KARUNA MEDICINALS

Member # _____

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4510 Victoria Drive, Vancouver BC V5N 4N8
Canada-wide mail order service!

Application for Registration

Applicant's name: _____

Address: _____

City: _____ Prov:_____ Postal Code: _____

Phone number(s): _____ _____

Date of birth: _____ E-mail: _____

Medical condition(s) and symptoms: _____

_____

_____

Physician's name: _____

Address: _____

City: _____ Prov:_____ Postal Code: _____ Phone number: _____

Are you presently taking any prescription pharmaceuticals? YES _____ NO _____

If you answered "yes", please list your drug regimen as well as any adverse 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? _____

Have you suffered from a mental disorder/depression? NO _____ YES _____ Are you currently diagnosed? _____

Do you have any food allergies? NO_____If YES, describe _____

I hereby declare that the information stated above is factual:

Applicant's signature: _____ Date signed: _____

Printed name: _____

* The Karuna Medicinals Society reserves the right to limit the amount of medication supplied to any of its members; without notice membership may be revoked at anytime.

Would you like to be added to our email list for updates, news and promotions? YES ____ NO ____