The London Compassion Society

www.londoncompassionsociety.com

The London Compassion Society is a Medical Marijuana resource facility.

The London Compassion Society is a not for profit organization established in 1997 to serve two purposes: Our objective is to provide information relating the therapeutic use of cannabis; Our aim is to provide a consistent, safe and dependable source of medical marijuana for people suffering from illness or ailments for which marijuana has been shown to be effective.

The London Compassion Society exists because we believe people are suffering unnecessarily. Cannabis has been used effectively for thousands of years in the treatment of various medical conditions. Cannabis has been shown to be one of the safest therapeutically active substances known to mankind, and unlike most of the alternatives, it has no harmful side effects and produces no physical dependencies.

Membership is free and **STRICTLY CONFIDENTIAL.** What we require of any prospective member is, **PHOTO IDENTIFICATION**, **COMPLETED APPLICATION FORM**, and a **PROPER "ORIGINAL" DOCTORS LETTER**. Once this information is gathered, it is stored in a safe, secure location. The **PRIVACY** and **CONFIDENTIALITY** of all members will be respected and protected at all times.

While our information services are available to anyone, for obvious legal reasons the sale of medical marijuana is restricted to people who satisfy our membership requirements.

There are 3 categories that the London Compassion Society accepts new members in. There is no such thing as *"instant membership".*

MEMBERSHIP CATEGORIES

Category # 1.

Is for people who provide the LCS with a VALID, CURRENT Doctors letter of diagnosis confirming they are suffering from**, HIV/AIDS, CANCER, MUSCULAR DISTROPHY, GLAUCOMA, EPILEPSY, ARTHRITUS, INTRACTABLE PAIN, PARAPLEGIA, QUADRIPLEGIA, ACTIVE HEPATITUS C, FIBROMYALGIA** or **MULTIPLE SCLEROSIS**.

Category # 2

Is for people who require a Doctors letter of diagnosis and recommendations for treatment that specifies an ailment not found on our list.

Category # 3

Is for people who have received their **GOVERNMENT ISSUED SECTION 56 EXEMPTION** and provide the proper **CURRENT** documentation.

Please note;

For categories #1 and #2 the Doctors office **WILL** be contacted by phone or fax to confirm the information on the application form.

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Fax – (519) 432.1618/www. londoncompassionsociety.com

CODE OF ETHICS

Members are to respect the guidelines and rules that keep us open and enable us to serve you and other members. Memberships are a PRIVILEGE not a right and can be revoked at any time. Signing this form assures the LCS that all prospective members have an understanding of the rules that have been set.

#1. **DO NOT RESELL YOUR MEDICINE**. When you are caught doing this your membership will be revoked immediately.

#2. **DO NOT ARRIVE FOR SERVICE UNDER THE INFLUENCE** of alcohol or any other substance. Your membership may be revoked.

#3. **DO NOT LOSE YOUR MEMBERSHIP CARD**. If you lose or misplace it, report it IMMEDIATELY (24 HOURS) to the LCS. A Membership card will be replaced ONCE at a cost of $40.00. The second loss could result in your membership being revoked.

#4. **DO NOT SMOKE AROUND THE PREMISES** of the LCS. We provide a safe room for you to use your medicine. If you are caught out in plain sight around the building your membership may be revoked.

#5. **ONE MEMBER IN THE OFFICE AT A TIME**. Care givers will be allowed in if deemed necessary, otherwise they must remain in the waiting area.

#6. **CALL TO MAKE AN APPOINTMENT EVERY TIME**. Leave a message informing us of your intentions and leave your membership # and your phone #. Failure to inform us of your intentions to come in could result in not being serviced that day.

#7. **BRING YOUR MEMBERSHIP CARD WITH YOU EVERYTIME**. Failure to do this could result in not being serviced that day.

#8. Please respect that you have a reliable safe source of Medical Marijuana. Do not abuse your privilege.

I understand the above rules, if violated, put my membership at risk.

Name:_____, Signature:_____, Date:_____

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DOCTORS FORM

Every prospective member must have their Doctor fill in the form letter supplied below. This letter must be CURRENT dated within the last 6 months and must be from your treating General Practitioner or treating MD specialist.

Dear Physician,

The LCS is a resource centre established for the benefit of people suffering from conditions such as HIV/AIDS, Cancer, Muscular Dystrophy, Glaucoma, Epilepsy, Arthritis, Intractable pain, Paraplegia, Quadriplegia, Active Hepatitis C, and Fibromyalgia.

Your patient is requesting a letter of diagnosis from you on our behalf. The purpose of the letter is simply to document for our records that this person has been diagnosed with a serious illness or ailment. We have provided a form letter for your convenience.

_____
day/month/year

Dear LCS

This letter is to certify that _____ *(patients name),* has been diagnosed with _____ *(medical condition).*

FOR CATEGORY #2 APPLICANTS

I as _____ *(patients name),* Physician, feel that Medical Marijuana may be beneficial to him/her.

I am a licensed Physician permitted to practice medicine and write prescriptions in the province of Ontario. I understand that myself, or my office will be contacted by phone or fax to verify this information.

Yours Truly

_____
(Physicians original signature)

_____
(Physicians stamp or license identification number)

Please keep a copy of this letter and the accompanying release of confidential medical information in your patients file as some one from the LCS will call to verify the validity of this letter.

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LONDON COMPASSION SOCIETY (copy)
Release of confidential medical information

Every prospective member who falls into category 1 and 2 must fill this sheet out in full. One original document for the LCS and another original copy (below) for the Physician.

Date: _____

I, _____, do hereby grant permission for the release of my medical information to the LCS. I give permission for the Physician noted below to verify my medical status with a staff member from the LCS by telephone or fax. The LCS agrees to use this information for the sole purpose of determining eligibility and also agrees to keep this information completely confidential.

Signature; _____

Physician's name; _____

Physician's telephone number; _____

(please tear carefully along line, Drs. Office to retain one copy, the other is to be included in your application)

Please keep a copy of this letter and the accompanying release of confidential information in your patients file, as some one from the LCS will call or fax to verify the validity of the letter.

PHYSICIAN'S (copy)
Release of confidential medical information

Every prospective member who falls into category 1 and 2 must fill this sheet out in full. This document is for your Physician's records.

Date: _____

I, _____, do hereby grant permission for the release of my medical information to the LCS. I give permission for the Physician noted below to verify my medical status with a staff member from the LCS by telephone or fax. The LCS agrees to use this information for the sole purpose of determining eligibility and also agrees to keep this information completely confidential.

Signature; _____

Physician's name; _____

Physician's telephone number; _____

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APPLICATION FORM

Please print clearly

NAME

ADDRESS

TELEPHONE, HOME/OFFICE/OTHER

DATE OF BIRTH

EMERGENCY CONTACT

EMERGENCY CONTACT, PHONE

ALLERGIES, REACTIONS AND ANY SIDE EFFECTS MUST BE REPORTED AND NOTED.

Staff use only

Comments	Client information
	I.D.
	ESTIMATED DOSAGE
	MEMBERSHIP TERM
	PHYSICIAN CONTACT
	CATEGORY