FLORIDA COMPASSIONATE CARE CENTERS LLC

PARTICIPANT INFORMATION

PLEASE PRINT ALL INFORMATION CLEARLY

Date: _____

Please Print Name EXACTLY as shown on your Florida Driver License

_____ _____ _____

First Name **Middle Name or Initial** **Last Name**

DOB: _____ SSN: ____-___-_____ Sex: Female__ Male__

Phone Number(s) with area codes(s): Home: _____
Cell:_____ (ok to send texts) Yes__ No __
Work: _____

E Mail address: _____@ _____. _____

Street Address: _____ City: _____ Zip: _____
P.O. Box: _____ City: _____Zip: _____

Please list the name and phone number of your Primary Care Physician:

Name: _____ Phone Number: ( )_____

Have you ever been placed on the Florida State Medical Marijuana Use Registry by another physician?
Yes ___ No ___ If yes, what is the name of the physician _____

How did you hear about Florida Compassionate Care Center? _____

_____

Are you currently pregnant or nursing? Yes____ No____ Are you planning to get pregnant? Yes ___ No ___

Are you currently taking other medications? Yes ____ No ____ If yes, please list below ALL medications you are currently taking.

_____
_____
_____
_____

Official Debilitating Conditions

CIRCLE ALL THAT APPLY

CANCER EPILEPSY GLAUCOMA HIV/AIDS PTSD (Post-traumatic stress disorder) ALS (Amyotrophic lateral sclerosis) CROHN'S DISEASE

PARKINSON'S DISEASE MULTIPLE SCLEROSIS CHRONIC NONMALIGNANT PAIN A TERMINAL CONDITION DIAGNOSED BY ANOTHER PHYSICIAN

Other: _____

If your condition is not listed above – that does not imply that you are not qualified. There are over 30 additional conditions that have qualified patients for MMJ in Florida. These are not on the official Florida list of debilitating conditions however patients have been certified by a recommending doctor and received their Florida MedCard.

Please read the following and sign below;

I hereby declare that I have completely and truthfully disclosed all information regarding my medical conditions(s)) and attest that I do not intend to use my medical recommendation for the purpose of illegally obtaining, growing or distributing medical marijuana. I am aware that my recommendation can be revoked at any tine and legal actions will be taken if I have perjured or misrepresented myself or my medical conditions, my intentions or falsified any medical records to the physician. I also, hereby authorize Florida Compassionate Care Centers, LLC, or its representatives to discuss my medical condition(s) for verification purposes. Additionally, I acknowledge the attending physician informed me of the nature of a recommended treatment, including but not limited to, any recommendations regarding medical marijuana. The risks, complications and expected benefits of any recommended treatment, including its likelihood of success, risks and benefits. The physician may request that I visit another physician or specialist to further substantiate my condition. I will be informed of all the above mentioned regardless of whether or not I qualify as a patient. AUTHORIZATION FOR RELEASE OF CONFIDENTIAL RECORDS –

I hereby authorize Florida Compassionate Care Centers, LLC to disclose and verify my records as a patient to law enforcement should I be arrested or detained. I understand that Florida Compassionate Care Centers, LLC will only verify my being a patient for the purpose of providing proof as justification for possession. This is valid during the period of time for which the recommendation has been issued. I give permission for my medical records and file to be reviewed by another physician working with Florida Compassionate Care Centers, LLC. I understand this may happen if the original doctor that evaluated me needs a secondary opinion or is not available. I have been advised that the use of medical marijuana may affect my coordination, motor skills and cognition in ways that could impair my ability to drive. I agree not to operate heavy machinery or to drive motor vehicles while using my Medical Marijuana. I understand that side effects may occur while I am taking medical marijuana. Side effects of medical marijuana can include but are not limited to: Euphoria, difficulty in completing tasks, low blood pressure, sedation, dysphoria, dizziness, anxiety, confusion, impairment of motor skills, and paranoia. I agree that if I am a female patient that I will contact my attending physician and my OBGYN physician, if I become, or am thinking about becoming pregnant. I acknowledge that the use of medical marijuana may create a passthrough problem to a fetus during pregnancy and to a baby during breast feeding. I understand that using marijuana while under the influence of alcohol is not recommended. 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. I am not permitted to smoke within 1000 feet of a daycare or school. The physician and staff at Florida Compassionate Care Centers, LLC are addressing specific aspects of my medical care and, unless otherwise stated, are in no way establishing themselves as my primary care physician. Furthermore, the undersigned, my heirs, assigns, or anyone else acting on my behalf, hold the physician and his/her principals/agents, and employees, free of and harmless from any declarations.

My signature below will certify that I have read this document and acknowledge that I fully understand it's declarations.

Signature: _____ Date: _____

Print Name as signed above: _____

Care taker Name: _____ Signature: _____

Care Taker acknowledges complete understanding of the above declaration and information provided on this form.

Witness Name: _____ Signature: _____ Date: _____