




BCPS Canada  
www.bcpscanada.com  
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Membership agreement please read and initial all sections.

## BC Pain Society Membership Application

- |  |  |         |  |  |  |  |  |  |  |
|--|--|---------|--|--|--|--|--|--|--|
| <ul style="list-style-type: none"><li>• Use of BCPS Canada is at your own risk and you have chosen to enter the premises voluntarily</li><li>• BCPS Canada has the right to revoke my membership at any time for any reason without prior notice</li><li>• I must provide my membership card as requested by BCPS Canada or law enforcement officials</li><li>• I am applying for a membership to treat a medical condition that has been discussed by my doctor</li><li>• I will not re-sell, trade, barter, share, give away or traffic in any way, the products I receive from BCPS Canada</li><li>• To the best of my knowledge all information provided on this form is complete and accurate</li><li>• I am of sound mind to make decisions regarding my health and have chosen to use cannabis as an alternative to traditional medicine and am aware of the health risks involved. I acknowledge that nothing on this form has been evaluated by Health Canada and absolve staff and management of BCPS Canada of all liability, I am also aware of the laws regarding marijuana possession and accept the risk involved</li></ul> | <table border="1"><tr><td>Initial</td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table> | Initial |  |  |  |  |  |  |  |
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Name (to appear on ID card) First: \_\_\_\_\_ Last: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### Office use:

IDV: \_\_\_\_\_ Type: \_\_\_\_\_

Other dispensary: \_\_\_\_\_ Membership #: \_\_\_\_\_

Scanned: Y / N

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_