



A California Non Profit Mutual Benefit Corporation

**B.O.E Member Info:**

**STEP 1** Please complete this form

*\*all info is required and will be kept strictly confidential*

**Full name:** \_\_\_\_\_

**Email address:** \_\_\_\_\_

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

**COMPLETE Delivery Address:** \_\_\_\_\_

\_\_\_\_\_

**Phone #** \_\_\_\_\_ **Cell#** \_\_\_\_\_

How do you prefer we contact you?  email  phone

**Doctors Name:** \_\_\_\_\_

**Doctors State License Number:** \_\_\_\_\_

**Doctors Verification Phone ( )** \_\_\_\_\_

**Your Patient ID Number:** \_\_\_\_\_

Expiration Date

Please email info to [membership@boesbuds.com](mailto:membership@boesbuds.com)

OR call OR print and fax

**Phone (818) 626-8550**

**FAX: (818) 698-0361**