



**GREENCROSS MEDICINAL CANNABIS SUPPORT GROUP of
NEW ZEALAND Inc.**
www.greencross.org.nz
17 Graham St
Levin
Ph (06) 3688181

Application for Full Patient Membership

To be completed by the patient & referring doctor or NZ registered specialist.

Full Name:

Date of Birth:

Address:

Mailing Address:

Email Address:

Phone Number:

Mobile Number:

Medical Condition / Complaint:

Do you have any psychological or other conditions that can be exacerbated by the use of cannabis? Yes/No

Name of your doctor / specialist:

Doctor's contact No:

Hospital or medical institution you attend:

Please include any relevant information or doctor's / specialist's letters with this application form.

From time to time we are contacted by the media wanting people to talk to. Would you be prepared to speak to the media even anonymously? YES NO (circle one)

I am not a member of, nor will I give any GreenCross information to, any law enforcement agency.

I agree to pay \$20.00 for the initial membership fee; this covers the cost of the ID card.

If questioned/arrested we advise you to be polite but firm, be quiet, enter 'no plea' and contact GreenCross

IN SIGNING THIS APPLICATION FORM I DECLARE THAT I HAVE ANSWERED ALL THE INFORMATION TO THE BEST OF MY KNOWLEDGE TRUTHFULLY AND ACCURATELY.

Patient's Signature:

Date:

This section to be completed by a NZ registered medical practitioner:

Patient's Full Name:

Date of Birth:

Doctor's / Specialist's Name:

Office or Surgery Address:

Office or Surgery Phone #:

Office or Surgery e-mail:

Patient Diagnoses / Condition:

In your opinion do you believe cannabis will benefit your patient's health?

Do you support your patient's regulated use of cannabis as a medicine?

GreenCross would educate the patient on the safest vaporisation or ingestion methods. With this in mind, is it likely that the benefits of controlled cannabis use for this patient will outweigh any possible negative effects?

Would you like to become a volunteer / supporter of GreenCross? Yes No

By signing this application form you have agreed that every answer you have given is accurate to the best of your knowledge.

This information is kept totally confidential.

THANK YOU for completing this Supporting Application and the questions contained within it.

We appreciate your comments and your taking the time to help us and your patient.

This information is used for membership and information on the diseases and conditions that the use of cannabis may be able to help with.

SIGNED

DATE