



MONTREAL COMPASSION CLUB
4169 Papineau Ave
Montreal (Quebec)
H2K 4K2

Membership Application Form

(Fill in block letters please)

First name _____ Last name _____

Address _____

_____ Postal code _____

Date of birth ____ / ____ / ____ Gender _____

Telephone () _____ - _____ Fax (*optional*) () _____ - _____

Designated person (*if any*) _____ Telephone () _____ - _____

Medical condition(s) & symptoms _____

(Don't forget to enclose a physician's statement of diagnosis along with this form.)

Caregiver (*other than physician*) _____

If you are presently using cannabis, how often and how much are you consuming? _____

I hereby declare that the information stated above is factual and I authorize the Montreal Compassion Club to make all verifications deemed necessary.

Patient's signature _____ Date _____

We reserve the right to refuse or revoke memberships at any time.