THE APOTHECARIUM DISPENSARY

THE APOTHECARIUM COMPASSION PROGRAM APPLICATION

To apply for membership:.

1. Complete this application form in full.
2. Attach all supporting documentation, including personal identification, proof of income, proof of residency, and medical cannabis recommendation or card for both you and your caregiver if applicable.
3. Submit application and all supporting documentation by mail to:

Sara Payan
Apothecarium
2029 Market St.
San Francisco, CA 94114

If accepted into the program, you will be enrolled for one year, after which time you must re-apply for continued enrollment. Please read this document in its entirety before filling out the application. Due to high demand, we can only enroll patients who meet the strict criteria. Submitting a completed application does not guarantee enrollment.

PLEASE WRITE CLEARLY. ILLEGIBLE APPLICATIONS WILL BE CONSIDERED INCOMPLETE.

CONTACT INFORMATION

Legal Name: _____

Preferred Name: _____

Phone Number: _____

Email: _____

Preferred Method of Contact O Telephone O Email

Best time to call: _____

Can we leave you a voicemail message? O Yes O No

ABOUT YOU

1. Your age: Month/Day/Year: ____/____/____

2. Your Gender (Select only one)
O Female
O Male
O _____

3. Your Ethnicity To promote diversity and prioritize those who have been adversely affected by the war on drugs, we ask you to identify your ethnicity:

O American Indian or Alaska Native O Asian O Black or African American ONative Hawaiian or Other
O Pacific Islander O White O Hispanic or Latino O Other _____ O Decline to State

4. Veteran Status To promote diversity and prioritize those who have been impacted by military service, we ask you to identify your military status:
O Veteran O Inactive

5. Are you on SSI or disability
O Yes O No

6. Employment Status: O Full Time O Part Time O Unemployed

Are you a dependent? O Yes O No

Do you have any dependents? If so, how many? _____

What is your houseing status? O Assisted Living O Section 8 Housing O Live with Family O Rent
O I do not have housing O Other _____

Do you require delivery? (We cannot deliver to Section 8 housing as per Federal Law)
O Yes O No

CAREGIVER INFORMATION

Name: _____

Contact Information _____

Caregiver Medical Recommendation- Please attach.
(Required if someone is picking up for you)

MEDICAL INFORMATION

7a. Diagnosis (official)
All participants in the program MUST have a verifiable medical cannabis recommendation.

(*Select all that apply)*
O Cancer
Type:
Stage:
Treatments: (circle what applies) Radiation , Chemo , Surgery

O HIV/AIDS
O Multiple Sclerosis
O PTSD
O
O Epilepsy
O Heart Disease
O Psychological Imbalance

7b. Diagnosis (self-determined) _____

_____

8. Symptoms you are experiencing/addressing:
(Select all that apply)

O Neuropathy
O Nausea
O Skin Issues
O Inflammation
O Sleep
O Trouble Eating/Digesting
O Pain
O Respiratory Difficulty
O Side-Effects from Meds
O Cognitive Impairment
O Anxiety
O Depression
O _____

Please describe: _____

_____

_____

Tell us how cannabis helps you address your medical needs: _____

_____

_____

ABOUT YOUR CANNABIS USAGE

9. What is your cannabis experience?
O Never use O New user O Fairly Experienced O Experienced

10 Which type(s) of Cannabis do you most frequently use?
(Select all that apply)

O Indica
O Indica Dominant Hybrid
O Sativa
O Sativa Dominant Hybrid
O Hybrid (50/50)
O High-CBD
O I don't know

11. How do you use cannabis?
(Select all that apply)

O Smoke
O Vaporize
O Hash
O Concentrates
O Oil
O Edibles
O Tinctures/ Sublinguals
O Capsules
O Topicals

12. Are there any items to which you have a sensitivity or allergy?
(Describe below. For example: "sativas makes me anxious" or "I'm allergic to dairy")

_____

_____

13. Do you have a caregiver who picks up cannabis products on your behalf?
(Select only one) O Yes O No

14. Are you willing to share feedback on your product experience?
(Select only one) O Yes O No

We reserve the right to change policy and guidelines or stop the program at any time. There are a limited number of spots in the program. Eligible applicants not selected for enrollment will be added to the waitlist. In the event a patient withdraws or is dropped from the program, then a new applicant will be added from the active waitlist. All applicants and their caregivers must have a verifiable medical cannabis recommendation or card. All of the information you provide will be kept strictly confidential and solely for the purposes of determining eligibility for the Compassion Program. Any packages that are not picked up within two weeks of availability are forfeited. If you miss four (4) consecutive package pick-ups, you will be dropped from the program.

SIGNATURE X _____ DATE: / /

I understand and agree that space is limited for this program and my acceptance is not guaranteed. I have an obligation to let The Apothecarium know if my status changes in a way that would impact participation in this program.

[END OF SURVEY]

Office Notes:

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