Patient Received By:__________

Physician Contacted By:__________
□ Verified □ Not Verified
Date:_________________________

PCH Collective, Inc.

Patient's Information

Name:____
Home Address:____
City, State, Zip ____
Date of Birth:______________________**Phone Number:**________________________
Email:____
CA Driver's License No:______________________**Expiration Date:**______________

Are you now or have you ever been employed by any Law Enforcement Agency(s)?

Yes:______ **No:**______

Prescribing Physician's Information

Physician's Name:____
Address:____
City, State, Zip:____
Phone Number:(____)_________________
Date of Last Visit:_____________________**Date of Next Visit:**___________________

Medical Release:

I hereby authorize my treating Physician, as required by State and Federal Laws Including HIPPA regulations, to release my medical information concerning my diagnosis, condition, and/or prescription to PCH Collective, Inc. and its duty authorized representatives.

Patient's Signature: _________________________________**Date:**________________

PCH Collective, Inc.

Membership Agreement

As a qualified patient protected by California Law, Health & Safety Code §11362.5 and §11362.7, et seq., and in conjunction with California State Senate Bill 420, you are required to read and agree to the following statements to become a member of PCH Collective,Inc. Please understand that these are for your protection, as well as ours. Please read the following statements and initial that you have read and understand each statement and sign the bottom of this form.

I. I hereby declare that I am a qualified patient under CA H& S Code §11362.5, §11362.7, et seq., and my doctor has recommended, prescribed and approved my use of medical marijuana. As per CA H&S Code §11362.51, I am legally able to use, possess, and cultivate cannabis for medical purposes. I understand that I am allowed to do so through safe and affordable access such as the type provided by PCH Collective, Inc. I therefore, designate PCH Collective Inc., as my care provider for this purpose. In doing so, I agree to sign and follow all PCH Collective, Inc. rules and regulations regarding their services. I also agree to pay all personal out-of-pocket expenses and reasonable compensation for PCH Collective, Inc.'s member services.

Patient/Member Initials: ____________________

II. I hereby declare under penalty of perjury under the laws of the State of California that medical doctor recommended or approved my use of medical marijuana. I have been diagnosed for a serious illness for which cannabis provides relief.

Patient/Member Initials:_____________________

III. I hereby verify that I am a California resident and my personal medical marijuana will not be taken out of the State of California. I further verify and agree that my medical marijuana shall not be shared, sold, bartered, traded, exchanged or delivered in any other means to any other person.

Patient/Member Initials:_____________________

IV. I hereby declare and understand that my contributions to PCH Collective, Inc. for and through prescribed medicinal products I may acquire from PCH Collective, Inc. are used to ensure the continued operation of PCH Collective, Inc. and that any said transaction in no way constitutes a commercial promotion or sale of any item.

Patient/Member Initials:_____________________

V. As a member, I hereby agree, appoint and designate PCH Collective Inc. and their representatives, as my true and lawful agents for the limited purpose of assisting me in obtaining my legally prescribed medicinal marijuana. I understand that this means PCH Collective, Inc. will be required to purchase, possess, transport and distribute my medication to me as prescribed by my physician and I grant them the limited authority to do so. I further authorize PCH Collective, Inc. to enter whatever agreements are necessary with growers or other medicinal providers, as my duly authorized primary caregiver, to assist me with obtaining my medication(s).

Patient/Member Initials:_____________________

VI. As a member, I understand that PCH Collective, Inc. has other members with similar Membership Agreements. I hereby authorize PCH Collective, Inc. to jointly possess the medical marijuana as described under this Agreement jointly with other PCH Collective, Inc. members under similar Membership Agreements. I agree the medicinal marijuana possessed by PCH Collective, Inc. at any time is the collective property of every patient who is also under this Membership Agreement and the care of PCH Collective, Inc.

Patient/Member Initials:_____________________

VI. I agree to possess my original, or a true and correct copy, of my prescription when I am on PCH Collective, Inc. property. I understand that my failing to do so may result in refusal of services. I hereby agree to all future changes of these policies as the laws for safe access develop. I agree that any violation of the terms of this Agreement or any other club rules are grounds for immediate termination of membership.

Patient/Member Initials:_____________________

VIII. I agree to provide PCH Collective, Inc. with all changes in my contact information, diagnosis, or primary physician immediately.

Patient/Member Initials:_____________________

I hereby affirm that I read, understand and agree to the terms of the PCH Collective, Inc. Membership Agreement.

Patient's Signature:_______________________________________Date:___________________