETE THE APPLICATION. THERE IS A BUTTON (TOP RIGHT) TO HIGHLIGHT THE FIELDS.
- MAKE SURE ALL THE MANDATORY FIELDS ARE FILLED IN CORRECTLY. (RED OUTLINE)
- PLEASE COMPLETE THE FORMS IN AS MUCH DETAIL AS POSSIBLE.
- THIS IS A MEDICAL DOCUMENT AND SHOULD BE FILLED OUT IN DETAIL.
- SIGN THE DIGITAL SIGNATURE. (SEE-"WHAT IS A DIGITAL SIGNATURE" BELOW)
- SAVE YOUR FILE AS: "YOURNAME-MMS REGISTRATION."
- SCAN AND EMAIL YOUR SUPPORTING MEDICAL DOCUMENTS TO THE ADDRESS BELOW.
- YOU CAN ALSO TAKE A PHOTOGRAPH OR SCAN OF YOUR SUPPORTING MEDICAL

BY MAIL

(SLOWEST PROCESSING TIME – 7-14 DAYS)

MMS
3920 ANTOINE-BEDWANI
LAVAL, QC
H7W 0H6

TRY TO SEND YOUR PACKAGE WITH A TRACKING NUMBER.

PLEASE DO NOT ASK FOR SIGNATURE TO RECEIVE THE PACKAGE.

Your Registration Checklist

Please make sure that all of the components listed below are complete before mailing, faxing or emailing your application to MMS

CHECK AS COMPLETED

- ☐ Patient Assessment Form (All fields completed and Signature on Page 3)
- ☐ Patient Doctor Contract (Every page initialled and Signature on Page 2)
- ☐ Membership Contract (All fields completed and Signature at the bottom)
- ☐ Supporting Medical Document(s) (See instructiions for authorized list)
- ☐ A clear copy of your photo heath card (all 4 corners must be visable)
- ☐ Financial Documents (if applying for discount from MMS or LP's)
- ☐ Your completed Licensed producer forms. Please note that the following Gold Member Registraton forms are available for download on the signup page.Tweed-Bedrocan-Aphria-Medreleaf-Organigram or Mettrum

MMS
Medical Marijuana Services

Patient Assessment Form

Patient Assessment Form

For Patients Seeking a Medical Cannabis Document

General Details

First Name	
Last Name	
Lic. Producer	
Best Time to Reach You (eg After 5)	

D.O.B.	year	month	day
Gender	male ☐	female ☐	Current Age
If female, are you pregnant or nursing?	yes ☐	no ☐	
Heathcard #			

Contact Information

Address	
City	
Province/Postal C	

Home Phone	
Cell Phone	
Email	

General Practitioner Information

Name of Doctor	
Doctor's Address	
Doctor's City	
Province/Postal C	
Date of last visit	
Reason for last visit	

Are you seeing a Specialist?	yes ☐	no ☐	
Specialist Name			
Date of last visit			

Additional Notes

Patient Assessment Form

For Patients Seeking a Medical Cannabis Prescription

Your Medical Condition and Symptoms

Primary Condition	

Check off symptoms associated with your primary condition. Circle level of symptom severity. Level 1-not severe Level 5-very sever			
	Pain 1 2 3 4 5	Anxiety 1 2 3 4 5	Nausea/Vomiting 1 2 3 4 5
	Muscle Spasms 1 2 3 4 5	Depression 1 2 3 4 5	Low Energy 1 2 3 4 5
	Mobility 1 2 3 4 5	Concentration/Focus 1 2 3 4 5	Diarrhea 1 2 3 4 5
	headache 1 2 3 4 5	Sleep Disturbance 1 2 3 4 5	Constipation 1 2 3 4 5
	Seizures 1 2 3 4 5	Visual Disturbance 1 2 3 4 5	Medication Side Effects 1 2 3 4 5
	Involuntary Movements 1 2 3 4 5	Weight Loss 1 2 3 4 5	Other: _____ 1 2 3 4 5
		Lack of Appetite 1 2 3 4 5	_____ 1 2 3 4 5

Medical History

How much does your condition affect your daily routine? Circle level of symptom severity. Level 1-not severe Level 5-very severe	1 2 3 4 5 Comments:	How much does your condition affect your ability to work? Circle level of symptom severity. Level 1-not severe Level 5-very sever	1 2 3 4 5 Comments:
Current Medications: Please indicate the dosage	Medication: Medication: Medication:		
Drug Allergies			

What therapies have your tried? Check all that apply and circle level of effectiveness. Level 1-not effective Level 5-very effective			
	Physiotherapy 1 2 3 4 5	Current Prescription Medication _____ 1 2 3 4 5	
	Chiropractic 1 2 3 4 5	(Please also indication dosage) _____ 1 2 3 4 5	
	Naturopathic/Homeopathic 1 2 3 4 5	_____ 1 2 3 4 5	
	Counselling/Pyschotherapy 1 2 3 4 5	_____ 1 2 3 4 5	
	Therapeutic Injections 1 2 3 4 5	_____ 1 2 3 4 5	
	Acupuncture 1 2 3 4 5	_____ 1 2 3 4 5	
		_____ 1 2 3 4 5	

Have you been diagnosed with dependence on any drug, prescribed or otherwise?	y n	Would you feel at risk using cannabis outside your current medical treatment?	y n	Have you suffered from a Psychotic illness in the past or currently?	y n	Have you previously used cannabis for symptom relief?	y n	Have you ever been been prescribed synthetic cannabis?	y n
Has a close family member suffered from Psychotic illness?	y n	Do you suffer from heart disease?	y n						

Patient Assessment Form

For Patients Seeking a Medical Cannabis Prescription

Medical History Continued

The information you provide in this document is strictly confidential.

How much cannabis do you use per day?	☐ Less than 1g per day ☐ 1-2g per day ☐ 3-5g per day ☐ 6-10g per day		
What is your preferred method of taking cannabis?	Inhalation/Smoke ☐ Oral/Eat ☐ Topical/Cream ☐	What are your treatment goals?	Reduce pain ☐ Improve Daily Function ☐ Improve Appetite ☐ Improve Mood ☐ Improve Sleep ☐ Other _____
Why is cannabis appropriate as a medical treatment?			
How long have you been using cannabis?	☐ Less than 1 year ☐ 1-2 years ☐ 3-5 years ☐ 6-10 years ☐ 10-20 years ☐ 20-35 years ☐ 35+ years	Is cannabis your most effective medicine?	☐ Yes ☐ No
Has cannabis helped lower the dose of other prescription medications?	☐ Yes ☐ No		
If yes then which medication(s)?			
Have you ever experienced any negative side effects?	☐ Yes ☐ No		
If yes, please describe.			
Have you ever taken a break from cannabis?	☐ Yes ☐ No		
If yes, what happened?			

Signature			
Name			
Date Signed	month	day	year

PHQ-9 & GAD-7

Name:_____ Date:_____

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? Circle the most appropriate number for each.		Not at all	Several Days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9	Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3
		PHQ9 Total Score:			

GAD-7

Over the past 2 weeks, how often have you been bothered by any of the following problems? Circle the most appropriate number for each.		Not at all	Several days	Over half the days	Nearly every day
1	Feeling nervous, anxious, or on edge?	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it's hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid	0	1	2	3
		Total score for GAD7:			

Treatment Agreement between Doctor and Patient

For Patients Seeking a Medical Cannabis Document

I _____

I understand that this Release and Acknowledgement contains IMPORTANT information about medical cannabis that the assessing physician requires that I acknowledge and understand before he/she may issue a prescription and/or authorizaton for use of medical cannabis.

I further understand that the consulting physician will not necessarily be assuming care for me. He/She will, however, assess and evaluate the appropriateness of my request to use medical cannabis to assist in treating the conditions and associated symtoms that I believe; from my own personal experience, medical cannabis to be helpful in treating.

I accordingly confirm that the assessing physician will be my medical practitioner for the sole purpose of medical cannabis authorization and/or prescriptions.

I agree not to make any claim or commence any legal proceedings against the assessing physician, his/her practice, my family physcician or any other involved physicians (such as specialists) in relation to:

a) My use of cannabis as a medicine; and

b) My Application, or, prescription for possessing, obtaining, and using medical cannabis.

I am well aware that physicians generally agree that medical cannabis;

- May distort perception (sight, sounds, time, touch);
- May impair memory and learning
- May impair coordination (Avoid driving for 4 hours after smoking and 8 hours after injesting)
- May impair thinking and problem-solving
- May increase heart rate and reduces blood
- May produces anxiety, fear, distrust, or panic

I am well aware there is considerable debate and a great lack of consensus among physicians about:

- The appropriate medical use of cannabis
- The appropriate dosage for medical cannabis
- The risks of smoking medical cannabis as compared to vaporizing or ingesting medical cannabis
- The risks of smoking whole plant medical cannabis as compared to extracting the medicinally active cannabanoids and medicating with same;
- The long-term health and psychological risks associated with the use of medical cannabis
- The degree to which regular consumption of medical cannabis:

a) May contribute to pulmonary infections and respiratory cancer
b) May damage the cells in bronchial passages which protect the body against inhaled microorganisms and decrease the ability of the immune cells in the lungs to fight off fungi, bacteria, and tumor cells. For patients with already weakened immune systems, this means an increase in the possibility of dangerous pulmonary infections, including pneumonia
c) May weaken various natural immune mechanisms, including macrophages and T-cells
d) May corelate in some cases with mental illness, such as bipolar disorder and schizophrenia

I am further well aware that the above listed medical concerns are further compounded by the lack of consistency and uniformity in available medical cannabis products. With conventional drug products I generally consume a medication of a precisely known molecular quantity. I recognize that raw plant Medical Cannabis does not work this way. I appreciate that I will get varying compositions of different cannabinoids and varying proportions of different cannabinoids from strain of plant to strain of plant and even, to a lesser degree, from plant to plant of the same strain.

I further appreciate that there is a significant uncertainty regarding the consistency of the medical cannabis drug product I may medicate with which further complicates and compounds the practical issue of medicating with an inconsistent drug product like medical cannabis.

I am further aware that ingesting a high dose of medical cannabis can cause nausea and disorientation.

In seeking medical cannabis treatment and I confirm I have consulted with a physician regarding alternative and conventional treatment options for my condition.

Initials

Treatment Agreement between Doctor and Patient

For Patients Seeking a Medical Cannabis Document

Despite all these medical concerns, debates and practical issues I honestly believe that for the treatment of my condition(s) and symptom(s) the benefits of medicating with medical cannabis outweigh the risks.

I agree to receive a “medical document” (ie prescription) for medical marijuana only from one physician.
I agree to purchase my marijuana only from a licensed producer. I am aware that possession of marijuana from other sources is illegal.

I agree to safely store my marijuana so that no other person can access it either deliberately or accidentally. I am aware that young people (under 25) may experience psychosis after consuming marijuana and will ensure that no child or young person will be exposed to my medical marijuana either directly or indirectly. I will contact Poison Control immediately if any child gains access to my supply of medical marijuana.

I am aware that taking marijuana with other substances, especially sedating substances, may cause harm and possibly even death. I will not use illegal drugs (eg, cocaine, heroin) or controlled substances (eg, narcotics, stimulants, anxiety pills) that were not prescribed for me.

I will inform the doctor of all controlled substances that are prescribed to me by my regular doctor(s). I will inform my primary care physician that I am being prescribed medical marijuana. I agree to have a medical assessment performed by my regular doctor at least every 12 months.

I am aware that marijuana use is not advisable during pregnancy and breastfeeding. I agree to inform my physician, if I am pregnant. If I become pregnant while being treated with medical marijuana, I will immediately stop using it until I have consulted with a physician.

This is my decision and I also do not support any claims made by my family, friends or other interested parties against said clinic and physicians.

I hereby release Medical Marijuana Services, the assessing physician, his/her clinic, my family physician, and any other involved physicians from any and all actions, claims, causes of actions, complaints (even by family and friends) and demands for damages, loss, or injury whatsoever arising directly or indirectly as a consequence to my use of medical cannabis and my Application to posses medical cannabis.

This release from liability is to be binding on heirs, executors and assigns. I also consent to the disclosure, sharing and use of my personal information and medical data by the assessing physician, Medical Marijuana Services and my licensed commercial producer. The information may be used to contact, assess and register the patient and for analysis and research to better help our members.

I understand and acknowledge that while the assessing physician may execute a declaration that I stand to potentially benefit from medical cannabis, the assessing physician will not serve as my primary care physician. As such I agree to seek regular medical care from my primary care physician and that the assessing physician will only deal with assessing his support for my medical cannabis use. I also consent to the assessing physician notifying any specialists have seen of my decision to use medical cannabis and I accept any consequences of such notification.

I agree to notify my primary care physician myself about my intent to use cannabis medicinally as cannabis can interact with other medications. If licensed, I agree not to resell or give away any of my medication. I agree to check with local bylaws in my area. I also agree that any legal actions will take place in Ontario and be governed by the laws of Ontario, Canada.

Patient Signature				Doctor Signature			
Patient Name				Doctor Name			
Date Signed	month	day	year	Date Signed	month	day	year

Medical Marijuana Services Membership Contract

This agreement is dated _____2015.

891811-2 Canada Inc., operating as Medical Marijuana Services - "MMS"

- AND -

_____, - “Member."

MMS Membership Benefits:

1. MMS shall pre-screen Member Applications. Upon completion of the MMS Application Package, MMS will perform a preliminary assessment. Your Application will not be processed if MMS feels that you have no chance of being approved for Medical Marijuana, and you will not be charged for services;

2. Membership fees are due and payable immediately following pre-screening of the application;

3. MMS shall arrange a confidential interview by electronic means between the Member and a highly qualified member of the medical profession authorized to approve the use of medical marijuana;

4. MMS cannot guarantee that a Member shall be approved for a Medical Document (similar to a prescription). The doctor’s professional judgment is final and will not be questioned by either MMS or the Member;

5. If a Member is not approved for a Medical Document, Membership fees will be refunded in the amount of 80% of membership fee.

6. MMS provides advice on an ongoing basis regarding the best licensed producers and most appropriate strains of medical marijuana for the Member’s condition;

7. MMS Membership confers preferred status for our Members with Gold Standard licensed producers;

8. Members may purchase vaporizers and other accessories on an ‘at cost’ basis from MMS;

9. Members receive 24 hour/7 days a week emergency assistance if police or other authorities require verification of the Medical Document;

10. MMS shall provide automatic reminders when renewal of the Medical Document is imminent;

11. All medical information shall be kept in strictest confidence. MMS will never sell or allow access to the Membership roster except on orders of the police with a court-issued warrant;

Member Obligations

12. By signing this application, MMS Members undertake to be honest and forthright regarding their medical condition when preparing the Patient Assessment Form and during the medical assessment, and to openly disclose all other prescription and non-prescription medications to the physician;

13. By signing this application MMS Members acknowledge that violation of the physician-patient contract shall immediately terminate this contract;

14. By signing this application MMS Members acknowledge that they are solely responsible for any violation of the Criminal Code or the Controlled Drugs and Substances Act;

_____ _____

Member’s printed name Member’s signature

Date_____

MMS
Medical Marijuana Services

PARENT/ GUARDIAN CONSENT

Medicinal Marijuana

Long term cannabis use in patients under the age of 25 may be related to reducing neural development of the brain which has not fully developed until the age of 25. By signing this consent both the patient and parent acknowledge this fact.

_____	_____
Patient Name	Patient Signature
_____	
Date	
_____	_____
Parent/Guardian Name Parent	Guardian Signature
_____	_____
Relationship	Date

CREDIT CARD PAYMENT FORM

NAME: _____

ADDRESS: _____

CITY: _____PROVINCE_____POSTAL CODE:_____

CREDIT CARD INFORMATION

VISA ( ) MASTERCARD ( ) AMEX ( ) DINERS ( )

CARD#_____-_____-_____ -_____ EXPIRY DATE: _____ /_____

CRV CODE_____(THIS IS THE LAST 3 DIGITS ON THE BACK OF YOUR CREDIT CARD)

NAME OF CARDHOLDER_____

MEDICAL MARIJUANA SERVICES IS HEREBY AUTHORIZED AND DIRECTED TO ACCEPT TELEPHONE OR VERBAL OR WRITTEN ORDERS FROM THE ABOVE NOTED PERSON AND TO DEBIT CHARGES TO THE ABOVE NOTED CREDIT CARD ACCOUNT FOR THE PURCHASE OF SERVICES AND CONSULTATIONS PROVIDED BY MEDICAL MARIJUANA SERVICES.

THE UNDERSIGNED WARRANTS AND REPRESENTS THAT HE/SHE IS AUTHORIZED TO SIGN FOR CHARGES TO THE CREDIT CARD(S) LISTED ABOVE AND BY EXECUTING THE AGREEMENT CONSENTS TO THE CHARGES BEING PROCESSED ON THE SAME AND FURTHER CONSENTS TO THE EXECUTION BY ANY REPRESENTATIVE OF MEDICAL MARIJUANA SERVICES OF ANY CHARGE SLIP OR OTHER DOCUMENT REQUIRED BY MEDICAL MARIJUANA SERVICES CREDIT CARD COMPANY TO SUPPORT OR PROCESS THE CHARGES INCURRED.

CARD HOLDER SIGNATURE: _____

DATE: _____

NAME (PLEASE PRINT):_____

Medical Marijuana Services (MMS) is required to provide information to Veterans Affairs Canada in order to arrange direct billing, but we cannot do this without your permission as provided on this form.

I _____authorize MMS to disclose to Veterans Affairs Canada:

WOULD YOU PLEASE SELECT ONE OF THE FOLLOWING TWO OPTIONS:

Check option 1 if you are completing this form for yourself
Check option 2 if you are a Substitute Decision Maker* for the person obtaining medical marijuana

☐ 1. My personal health information consisting of: Dose information of marijuana used for medical purposes, the specific condition for which medical marijuana is being used, and any additional information required to validate my eligibility for coverage.

☐ 2. The personal health information of _____ consisting of: Dose information of marijuana used for medical purposes, the specific condition for which medical marijuana is being used, and any additional information required to validate my eligibility for coverage.

If you selected option 2 above, please read and check the following box as well.

☐ I represent and warrant that I meet all of the requirements to be _____'s substitute decision maker under the applicable legislation.

WE NEED YOU TO FILL OUT AND SIGN THIS SECTION.

I understand the purpose for disclosing this personal health information to Veterans Affairs Canada. I understand that I can refuse to sign this consent form.

YOUR INFORMATION:

First Name:_____ Last Name: _____

Telephone number: _____ Email:_____

Signature: _____ Date: _____

**A substitute decision-maker is a person authorized to consent, on behalf of an individual, to disclose personal health information about the individual under PHIPA or the applicable health information legislation in the jurisdiction in which the applicant resides.*