

215-4-U Member Registration

Please fill out the form below to become a patient of our services. All fields are required unless otherwise indicated. Your doctor recommendation must be verified. Verification may take up to 24 hours depending on your doctors availability. Once your recommendation is verified you will receive a email notification. Final verification will be complete on first visit. To complete registration an original of your doctors recommendation and a valid California ID is required. Thank you.

Patient Information

First Name: _____

Last Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____

E-mail Address: _____

Date of Birth: _____

Doctor Information

Doctor's Name: _____

Doctor's Phone Number: _____

Referral Expiration Date: _____

Cannabis Card ID # (optional): _____

Caregiver Information (if applicable)

Yes, I have a caregiver.

Caregiver's Name: _____

Caregiver's Date of Birth: _____

Caregiver's Phone Number: _____

Authorization for Cannabis Use

Please read the following terms and conditions:

I hereby certify that I am a Patient suffering from a serious illness and have obtained a recommendation or approval from a licensed physician in the state of California to use medical cannabis (marijuana) in treating my illness. A copy of my recommendation may be attached hereto.

I certify that I, the patient, will remain compliant with the California State Laws and the Laws of the County of the patient's residence according the California Proposition 215 and/or California Senate Bill 420.

I swear that I will not resell the medical cannabis provided by 2154u.com. _____(Initial)

I authorize my recommending physician to verify his or her recommendation or approval for the use of medical cannabis. I will not use this medication with alcohol or other mind altering medications. I will not drive or operate heavy machinery

I hereby agree to the above terms and conditions.

Signature

Date

Print Name