



# WAMM

Wo/Men's Alliance for Medical Marijuana

Mailing Address: 309 Cedar St. #39 Santa Cruz, CA 95060

Phone: 831-425-0580

Fax: 831-425-0582

Email: [info@wamm.org](mailto:info@wamm.org)

Dear Applicant,

Thank you for applying to the WAMM collective. WAMM is a collective of patients and caregivers, creating community, building hope, dissolving barriers, providing support and medical marijuana. We are the longest running medical marijuana organization in Santa Cruz, in California, and in the Nation!

WAMM offers heirloom varieties of medical marijuana dating back to the early 1970's, grown organically and locally. In terms of both our medicine and our community, you will not find anything like WAMM in the world; we are truly unique.

Since our inception in 1993, WAMM has been on the forefront of medical marijuana politics, legislation, and patient services in the form of provision, care and assistance. WAMM's reputation exceeds that of any other medical marijuana provider in the nation. Joining WAMM is an invitation to participate in the organization that has legitimized medical marijuana today, with the focus on the patient. In fact, our recent federal court victory makes WAMM the safest organization in the nation. We are the model for all other medical marijuana collectives across the globe, and considered the "Gold Standard" by the Federal Government.

Our collective depends upon the donations, contributions, and participation of all our members, caregivers, and volunteers. **All WAMM members are required to remunerate cost of production for the health of our collective.** Please understand that your health, safety, and well-being is our concern. Feel free to explain any extenuating circumstances for that we should know in consideration of your membership.

Be aware that we determine membership based on our current supply and our collective ability to provide for your health. Due to limitations, your application may be placed on our waiting list for future consideration.

In order to use medical marijuana in compliance with Proposition 215 (HS11262.5), Senate Bill (SB) 420, WAMM Protocols and Guidelines, and to protect your doctor, complete all of the attached forms and follow the instructions provided.

Ask your doctor to include the following information in your medical records; your diagnosis/condition, your use of medical marijuana and the symptoms relieved, and your doctor's continued monitoring of your use of medical marijuana in the treatment of your symptoms.

WAMM has been instrumental in creating the legislation that protects you:

Proposition 215 (HS11362.5), Santa Cruz County Guidelines, Santa Cruz City Ordinance SC2000-06, SC2000-12, Senate Bill (SB) 420, *Conant v. Walters*, and *Santa Cruz v. Holder*. The laws are also available on our website at <http://www.wamm.org>.

**Due to the vast number of applicants and limited quantity of supply, please understand that your application does not ensure your admittance into our collective.**

Thank You.



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## WAMM Membership Application

Instructions: All information provided by applicant is kept confidential. Please answer the following questions so that WAMM can assess how to best help you.

**Your application does not guarantee membership into our collective.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ (mm/dd/yy)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: CA Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_ Website: \_\_\_\_\_

How Did You Hear About WAMM: \_\_\_\_\_

Current Diagnosis: \_\_\_\_\_

*(Please use the back of the page if you wish to elaborate on your medical condition)*

Are you planning on growing medical marijuana for your own personal use?  Yes  No

*(You must sign a Cultivation Contract (CPP) to register your grow with our 24/7 WAMM Member I.D. Program)*

How are you currently getting your medicine?  Dispensary  Friend  Street  Homegrown  Other

How much are you currently paying for your medicine? \_\_\_\_\_

Can you make a minimum donation of \$10 per gram?  Yes  No

### Estimated Weekly Use:

Product Type:	Yes	No	Amount (Per Week of Medicating):
Buds (for smoking)			Number of grams:
Baked goods (Cookies, Muffins)			Number baked:
Tincture/Elixer (Alcohol/Glycerin Base)			Liquid ounces:
Concentrates (Hash, keif, oil)			Liquid ounces:
Capsules (Butter Base)			# Total:
Topical (Rub A Dub, Salve)			Liquid ounces:

I affirm that the information on this application is accurate and true.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(your name)

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

# Wo/Men's Alliance for Medical Marijuana

## WAMM

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### Protocol's and Guidelines

#### **MEMBER REQUIREMENTS (All patients and caregivers must comply)**

##### **ARTICLE 1:**

###### **Section 1:**

All participants must complete any and all forms that are required by WAMM in order to be considered for participation. For consideration in the Compassion Program, you may be asked for proof of financial hardship. Each patient may assign a caregiver to serve for a period of one year who will act on behalf of the patient and in compliance with the tenets of WAMM. Patients must return WAMM I.D. card upon termination of membership.

###### **Section 2:**

No person shall be refused participation based on financial capability, and services are not dependent on any individual or group identified characteristic. Be aware that we accept donations appropriate to financial capability and that we determine membership based on our current supply and our collective ability to provide for your health.

###### **Section 3:**

WAMM members will help offset facility rental and administrative costs as well as donate the cost of production for all and any products received.

###### **Section 4:**

For the purpose of identification, it is necessary to produce a valid California driver's license, I.D. card, or passport. Any person under the age of 18 shall be considered for membership only with the consent of a parent or guardian and a physician's recommendation.

###### **Section 5:**

**Under no circumstances shall any participant of WAMM or her/his caregiver participate in the sale, transfer, supply, or diversion of any kind, of any medical marijuana to any person(s).** All medical marijuana provided by WAMM, or grown under the WAMM Cultivation Partnership Program (CPP) (see CPP contract), shall be used by the patient for her/his express use only. Any breach thereof is reason for immediate dismissal from our collective.

**Patient Initial:** \_\_\_\_\_

**Caregiver Initial:** \_\_\_\_\_

###### **Section 6:**

If any participant misuses the services of WAMM, or misrepresents her/his membership, such action is cause for immediate termination of participation. An individual has ten (10) days to set a date to come before the WAMM Board of Directors for redress. Participants must act discreetly applying decorum and etiquette in accordance with the principles of the safe and responsible use of medical marijuana.

###### **Section 7:**

Individual allotment of medical marijuana to participants may vary from time to time. Readjustments of allotment will be based on a doctor's recommendation, emergency, or other need, and our supply availability.

### **PROTECTION AND THE LAW**

#### **Article II**

##### **Section 1:**

In the event of a police or law enforcement encounter, a patient and caregiver is protected by the Necessity Defense and in the state of California by HS11362.5, Prop. 215, and SC2000-06 and SC2000-12, and may be protected under SB420 (HS Code 11362.7) and SC County Section 7.124.105. Laws are subject to change. All encounters with police or law enforcement must be reported to the WAMM office; this includes but is not limited to the arrest or detention any WAMM member or caregiver, or any theft or confiscation of WAMM medicine or plants.

**Please sign below to acknowledge that you have read, understand, and will comply with the tenants of WAMM.**

**Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Caregiver Signed:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Intake by:** \_\_\_\_\_

# CONFIDENTIALITY STATEMENT

**I**n order to preserve the dignity and privacy of all people, it has been recognized that any intimate information by or given to people in the helping profession is so privileged, and that such information is protected under the law with prescribed method, circumstances and penalties.

**T**he sole duty of this agency, its individuals, employees, and volunteers is to treat people who come to us with trust, respect, compassion, and to protect the confidentiality of any information provided by or about them.

**I**nformation obtained about WAMM, WAMM members, WAMM staff, WAMM volunteers, or any other person(s) associated with WAMM, while working in the office, or on any site, or in one of its programs, is also considered to be of a delicate and sensitive nature. **It is completely confidential.**

**I**n becoming a volunteer or member, you have accepted a responsibility that carries with it a privilege of service to our community. As such, you are an integral part of this agency and accept the same ethical responsibility as the program's staff and participants. **ALL** information that you may hear, directly or indirectly, concerning any person within WAMM, their family, friends, and/or anyone else connected with the program, must be considered **strictly** confidential.

**W**AMM is a collective organization. There are many parts that make up the whole of the organization. All of these parts work because of volunteer efforts. If each participant works a few hours each week, the entire organization works for each member. Without your volunteer time, undue stress is put upon others who do volunteer their time. Please be responsible, fair, and considerate. Volunteer for work you know you **can** do. Don't overload yourself.

**I** agree not to divulge any information while volunteering for WAMM to any unauthorized person(s). I recognize that unauthorized release of confidential information may make me subject to civil action under provisions of the welfare and institutions code of the State of California, and applicable federal laws concerned with the individual's right to privacy, and may be cause for immediate termination of WAMM membership.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print Name(s)** \_\_\_\_\_

**Caregiver** \_\_\_\_\_ **Date** \_\_\_\_\_

**Print Name(s)** \_\_\_\_\_

**Intake by** \_\_\_\_\_

**WAMM**  
**Wo/Men's Alliance for Medical Marijuana**

**CAREGIVER FORM**

**MEMBER INFORMATION**

Date: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: home: \_\_\_\_\_ cell: \_\_\_\_\_

MEMBERSHIP #: \_\_\_\_\_

**CAREGIVER INFORMATION**

CAREGIVER NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE NUMBER: home: \_\_\_\_\_ cell: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

CALIFORNIA DL/ID #: \_\_\_\_\_

**I have read and agree to all the articles and sections in the Protocol's and Guidelines regarding WAMM as an organization and my participation in WAMM.**

Caregiver Signature \_\_\_\_\_ Date: \_\_\_\_\_

Member Signature \_\_\_\_\_ Date: \_\_\_\_\_

**To receive your New Caregiver's Card:**

- notify your previous caregiver of invalid status.
- bring in your old caregiver's card.
- your caregiver must agree to serve for a one year period.
- have new caregiver sign WAMM's Protocols & Guidelines and Confidentiality Form

**THIS FORM REPLACES ANY PREVIOUS CAREGIVER AGREEMENTS.**

Administrative data entered on: \_\_\_\_\_ Initials: \_\_\_\_\_

# Medical Marijuana Recommendation Form

**Patient Information:** (all information on this form must be completed)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Other Alias Names: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ CA. Driver's Lic. or ID #: \_\_\_\_\_

Home Address:

Street: \_\_\_\_\_

City and State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Area Code & Phone Number(s): \_\_\_\_\_

**The Following must be completed and signed by a Medical Doctor (M.D.) Licensed to Practice Medicine in the State of California.**

To: \_\_\_\_\_  
(Patient's Name)

It is my medical opinion that your health may benefit from the use of marijuana in the treatment of

\_\_\_\_\_,  
(specify condition diagnosis)

and from a purely medical perspective, I therefore deem such as appropriate and Recommend, Approve, Endorse, Suggest, or Advise (circle one) such use for the treatment of your condition.

This is not a formal prescription, but is merely a statement of my professional opinion that use of marijuana may be medically beneficial in your case. You should understand that marijuana is considered a Schedule I drug by the federal government, and that under federal law possession, use, cultivation and the sale of marijuana is illegal. I cannot suggest to you where you might obtain marijuana and I do not, by this recommendation, intend to encourage you to engage in illegal activity, I am only providing you with my opinion, based upon my understanding of the currently available medical and scientific evidence, of the potential efficacy of marijuana use for your condition. This document is prepared in accordance with HS11362.5.

Physician's Name (Printed): \_\_\_\_\_ Ca. Med.Bd.Lic.#: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_ Physician's Fax: \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
(Street & mailing address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

\_\_\_\_\_  
(Zip)

Signed Dr: \_\_\_\_\_ Date: \_\_\_\_\_  
(physician signature)