CONSUME
ASHTABULA

PATIENT INTAKE FORM

DATE

PATIENT NAME: FIRST, MIDDLE, LAST

MEDICAL MARIJUANA CARD #

DRIVER'S LICENSE #

PATIENT INFORMATION

HOME PHONE

CELL PHONE

EMAIL ADDRESS

ADDRESS

CITY

STATE

ZIP CODE

DATE OF BIRTH

GENDER

DO YOU HAVE A LICENSED CAREGIVER?

CAREGIVER NAME / CAREGIVER ID #

ARE YOU INDIGENT?

ARE YOU A VETERAN?

REFERRED BY

SIGNATURE REQUIRED ON BACK

CONSUME
ALLIANCE

TERMS AND CONDITIONS

1. I certify that I am a qualified patient under the rules and regulations established by the State of Ohio Medical Marijuana Control Program.

2. I am a legal resident of the State of Ohio.

3. I am and will continue to be in compliant with the State of Ohio Medical Marijuana Control Program.

4. I acknowledge that obtaining Medical Marijuana from “Consume Alliance” does not exempt a qualified patient or caregiver from prosecution under Federal Law and penalties provided by Federal Law.

5. I understand that smoking of medical marijuana is not permitted per Ohio law.

6. I understand that I should not be driving a vehicle while using marijuana and that I can get a DUI for driving under the influence.

7. Medical Marijuana is not FDA approved.

8. I understand that Medical Marijuana should not be used by women who are pregnant or breastfeeding.

9. I agree to indemnify and hold “Consume Alliance” harmless for any consequences resulting from the use or purchase of Medical Marijuana.

10. I am aware that medical marijuana has not been approved under Federal Regulations and I understand that medical marijuana has not been deemed legal under federal law.

11. I do not intend to use my medical recommendation for the purpose of illegally obtaining, growing or distributing medical marijuana.

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PATIENT SIGNATURE **DATE**