BUILDING GUIDELINES

To provide a safe atmosphere in and around CBCB, all patients must follow these guidelines:

- ❏ All patients must present to reception a valid and verifiable physician's recommendation to enter the building.
- ❏ If under 18, a patient must be accompanied by their parent or legal guardian to join CBCB and receive allocations of medical cannabis.
- ❏ No cell phones, cameras, or recording devices may be used in the building.
- ❏ No loitering is permitted in the building's parking area or the surrounding neighborhoods.
- ❏ Treat everyone in and around the building, including neighbors, with respect and courtesy.
- ❏ No weapons of any kind are allowed on the premises.
- ❏ No pets other than service pets are permitted in the building.
- ❏ No dispensing or consumption of alcohol in the building or parking area.

GOOD NEIGHBOR POLICIES

Building and maintaining positive relationships with CBCB neighbors is vital to our operations, and we have the following policies to reflect this:

- ❏ Always drive carefully and courteously on the streets and around the building.
- ❏ Never consume medicine on the premises or in the surrounding neighborhoods.
- ❏ Keep car stereo volume at non-disruptive and courteous levels.
- ❏ Use only the CBCB parking area or public parking when visiting.
- ❏ Do not linger in a vehicle or on the sidewalk after visiting CBCB.
- ❏ Do not sell or distribute medicine received from CBCB.
- ❏ Overnight parking is not permitted in the CBCB parking area.
- ❏ Do not leave children unattended in the parking area or in a vehicle.

INITIAL HERE: _____________

The information on this form is confidential and will not be provided to any third party unless required to do so by a court of law. Please print clearly to avoid errors that could delay processing.

Last Name:	First Name:	Middle Initial:	
Birthdate: ____/____/_______ Month Day Year	Driver License/Passport #:	Home Phone:	Mobile Phone:
Email Address:		Would you like to participate in the cannabis research project?	Yes / No
Street Address:		City: State:	Zip Code:
Recommending Physician's Name:			
Are you any of the following?	☐ Student ☐ Veteran	☐ Teacher ☐ Senior (55+)	
How did you hear about us? ☐ Facebook ☐ Other: ______________________________	☐ Web Search	☐ Weedmaps	☐ Friend

WARNING: Medical cannabis products, including edibles, are not tested by local, state, or federal governmental agencies for health, safety, or efficacy. There may be health risks associated with the consumption of these products.

By signing below I affirm that I have read, understand, and agree to the above warning statement and each of the following:

- I have read, understand, and I am subject to the attached Terms and Conditions.
- I authorize the dispensary to speak with my physician to verify my recommendation to use medical cannabis.
- I have completed this form truthfully and to the best of my ability.

____ ____________________

Patient Signature Date

____ ____________________

Staff Witness Signature Date

FOR OFFICE USE ONLY

State Program Card:	*Attached:* **Y / N**	*Verified:* **Y / N** *By:*____________	*Expiration:* ____/____/____
Dr.'s Recommendation:	*Attached:* **Y / N**	*Verified:* **Y / N** *By:*____________	*Expiration:* ____/____/____
	License Verified: **Y / N**	*License Type:* *Medical Board*	*Osteopathic Medical Board*
Caregiver Designation:	*Attached:* **Y / N**	*Verified:* **Y / N** *By:*______________________________________	
Valid Identification:	*Attached:* **Y / N**	☐ *Accepted* ☐ *Rejected* *By:*__________________________	

Entered:____ /____ /20_____ By:__________