Patient Agreement and Consent

- [ ] I hereby declare that I have truthfully and completely disclosed all information regarding my medical and behavioral health condition(s).
- [ ] I agree to provide supporting documents pertaining to my medical condition(s) if requested.
- [ ] I connect to an evaluation by the Eastern Shore MedicCann Clinic, LLC practitioner to be certified for the medical use of cannabis.
- [ ] I have received a copy of the Eastern Shore MediCann Clinic Notice of Privacy Practices, and accept those practices.
- [ ] I acknowledge that it is my sole responsibility to participate in the follow up with Eastern Shore MediCann Clinic, LLC during my sixth month of treatment.

_____
Patients Name (Print)

_____ _____
Patients Signature Date

_____ _____
Witness Signature Date