Natural Healing Care Center Please fill out form below

1.)How did you hear about NHCC?

*(**SPECIFY REFERRAL/PERSON**, place, or website):*_____

*2.)Is your Arizona Medical Marijuana Card currently active? (Circle) Yes **or** No **or** I am a first time patient*

Arizona Medical Marijuana Card Application Patient Information

(Attention: it is important for your information to be legible and accurate. All information will transfer to your state application. Errors can delay or interrupt your card process. Thank you!)

First name: _____ Middle (optional):_____ Last:_____

Date of Birth: _____ Phone:_____ Gender: (circle) Male or Female

Physical Address

Street: _____

City: _____ St:_____ Zip Code: _____

Mailing Address
(Leave this section blank if it is the same as your physical address)

Street: _____ _____

City: _____ St:_____ Zip Code: _____

Contact email provided to AZDHS

Please note that confidential and **time sensitive** information will be sent to this email including emails notifying the applicant that the application has been approved and/or if there are deficiencies that need to be corrected. **Failure to respond to e-mails may result in your application being withdrawn or denied.** It is the applicant's responsibility to add AZMedicalMarijuana@azdhs.gov to their list of safe senders to avoid having messages sent to their junk e-mail folder

(1) Do you operate via email? (circle) Yes or no if yes, provide EMAIL: _____

Natural Healing Care Center has dedicated an email to patients that is checked daily. We will call you when your application has been approved and will fix all errors sent back from the state. (This service is recommended)

(2) I prefer to have Natural Healing Care Center use their email on my application**.** Yes or No

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(3) Would you like to request cultivation (growing) rights? Yes or No
(Patients must live 25 miles away from an operating dispensary)

(4) Are you eligible for SNAP assistance(food stamp)? If proper documentation is provided, your application fee will be reduced from $150 to $75 Yes or No

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(5) Would you like to assign a caregiver to you today? (circle) Yes or No if yes, please fill out caregivers information:

Full Name: _____

Date of Birth: _____

Address: _____

City: _____ Zip: _____

Are you giving your cultivation(growing) rights to your caregiver? *Yes or No*

I have read and agree to the terms and conditions of Natural Healing Care Center and Arizona Department of Health Services.

_____ _____

Signature of Patient (or patient rep) Date

_____

Printed name of Patient (or patient rep)

AZDHS Optional Survey:

PLEASE TAKE A MOMENT TO HELP US GATHER INFORMATION REGARDING IMPORT RULE CHANGES TO THE ARIZONA MEDICAL MARIJUANA PROGRAM. (AZDHS is trying to add more discounts for new patients and renewals)

ARE YOU A U.S. VETERAN? YES NO

DO YOU RECEIVE SOCIAL SECURITY INCOME (SSI)? YES NO

DO YOU REICEVE SOCIAL SECURITY DISABILITY INSURANCE (SSDI)? YES NO

ARE YOU CURRENTLY IN HOSPICE CARE? YES NO