



Mendocino Farmers Collective, Inc.

PO Box 2129 Laytonville CA 95454

707-489-1232

www.mendocinofarmerscollective.org

Membership Application

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

California DL/ID: _____ CA State Card (MMIC) holder? (Y/N) _____

Applicant's Agreement to Membership Terms:

I agree to abide by current MFC rules and Bylaws, as well as additional requirements MFC may implement for the mutual benefit of the membership and the Association. I understand that it is a condition of my membership in MFC that I follow these regulations, including a strict policy of non-diversion of medical cannabis outside of 'closed loop' membership associations and of keeping medical cannabis inaccessible to minors. Furthermore, I agree only to obtain from MFC amounts consistent with the Trippet standard and/or provide amounts in compliance with state and local regulations.

I understand that MFC may amend, modify, or expand membership requirements. I also understand that I must keep current and update my contact information. I agree to keep current all medical cannabis authorization and physician information including physician contact info. I affirm that I have read and agree to abide by the membership rules of Mendocino Farmers Collective Inc. I affirm under penalty of perjury that the information provided by me to Mendocino Farmers Collective Inc. herein is true and accurate.

Signature of Applicant _____ Date _____

Should you be interested in reading more about our legal framework, please request a copy of our Bylaws. Patient Initial _____

Disclaimer: MFC has done a great deal of work to assure that it is in compliance with all relative state and local laws as well as Ca. Attorney General guidelines. Medical marijuana, however, remains illegal under federal law, and we are not able to guarantee against arrest or prosecution. Initial _____

----- Do not fill out below - for Office Use -----

CA. DL/ID and M.M. Rec. viewed by _____ Date _____ Initials _____

Authorization Verified By _____ Date _____ Initials _____

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

A. EXPLANATION: This authorization for use or disclosure of your medical information is required of you in order to comply with the terms of the CA Confidentiality of Medical Information Act of 1981, §56, et seq., CA Civil Code, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules. .

B. AUTHORIZATION: I _____
Print First, Middle and Last name

hereby authorize my physician to verify my current status as a qualified medicinal marijuana patient to Mendocino Farmers Collective Inc. (hereinafter MFC).

C. USES: MFC is authorized to use my patient's medical records to establish that a physician licensed by the State of CA has approved, authorized or recommended my use of medical marijuana, as permitted under CA State Law.

D. DURATION: This authorization is valid until otherwise revoked in writing by the undersigned. The undersigned may revoke this authorization (in writing) at any time, except to the extent that action has been taken in reliance thereon. If the undersigned revokes authorization, they will be suspended from membership in MFC. In order for membership to remain valid, medical authorization must remain current and any changes in provider or other related information must be provided to MFC, including copies of relevant documents.

E. RESTRICTIONS: I understand that any further use or disclosure of medical information will be limited to purposes necessary to comply with membership in MFC and/or as required or permitted by law.

F. ADDITIONAL COPY: I understand that I have a right to receive a copy of this authorization upon my request. Initial _____

G. PATIENT SIGNATURE _____ Date _____

This form may be returned to MFC by hand, by FAX, USPS or email attachment.
FAX to: (707) 984-8701 or email: verify@mendocinofarmerscollective.org
You must bring originals of all required documents at the time of your first visit.

Medical Marijuana Authorization Information:

Physician Name: _____ Physician CA Lic. # _____

Physician's address: _____

Phone: _____ Fax: _____

Date of Issuance: _____ Renew by: _____

Authorized Amount: _____ Physician assigned ID if any _____

----- Do not fill out below - for Office Use -----

Verification Method _____ Date _____ Initials _____

Physician's License on file _____ Added By _____ Date _____