COLLECTIVE
Membership Registration Form
* Please print clearly to avoid errors *

Name _____
First Last

Address _____

City _____, CA Zip_____

CA DL or ID No _____ Date of Birth _____

Phone _____ (for administrative use only)

Email Address _____
(Optional) (To keep you updated of our products/services)

Please provide information on your Medical Marijuana ID Card Issued by State guidelines under SB420 (Health & Safety Code Section 11362.7)

ID Card Issued by _____

ID Card Number _____ Expiration Date _____

- ❖ I have read and understand the rules and guidelines and consent to joining our Collective.
- ❖ I certify under penalty of perjury that (1) the information provided is true and accurate; and (2) I am not seeking membership for any fraudulent purpose.
- ❖ I will not distribute medicine received here to any other person nor use it for non-medical purposes.
- ❖ I authorize my recommending physician to verify his or her recommendation or approval for the use of medical marijuana.

X _____
Member Signature Date

Instructions: Complete this form and be prepared to show you California ID and valid MEDICAL MARIJUANA ID CARD upon delivery.

Plant Providers Plus Collective
www.plantprovidersplus.com
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