Phone: 450-477-0503

Fax: 450-477-6088

Email: info@laforetverte.ca

Address: 1430 Montée Major, Terrebonne suite 100, J7M 2G3

Physician's name: _____

Address: _____ City: _____ Prov: _____

Postal code: _____ Phone number(s): _____

Optional Question: _____

Are you presently taking any prescription pharmaceuticals? Yes ___ no _____

If you answered "yes", please list your drug regimen as well as any 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 much/how often do you use cannabis? _____

Dose this dosage alleviate your symptoms?

I hereby declare that the information stated above is factual:

APPLICANT'S SIGNATURE: _____

DATE SIGNED: _____

PRINTED NAME:

*Centre de Compassion Forêt Verte RESERVES RIGHT TO LIMIT THE AMOUNT OF MEDICATION