FORM INSTRUCTIONS

Option 1
Submit form with Adobe Acrobat

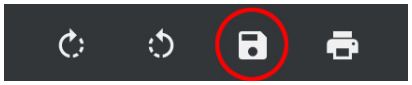
- Save the pdf to your computer (see instructions below)
- Open in Adobe Acrobat and fill out
- hit submit

Option 2
Use your browser

- Fill out the form in your browser
- Save the pdf to your computer (see instructions below)
- Attach the pdf to an email and email it to info@maringardens.org

If you do not already have Adobe Acrobat installed on your computer you can download it for free from this link:
https://acrobat.adobe.com/us/en/products/pdf-reader.html

To save the pdf to your computer:
Click on the Save/Download icon in the top right corner of the pdf in your browser window
(the icons may look slightly different depending on the browser you are using)



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FIREFOX

MEMBERSHIP APPLICATION AND AGREEMENT
MARIN GARDENS, INC.
A Nonprofit Mutual Benefit Corporation

GENERAL PATIENT INFORMATION

Full Legal Name:_____ **DOB:**_____

Address:_____ **Email:**_____

Phone Number:_____ **CA DL #:** _____
CA DL Exp:_____

MEDICAL MARIJUANA RECOMMENDATION INFORMATION

Recommending Physician:_____ **Lic#**_____

Recommending Physician's Phone: _____

Recommending Physician's Address:_____

Recommendation Number:_____ **Date Issued:**_____

Website for Verification:_____

Expiration Date: _____ **State Card Holder:** ☐ **yes** ☐ **no**

If yes, Card No:_____ **Exp:**_____

MEDICAL CANNABIS ASSOCIATION MEMBERSHIP AGREEMENT

1. I,_____ am a qualified patient with a valid doctor's recommendation for the therapeutic use of cannabis. As a qualified patient, I am associating with other qualified patients, primary caregivers, and/or state I.D. cardholders through Marin Gardens, Inc., A Nonprofit Mutual Benefit Corporation, within the State of California in order to collectively or cooperatively cultivate marijuana for medical purposes. Pursuant to Health and Safety Code § 11362.775 it is my belief and expectation that by virtue of this association with other patients, primary caregivers, and/or state I.D. cardholders, for the purposes described above, I shall not be subject to state criminal sanctions under Health and Safety Section 11357, 11358, 11359, 11360, 11366, 11366.5, or 11570.
2. As a patient member of the aforementioned Association, I will ensure that my conduct complies with the California Attorney General's Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use (2008), the Compassionate Use Act, the Medical Marijuana Programs Act, and the Medical Marijuana Regulation and Safety Act. My expectation is that other member of the Association will also comply with these regulations.
3. As a patient member and beneficial member of this Association, I understand that I do not have voting rights in the Association pursuant to the Bylaws unless I am appointed as a member of the board of directors of the Association. Additionally, I understand and agree to all provisions of the Bylaws, a copy

of which will be provided to me upon request.

4. As a member of this Association I understand that it is the intent of this Association to change its status from a nonprofit entity to a profit making entity once California State Law is changed to allow for-profit cannabis businesses. Additionally, I understand and hereby agree that upon the change of status from a Nonprofit Mutual Benefit Corporation to that of a non-member based entity, there will no longer be beneficial members of the entity and all prior beneficial members shall be terminated as of the official change of status date.
5. As a member of this Association, I authorize other members of this Association to possess, cultivate, process, transport, and distribute medical cannabis for my medical needs. As a member of this Association, I am authorized to possess, cultivate, process, transport, and distribute medical cannabis for other members of this Association.
6. Any monetary transactions between Association members shall only be for amounts reasonably calculated to cover overhead costs and operating expenses. I further agree not to divert the Association's cannabis to non-members.

I declare under penalty of perjury that the foregoing is true and correct except as to matters stated under information and belief, which I believe to be true. Signed on this the_____ day of_____ 20_____, in _____, California.

Dated:_____ Patient Member Name _____

Patient Member Signature _____

BELOW THIS LINE FOR STAFF USE ONLY

Initial When Complete:

____ Medical Recommendation/ID Card Verified
____ Copy of Medical Recommendation Obtained
____ Copy of Identification Card Obtained
____ Patient Membership ID Number Assigned

Patient Membership ID Number:_____

Authorized Staff Signature: _____ Date: _____

-Notice to Law Enforcement-
For inquiries please contact
Rogoway Law Group
A Professional Corporation
707-526-0420

Marin Gardens, Inc.

A Nonprofit Mutual Benefit Corporation

Authorization for Release of Protected Health Information or Mental Health Records

I, _____ DOB : _____

Hereby authorize Marin Gardens, Inc. to provide to:

LAW ENFORCEMENT AGENCIES

A copy of my medical recommendation for the therapeutic use of cannabis and/or State Issued Medical Marijuana Identification Card.

The use or disclosure of protected health information/medical records authorized herein is required for the following purposes (s): LEGAL MATTERS

And disclosure shall be limited to the following specific types of information: NONE

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in reliance on this authorization. I understand that I have the right to receive a copy of this authorization. I understand that once the specified information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient only as permitted by law. However, re-disclosures of information may not be protected by federal HIPAA privacy regulations. I understand that if I refuse to sign this authorization, my records will not be released.

☐ Refuse to sign. Initial _____ Date _____

This authorization is effective immediately and will remain in effect from the date of signature for as long as services are continuously being provided and allow the provider to provide verbal information and physical documentation to law enforcement, if contacted.

Signature _____ **Date** _____

If signed by other than Member, indicate relationship _____

Witness Signature _____ Date _____

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