

SECTION 56

Medical Marijuana Resource Centre

416-833-9664
info@section56.ca
www.section56.ca



Membership Form

Last Name :

First Name:

Initial:

Address:

City:

Province:

Postal Code:

Phone:

Emergency Name & Phone contact :

Your Diagnosed illness for which you administer cannabis:

HC File Number (If applicable) :

Physician Information:

Name:

Phone:

Address:

City:

Province:

Postal Code:

I hereby certify that the above information is true and accurate. I agree to abide by the rules and guidelines of the club "Section 56" in order to maintain my membership. I understand that my medical practitioner will be contacted to verify that I am current patient with the condition listed above. Further, I warrant that the signature given below is that of my doctor as witnessed by myself.

Signed

Date

Attn, Section 56

This signature is to certify that the patient listed above has been diagnosed with the medical condition noted above.

I am a duly licensed physician permitted to practice medicine in the Province of Ontario. I understand that myself or my office will be contacted by telephone to verify this information only. I am aware of my patient's use of cannabis. This form does not constitute any type of prescription or recommendations.

Signed

Date