



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: _____

PhoneNumber: _____

Email: _____

Certifying Physician's Name: _____

OH Medical Marijuana ID #: _____

ID 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 a Veteran

_____ I am on SSI, SSDI, and/or Medicare

This information is related to potential qualifications for subsidy program

Qualifying Condition
(optional) _____

How did you hear about us?
____ Ohio Medical Marijuana Control
Program

Referral:
____ Patient
____ Physician
____ Employee

Other: _____
____ Web Search

Other (please specify):

For Office Use Only
Form Confirmed By:
_____ Agent

Initials: _____
Date: _____



Patient Waiver 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 procession or use of marijuana.

I hereby indemnify and hold harmless 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 resulting from, or in any way related to: (i) my being a customer of Dispensary; (ii) the status of any of my licenses or registration cards; (iii) my procession or use of marijuana or any other controlled substance.

It is my express intent that this Waiver of Liability and Hold Harmless Agreement (“Release”) bind the members of my family and spouse if I am alive, and my heirs, assigns, and personal representative if I am deceased, and that the Release is deemed a release, waiver, 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 this Release in the provision of any service or products to me;
- I have complied with all applicable Ohio Board of Pharmacy regulation regarding the acquisition, use, and procession of medical marijuana, including being in procession 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*