



Commonwealth

ALTERNATIVE CARE

www.commonwealthaltcare.org · @commonwealthaltcare

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PATIENT PROFILE INFORMATION

Patient Full Name: _____

Date of Birth: _____

Registration Card No. _____ Exp: _____

Caregiver Full Name: _____

Date of Birth: _____

Registration Card No. _____ Exp: _____

Drivers License/ID No. _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

How did you hear about us?

CAC Website

Social Media

Google

Word of Mouth

Doctor

Other: _____



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PATIENT ATTESTATION

Initial:

I acknowledge and understand that the possession and use of medical marijuana purchased at Commonwealth Alternative Care is only permissible in the state of Massachusetts

I acknowledge and understand the patient handbook provided by Commonwealth Alternative Care

I acknowledge and understand that I will not engage in the diversion of marijuana. The marijuana products purchased are intended for patient consumption only

I understand that driving or operating motor vehicles/machinery under the influence of marijuana is prohibited

I understand and acknowledge that the consumption of marijuana has not been approved by the FDA. There may be health risks associated with the consumption of marijuana

I understand and acknowledge that marijuana use during pregnancy and breast-feeding may pose potential harms

I acknowledge and understand the importance of safe storage and keeping marijuana products out of the reach of children

**If you sign this agreement, you consent to understanding the Massachusetts state medicinal marijuana program and its patient regulatory requirements

Print Name: _____

Patient/Caregiver Signature: _____ Date: _____