MediCanna
Medicinal Cannabis Dispensary

3673 East Hastings St.
Vancouver BC V5K 2B1
604 320 0400
info@medicanna .ca

MEMBERSHIP APPLICATION FORM

Applicant Name: _____ (please print)

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone Number: (___)_____ Email: _____

Date of Birth: _____

MMAR Number (if apllicable): _____

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 hereby declare that the above information is factual.

Applicant Signature: _____ Date Signed: _____