MEMBERSHIP APPLICATION AND AGREEMENT
OLD GROWTH COLLECTIVE
A CALIFORNIA NON-STATUTORY MEDICAL CANNABIS COLLECTIVE

(AS REQUIRED PER ATTORNEY GENERAL'S GUIDELINES)

COLLECTIVE MEMBERSHIP GENERAL RULES

I will not sell, furnish, or in any way distribute cannabis to non-members; use the cannabis for any purpose other than to treat my medical condition; and at all times, maintain a valid verifiable Prop. 215 Physician's Recommendation. If it expires or is revoked or rescinded for any reason, I will immediately notify the Collective and will not, under any circumstances, attempt to obtain cannabis from the Collective until it is renewed or a new Recommendation is obtained.

Patient: Please fill out the Verification Information Below

Recommendation #

Doctor Name and License:

Recommendation Expiration Date:

MEMBERSHIP AGREEMENT

I agree that as a condition of my membership in the **OLD GROWTH COLLECTIVE** ("Collective"), I will comply with all terms and conditions in this Membership Application and Agreement.

Terms and Conditions

- As a qualified medical marijuana patient under the compassionate use act, and the Medical Marijuana Program Act, I intend to associate with the members of the medical marijuana collective, in part to collectively cultivate marijuana for medical purposes pursuant to the Medical Marijuana Program Act, which includes in part, California Health and Safety Code 11362.775 and Section 1(b)(3) of the un-codified portion of the Medical Marijuana Program Act, which was enacted by the people of the State of California, in part, in order to promote uniform and consistent application of the Compassionate Use Act among the counties within the state, and to enhance the access of patients and caregivers to medical marijuana through collective, cooperative cultivation projects.

- As a member of the medical marijuana collective, I understand and agree that each and every member of this collective will contribute labor, funds, supplies, services, and/or materials towards the cultivation and/or procurement of marijuana for medical purpose; and by executing this agreement, I agree that a requirement of my membership is that I be available for such tasks when needed; or in the alternative, I may be required to reimburse the members for their

operating costs and expenses.

- As a qualified medical marijuana patient and member of the collective pursuant to California Health and Safety Code 11362.775, I specifically authorize the Collective, through its Board of Directors, to cultivate, transport and otherwise prepare Marijuana for my medical use and benefit.
- In order to become a member of the Collective, I must provide to the Collective a Valid California Identification card or Driver's License; and either one of the following items of proof of qualified patients status: A State of California Medical Marijuana Program Identification Card; or a valid and verifiable California Physician's Recommendation for the use of Medical Cannabis. By Signing below, I certify that a true and correct copy of my current written physician's recommendation and/or a State of California MMP identification card is attached hereto.
- **I understand that as a member of this collective I have a right to vote on issues which the by-laws of this collective permit members to vote on; however, I wish to issue a proxy which shall last for one year from the signing of this agreement and allow any member of the board of this collective to vote in my stead. My proxy shall be renewed after one year and renewal shall occur upon any use of the services of this collective after the first year period of membership.**

Patient please Initial to verify you agree to the above

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By signing this Application and Agreement, I acknowledge that I have read this entire Membership Application Agreement, and I agree to abide by the Rules as stated herein. I Understand that my membership may be terminated at any time by the Collective management if it is determined that I have violated any of the rules or other conditions of this Membership Application Agreement.

Patient Signature:____

Date: _____________

For Collective Management Use Only

Patient Verified: YES NO **Valid CA ID:** YES NO

Patient Membership ID#: ________________________