



Strawberry Fields Ohio Patient Information Form

Patient Name(as written on ID): _____

Date of Birth (mm/dd/yyyy): _____ Gender: ___M or ___F

Home Address, City, State & Zip: _____

Phone Number: _____ Cell Phone: _____

Email Address: _____

Drivers License/State ID #: _____ Expiration Date: _____

Certifying Physician's Name: _____

Physician's License Number: _____

OH Medical Marijuana ID# _____

ID/DL Expiration Date: _____ Patient Certification Date Issued: _____

Expiration Date: _____

Would you like to be contacted regarding dispensary promotions?

Email: ___Yes or ___No

Text: ___Yes or ___No (standard message/data rates apply)

Emergency Contact: _____ Phone Number: _____

Relation to Patient: _____

Personal Caregiver Name (if applicable): _____ Phone Number: _____

Registry ID #: _____

Address, City, State & Zip: _____

Check the following if they apply to you:

_____ I am on SSI, SSDI and/or Medicare

_____ I am a Veteran

This information is related to potential qualifications for subsidy program

Qualifying Condition:

How did you hear about us?

_____ Ohio Medical Marijuana Control Program

_____ Web Search

Referral:

Other (Please Specify) _____

_____ Patient

_____ Physician

_____ Employee

Patient Wavier of Liability and Hold Harmless Agreement

I, _____ (Print name), am fully aware of the risks and hazards (legal, medical, social and otherwise) involved with acquiring and using approved medical marijuana products I obtain from Strawberry Fields (“Dispensary”) for any purpose, medical or otherwise. I am fully aware that there may be risks and hazards unknown to me, the Dispensary, Dispensary Agents, or any other person with whom I have consulted.

I voluntarily assume full responsibility for any risks, loss, damage or personal injury (including death) that I sustain as a result of being a customer of Dispensary and/or my possession or use of medical marijuana.

I hereby indemnify and hold harmless the Dispensary and its affiliates, officers, directors, agents, representatives and employees from and against any and all damages, liabilities, obligations, penalties, fines, judgements, claims, deficiencies, losses, costs and expenses (including attorneys’ fees and costs) arising out of or resulting from: (i) my being a customer of Dispensary; (ii) the status of any of my licenses or registration cards; (iii) my possession or use of medical marijuana or any other controlled substance.

It is my express intent that this wavier of liability and hold harmless agreement bind the members of my family; my spouse, my heirs and personal representative if I am alive or deceased, that this release is deemed a release, wavier, discharge and covenant not to sue Dispensary or any of its affiliates, officers, directors, agents, representatives and employees.

In signing this release, I acknowledge and represent that:

- *I have read the foregoing release and indemnification, understand the entire release and sign it voluntarily*
- *No representations, statements or inducements (oral or otherwise), apart from the foregoing written agreement, have been made to me regarding medical marijuana or Dispensary*
- *I am at least 18 years of age and fully competent; and I execute this release in full, adequate and complete consideration fully intending to be bound by the same. Dispensary is relying on the release in the provision of any service or products to me*
- *I have complied with all applicable Ohio Board of Pharmacy regulations regarding the acquisition, use and possession of medical marijuana, including being in possession of a valid State-Issued Registry Identification Card.*

Patient Signature: _____ Date: _____

Agent Signature: _____ Date: _____

*In the event that a patient is under 18 years old, a legal guardian must execute this release on the behalf of the patient

