Appt. Time: _____	Date: _____			NEW	RENEWAL	
Cost of Service: $_____	Service :	$125	$150	$175	Pre-Registration :	$25
PAID WITH: CASH ☐					Location: HOLLAND	

PURE WEST
840 N Black River Dr Suite 80
Holland, MI 49424
616-772-9420
purewestclub@gmail.com

OFFICE NOTES: _____
_____
_____

CK IN _____ QUE CK _____ CK OUT _____

PATIENT GENERAL INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ Apt #: _____ Date Of Birth: _____

City: _____ State: _____ Zip: _____ Sex: Male ☐ Female ☐

DL: _____ Phone No.: _____ E-Mail: _____

Are you a Veteran? Yes ☐ No ☐

Emergency Contact: Name: _____ Phone No. _____

How did you hear about PURE WEST (please be specific).
Google Search ☐ Get Legal America ☐ Marijuana Doctors.com ☐
Leafly ☐ Weed Maps ☐ MMMP Report ☐

Other: _____

PATIENT PRE-QUALIFICATION FOR THE MICHIGAN MEDICAL MARIJUANA PROGRAM

Is this a NEW or RECERTIFICATION with MMMP? Circle One NEW RECERTIFICATION

Do you have a caregiver? ☐ Yes ☐ No

If yes, provide first and last name? _____ **DOB** _____

Address _____ Phone _____

DL# _____ Email _____

The following conditions are qualifications for the MMMP program.
Please select the condition(s) you are seeking qualifications for the MMMP program.

Amyotrophic Lateral Sclerosis: ☐
Agitation of Alzheimer's: ☐
Arthritis: ☐
Cachexia Disease: ☐
Crohn's Disease: ☐
Cancer: ☐
Glaucoma: ☐
HIV/AIDS: ☐
Multiple Sclerosis: ☐
Nail Patella: ☐
Muscle spasms: ☐
Persistent Migraines: ☐
Severe Nausea: ☐
Seizures: ☐
Chronic Pain: ☐
Severe Pain: ☐
Hepatitis C ☐
Post-Traumatic Stress Disorder ☐

Other _____

Hospitalizations? _____

Surgeries?_____

Current Medications_____

Previous counseling? With Whom?_____ When?_____

Suicidal Ideation?_____ Sleep or Appetite Problems?_____

Serious Accidents?_____

Infectious Diseases?_____ If Yes, Please describe_____

Allergies or Adverse Reactions?_____ If Yes, Please Describe_____

How Long Have You Been Experiencing Your Symptoms? _____

How Long Have You Been Receiving Treatment for this Condition? _____

Do you smoke Marijuana? Yes [ ] No [ ] Has Marijuana helped with your condition? Yes [ ] No [ ]

Explain your Marijuana use and results _____

_____

_____

Are You Allergic to Any Medications?_____ If Yes_____

Do You Currently Take Prescription Medication? Yes [ ] No[ ]

Please List ALL Medications that you are currently taking. If You Already Have a List Prepared, You May Leave This Area Blank And Submit Your List To The Doctor.

Name of Medication	Dosage	Condition Used For

What is the name and address (city is fine) of the doctor(s) that you have seen for the condition(s)?

1 . _____

2 . _____

3. _____

I Hereby Certify That All The Information That I Have Provided On This For Is True And Accurate

_____ _____

Signature Date

Patient Waiver and Consent Form

I _____hereby authorize your Doctor to evaluate me for my
(Print your name here) medical condition.

I understaned that your Doctor will be conducting the evaluation in person and any information shared is private and confidential.

I understand that it is my responsibility to provide medical records, if available and also provide accurate information regarding my medical condition.

Providing information that is untruthful or inaccurate is solely my responsibility. Pure West and their doctor bear no liability regarding misinformation.

_____ _____
Your Signature Today's Date

Liability Waiver and Release

I _____, do hereby acknowledge that PURE WEST and their doctor are not liable
(Print Your Name Here) nor can be held accountable for;

Any action relating to or arising from my use or possession of marijuana. I further acknowledge that PURE WEST and their doctor are not affiliated with the State of Michigan, Licensing And Regulatory Agency (LARA)

Or the Michigan Medical Marihuana Program (MMMP) and that PURE WEST and their doctor cannot be held liable, should the LARA or the MMMP deny my application for any reason, whatsoever.

I further accept, understand, and acknowledge that:

1. PURE WEST is not a dispensary and cannot provide me with Medical Marijuana or any other medication.

2. The doctor's recommendation of Medical Marijuana is not a guarantee that it will cure or aid in the treatment of the condition it is intended for and that I am solely responsible for taking Medical Marijuana.

3. Your doctor has explained to me, the purpose of Medical Marijuana, its benefits and side-effects. I have been given the opportunity to ask any questions or raise any concerns regarding the use of Medical Marijuana or its possible side-effects and that all my questions have been answered to my satisfaction.

_____ _____
Your Signature Today's Date

Doctor's comments _____
_____
_____
_____
_____
_____
_____
_____
_____

840 N. Black River Dr. Suite #80 Holland, MI 49424

(616)772-9420 www.purewestclub.com purewestclub@gmail.com

STAY LEGAL WITH A FOLLOW UP VISIT

The State of Michigan now requires recertification every 2 years. At the same time,

it is required the Registrant have an ongoing physician/patient relationship. This requirement states "periodic review of the treatment efficacy (results)". You must have a follow-up visit with certifying physician to legally maintain the physician/patient relationship.

I, _____

(Print Name)

I commit to doing any diagnostics that the doctor orders today and to return in 12 months for a check-up with the doctor. ($75.00 Fee)

I understand that if I do not follow through that the doctor may call the state and revoke my card

X _____

(Signature)