



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



- 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 Anderson Township" 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 Anderson Township" 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.**

PATIENT SIGNATURE

DATE