



## New Patient Registration

Full Name \_\_\_\_\_ MA Patient Registration # \_\_\_\_\_

Address \_\_\_\_\_ Patient IF Card Exp Date \_\_\_\_\_

City/State \_\_\_\_\_ MA State ID # \_\_\_\_\_

Zip Code \_\_\_\_\_ MA State ID Exp Date \_\_\_\_\_

Phone \_\_\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_

Veteran (Y/N) \_\_\_\_\_ Add to the Mailing list? (Y/N) \_\_\_\_\_

Senior Citizen \_\_\_\_\_

Low-Income Assistance (Y/N) \_\_\_\_\_ (Additional application needs to be completed)

Minor (Under 18 years old) (Y/N) \_\_\_\_\_

Caregiver information ( if applicable)

Full Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

City/State \_\_\_\_\_ Zip Code \_\_\_\_\_

# Patient Acknowledgement Form

By initialling next to each statement listed below, I acknowledge and agree to the following:

\_\_\_\_\_ I understand that my registration card only allows for the possession and use of medical marijuana within Massachusetts

\_\_\_\_\_ I will not engage in diversion of marijuana and I understand that fraudulent distribution or resale of medical marijuana is a felony punishable by up to five (5) years in prison.

\_\_\_\_\_ I understand marijuana has not been analyzed or approved by the FDA.

\_\_\_\_\_ I understand there may be health risks associated with using marijuana, even for medical purposes.

\_\_\_\_\_ I understand that marijuana should be kept away from minors.

\_\_\_\_\_ I understand that driving under the influence of marijuana is illegal and machinery should not be operated while using marijuana.

\_\_\_\_\_ I understand I may not distribute marijuana to any other individual.

\_\_\_\_\_ I agree at all times to abide by Massachusetts law in regards to my use of medical marijuana, and hereby release and waive all claims against Fine Fettle Dispensary from any and all liability related to my use of medical marijuana.

\_\_\_\_\_ I agree not to bring any weapons into Fine Fettle facilities.

\_\_\_\_\_ I understand that Fine Fettle Dispensary may refuse to dispense medical marijuana to me if, at the discretion of the Agent/Manager, the public or myself will be placed at risk . In this event I understand that my certifying physician will be notified within 24 hours.

\_\_\_\_\_ I have received the Fine Fettle Dispensary Patient Education Pamphlet.