

HocG Total Care Program Application

Name as shown on OMMP card: _____

Expiration date: _____ How long have you been an OMMP patient? _____ Years

Address: _____

Phone: _____ Email: _____

Have you received medicine from HocG before? Yes No

If yes when: _____

Do you need a grower? Yes No Do you need a caregiver? Yes No

Please check each type of medicine that you are in need of: Topicals Edibles
 Marijuana Flowers Concentrates

Why are you applying for HocG's Total Care Program?

To qualify for HocG's Total Care Program you must be an OMMP cardholder.
Please return this application by email to Hocg@helpourcirclegrow.com