



## Confidential Patient and Primary Caregiver Registration Form

The information on this form is confidential and will never be provided to any other person, agency or organization.

- I am a patient.
- I am a primary caregiver for patient \_\_\_\_\_.
- I am designating a primary caregiver as per California Health and Safety Code Section 11362.5.  
Please complete the Designation of Primary Caregiver form.

Name \_\_\_\_\_  
First Middle Initial Last

### OPTIONAL information for updates on products, events, services and news.

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_\_) \_\_\_\_\_  
Email \_\_\_\_\_

State or County Medical Cannabis Identification Card Number \_\_\_\_\_

Medical cannabis recommendation issued by:

Physician \_\_\_\_\_ Recommendation expiration date \_\_\_\_\_

Physician phone number (\_\_\_\_\_) \_\_\_\_\_ Physician license number \_\_\_\_\_

I have received, read and understand the Yerba Buena Collective Membership Advisory and Facility Guidelines. I agree to abide by the rules, regulations, terms and conditions. I understand that my membership may be revoked for violation of the rules, regulations, terms and conditions. I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

I authorize my recommending physician to verify his or her recommendation or approval for my use of medical cannabis.

Member's Signature (Print out & Sign) Date

**Staff use only. Intake staff \_\_\_\_\_ Date \_\_\_\_\_**

- Date of birth on California Driver License or California Identification Card \_\_\_\_\_
- Verified physician recommendation.
- Made copy of physician recommendation.
- Provided copy of Yerba Buena Collective Membership Advisory and Facility Guidelines.