

Membership Application for Rainbow Med Cannabis Canada
Located at 556 Church Street 2nd floor Toronto, Ontario.
Tel 416.927.8639 Fax 416.927.1164 Email : rmccinfo@gmail.com
Website <http://www.rainbowmedicinalcannabis.ca>

Ensure all information is correct and clear. You and your doctor should retain a copy for your records.

Applicant Section

Name : _____ Date of Birth: _____

Address: _____ City _____ Province: _____ Postal _____ - _____

Phone (____) - ____ - _____ Email: _____ How did you hear about us: _____

Are you presently taking any prescription drugs? [Y] [N]?

If you answered 'YES' please list your prescribed drugs and any adverse side effects below.

Have you ever used cannabis before? [Y] [N]? If yes, for how long? _____

Have you ever used cannabis as a medicine? [Y] [N]? If yes, for how long? _____

If you use cannabis as a medicine, how does it relieve your symptoms?

Do you have a valid Health Canada Permit Card (ATP) (MMAR) to possess cannabis [Y] [N]?

If you answered no, you must take an application for Health Canada [Y] [N]?

* For those with Health Canada Permit (ATP) Cards please complete the info below and sign.

* For those with a Doctor note, PWA letters, of just this application with doc stamp skip to the signature.

Health Canada Permit # _____

Health Canada Permit Limit _____ Grams/month Expiry : _____

Signature, by doing so you agree info is true and that you have read and understand our rules and conditions

Sign: _____ Date: _____

Member id#:

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Doctors Section

Patient Name : _____ Date of Birth: _____

Doctor's Name: _____ Office Number: (____)-____-____

Address: _____ City _____ Province: ____ Postal ____ - ____

Diagnoses and symptoms include: _____

Do you recommend medicinal cannabis for relief of the above listed patient and symptoms ? [____]

Has this patient reported to you that their symptoms are relieved by cannabis and therefore, on the this knowledge, they should have access to it? [____]

IF you Do NOT recommend medicinal cannabis please choose and state the reasons below:

[__] Medical: Specify _____

[__] Legal: Specify _____

[__] Other: Specify _____

Your office will be contacted to confirm this applicant is indeed your patient.

Stamp below and sign: _____ Date: _____

Place Doctor Stamp Below

RMCC USE ONLY Member # _____

Confirmed with: _____

Caregiver Name: _____

Caregiver ID # _____

Photo ID# _____

Date : _____ Enter initials _____