KIND DELIVERIES

MEMBERSHIP RULES AND GUIDELINES

A California Nonprofit Mutual Benefit Corporation

1. All members must be 18 years of age or older and possess a valid government issued ID.

2. All members must have a valid physician's recommendation on file with the Collective at all times and agree that recommendations must be fully verified by an authorized agent of the Collective before any medicine may be provided. **Members are responsible for renewing recommendations prior to the expiration date. Kind Deliveries will not deliver to patients with an expired recommendation. NO EXCEPTIONS**

3. All members agree to come to the door alone, without any friends, family or children in the area, unless a member is disabled and needs help filling out paperwork or communicating with driver. Kind Deliveries and California State law does not allow sharing of meds to non-qualified patients. **Members may not exchange money, share money or split payments for obtaining medication or any other purpose at any time while in the presence of the delivery driver.**

4. Members acknowledge being advised that using marijuana might negatively affect their ability to drive a motor vehicle. Members are advised to medicate at home.

5. All members agree treat Kind Deliveries' staff, management and other members with dignity and respect and understand Kind Deliveries' staff and management reserve the right to refuse service to anyone at any time. Members understand that no acts of violence or threats of violence will be tolerated

6. All members understand and agree that maintaining safety, membership rules and adherence to the law are their collective responsibility.

I hereby affirm that I have read, understand and agree to the terms of the foregoing rules.

Date:_____

Patient/Member Name (Print): _____

Patient/Member Signature: _____

KIND DELIVERIES

HIPAA/CMIA AUTHORIZATION

Member Name: _____

Date of Birth: _____

I am either the Patient named above or the Patient's legally authorized representative.

This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320(d) and 45 C.F.R. § 160-164, and/or information governed by the California Confidentiality of Medical Information Act ("CMIA") Cal. Civ. Code § 56-56.37. Specifically, this release authority complies with the valid authorization requirements of 45 C.F.R. § 164.508(c).

Pursuant to HIPAA and/or CMIA, I authorize and direct any physician, healthcare professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give, disclose, and release, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, to include all information relating to the diagnosis and treatment of sexually transmitted diseases, mental illness, and drug or alcohol abuse to KIND DELIVERIES, a nonprofit mutual benefit corporation, corporate identification # 3492871.

The purposes of the usage and disclosure shall include determinations regarding my qualification to use medical marijuana and monitoring my health care to protect my legal rights where I reside.

I understand that, with certain exceptions, I have the right to revoke this Authorization at any time. If I want to revoke this Authorization, I must do so in writing. The procedure for how I may revoke this Authorization, as well as the exceptions to my right to revoke will be performed in accordance with applicable federal law and any applicable policy of my health care provider.

I understand that I may refuse to sign this Authorization. I also understand that my health care provider cannot deny or refuse to provide treatment, payment, and enrollment in a health plan, or eligibility of benefits if I refuse to sign this Authorization.

I understand that, once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by applicable federal medical privacy law and could be re-disclosed by the person or agency that receives it; however, I do not authorize such secondary disclosure.

The authority given to the persons or parties named above shall supersede any agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

NASSIRI LAW, INC. dba "Cannabis Law Group" has prepared this release and any questions regarding legal compliance and use may be directed to its principal office at 333 City Boulevard West, 17th Floor, Orange, CA 92868 or by telephone at (714) 937-2050.

I have read and understand the information in this Authorization form.

Signature of Patient:_____

Date: _____

KIND DELIVERIES

COLLECTIVE MEMBERSHIP APPLICATION AND AGREEMENT

A California Nonprofit Mutual Benefit Corporation

I _____, resident of the County of_____ hereby state that as a qualified patient or a primary caregiver who has received a valid physician's recommendation for the use of medical marijuana in accordance with the California Health and Safety Code § 11362.5 ("Proposition 215" or "Compassionate Use Act of 1996") and Article 2.5, commencing with Section 11362.7, to Chapter 6 of Division 10 of the California Health and Safety Code ("SB 420"), wish to voluntarily join and become a member of KIND DELIVERIES (the "Collective") and agree to follow the terms and conditions as set forth in this agreement.

1. I hereby declare under the penalty of perjury under the laws of the State of California that a medical doctor recommended or approved my use of medical marijuana for an illness for which cannabis provides relief in accordance with the Compassionate Use Act of 1996 and SB 420.

Patient/Member Initials: _____

2. As a member, I hereby appoint and designate the Collective and their representatives, as any true and lawful agents for the limited purpose of assisting me in obtaining my legally prescribed medical marijuana. I understand that this means that the Collective will be required to possess, purchase, cultivate, transport and/or distribute medical marijuana exclusively for member qualified patients or primary caregivers. Therefore, I grant the Collective's management and other fellow members the limited authority to engage in the afore-mentioned tasks. I further agree and authorize the Collective and its members to use information relating to my status as a qualified patient as use of such information is reasonably necessary for providing my medical marijuana for my medical benefit as a qualified patient.

Patient/Member Initials: _____

3. I authorize the Collective to create and/or assign agency rights in its own name for the purpose of growing marijuana for my personal medical reasons as well as for the medical benefit of other members of the Collective.

Patient/Member Initials: _____

4. As a member, I understand that the Collective has other members who have joined and agreed to uphold the Collective's rules and spirit by, among other things,

signing a similar membership agreement. I hereby authorize the Collective to possess the medical marijuana as described under this agreement jointly with other members of the

Collective under similar agreements. I agree that the medical marijuana possessed by the Collective is at any time the collective property of every patient who has joined the Collective, subject to the Collective's rules and guidelines established by and for the Collective for handling medical marijuana for the benefit of member patients.

Patient/Member Initials: _____

5. I agree to pay to the Collective all personal out-of-pocket expenses and reasonable compensation for services related to providing medical marijuana to me and other member patients.

Patient/Member Initials: _____

6. I hereby verify that I am a resident of California and my personal medical marijuana will not be taken out of the State of California. **I further verify and agree that medical marijuana shall not be shared, sold, bartered, traded, exchanged or delivered by any means to any other person for medical or other reasons. I understand that diversion of medical marijuana for non-medical purposes and/or to other individuals shall be grounds for the immediate termination of my membership.** I also agree to request amounts of medicine strictly for my medical personal use at reasonably necessary intervals.

Patient/Member Initials: _____

7. I agree to possess my original, or true and correct copy, of my physician's recommendation at all times. I understand that my failing to do so may result in the termination of membership and that verbal recommendations from physicians will not be accepted. I hereby agree to all future changes of the Collective's policies as the laws relating to access to medical marijuana might change. I further agree to provide the Collective with all changes relating to my contact information as well as my status as a qualified patient.

Patient/Member Initials: _____

8. I understand and agree that adherence to the rules of the Collective is the collective responsibility of all patient members, including myself. I agree that any violation of the terms of this Agreement or any other Collective member rules are grounds for the immediate termination of my membership.

Patient/Member Initials: _____

9. I understand and agree that while medical cannabis has been authorized by both the people of the State of California and its legislature, and consistently upheld by all

California courts, the Federal Government persists in enforcing portions of the Controlled Substances Act, which makes the possession and use of medical cannabis a federal crime.

I hereby certified that I have been advised by an authorized agent of the Collective that possession and use of marijuana for medical purposes might be grounds for prosecution under federal law.

Patient/Member Initials: _____

10. I have read over this entire Collective Membership Application and Agreement and certify that an authorized agent of the Collective has personally gone over and explained fully to me each paragraph of this agreement and that I will be provided a copy of this agreement if I ask.

Patient/Member Initials: _____

11. By joining KIND DELIVERIES, all patients hereby agree to indemnity and hold harmless KIND DELIVERIES from all alleged wrongdoing which may be the fruit of undercover investigations conducted by the patient during their membership with KIND DELIVERIES. Any undercover officers, narcotics investigators with or without identification who join the collective and obtain information about the collectives activities hereby acknowledge to relinquish all information and agree that said information may not be used in a court of law to support any testimonial evidence by the member/officer.

All new patients hereby agree that they have no associations with any law enforcement agencies or entities, and hereby agree not to mislead KIND DELIVERIES by failing to admit that the new member is an undercover officer.

All officers and law enforcement agents who pose as an undercover officer or not, hereby agree that all criminal evidence discovered as a result of the officer being a member of KIND DELIVERIES is irrelevant heresay and inadmissible evidence in either a civil or criminal court setting. For the purposes of this section, all undercover investigations means all evidence and witness information derived from the undercover officers posing as a new patient, including but not limited to any patients who may be informants, in witness protection programs, patients possessing fraudulent documents, licenses, or posing as sales reps or producers

Patient/Member Initials: _____

KIND DELIVERIES 'S VOLUNTARY CULTIVATION PROGRAM

KIND DELIVERIES understands that, for one reason or another, not all of its members can participate in the cultivation of the collective's medical marijuana. Therefore, KIND DELIVERIES does not require its members to participate in the cultivation process.

However, we do encourage and request that its members participate in the cultivation process, if they so desire and if they have any skills, time, knowledge or resources that can help the collective in its cultivation process. With this in mind, please answer the following questions:

12. I would / would not (circle one) like to participate in the cultivation of our collective's medical marijuana.

14. If you do not wish to participate in the cultivation process, are there any other skills, time, knowledge or resources you possess which you would like to contribute?

I hereby affirm that I have read, understand and agree to the terms of the KIND DELIVERIES Agreement. Further, I declare under the penalty of perjury that the above is true and correct to the best of my knowledge.

Executed on this date: _____, in the County _____, State of California.
Patient/Member Name (Print): _____

Patient/Member Signature: _____

Optional Contact Information:
Would you like to receive notice of expiring recommendation?

Patient Email (optional) : _____ _____

Patent Phone number (optional) : _____

Authorized Collective Agent Signature: _____