ETHNOBOTANICA

Caregiver Certification

I, ________________________________ , Do hereby affirm that, ____________________ ,
(Member Name) (Primary Caregiver Name)
is authorized to act on my behalf, in regards to Ethnobotanica, as my primary caregiver. This person consistently assumes responsibility for my housing, health, and safety.

______________________________ __________
Member Signature Date

______________________________ __________
Primary Caregiver Signature Date

Limit Increase:

I ______________________, state that my finances are sufficient to provide payment for the medication that
(Member Name)
I require on a weekly basis. I also verify and agree that my medication shall not be resold.

Member Signature:______________________________ Date:____________

I, ____________________, have seen proof that _____________________ has sufficient income to cover
(Driver/Witness Name) (Member Name)
the cost of a weekly medication limit above 28 grams.

Driver/Witness Signature:________________________ Date:____________

OFFICE USE ONLY

I, ____________________ have talked to_____________________ about __________________'s
(Office Staff Name) (Driver/Witness) (Member Name)
limit increase and find it acceptable.

New Limit:_______________
Office Signature:__________________________

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