# SECTION 56

**416-833-9664 * info@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**