Tel: 604-856-0288
Fax: 604-856-1860
motacancompassion@hotmail.com

MEMBERSHIP APPLICATION

Applicant Name: ____

Address: ____ City: ____________________

Province: ____________ Postal Code: _________________ Date of Birth: _________________

Phone Number: ______________________ Email: __________________________________

MMAR/MMPR # (if applicable): ____

Medical Conditions : ____

____

Optional Section :

Are you currently taking any prescription pharmaceutical drugs? Yes ____ No ____

If you answered “yes”, please list your drug schedule and side effects:

____

____

How long have you been using cannabis?____

How long have you been using cannabis as a medicine?________________________________

How does cannabis affect your symptoms?____

How often do you use cannabis?____

How did you hear about Motacan Compassion Society?________________________________

By signing below, I declare all information stated above is true and factual:

APPLICANT SIGNATURE: ___________________________ DATE SIGN: ___________________

MCS RESERVES THE RIGHT TO TRACK AND LIMIT MEDICATION QUANTITY