A California Medical Marijuana Collective
Nonprofit Mutual Benefit Corporation, Number C3840335

MEMBER REGISTRATION

Thank you for choosing to become a member of Southern Humboldt Royal Cannabis Company ("Collective"). The Collective is a lawfully organized Medical Marijuana Collective operating as a nonprofit mutual benefit company. The Collective's purpose and policy is act at all times within the scope of California State law governing medical marijuana, including *Proposition 215* (also known as the "*Compassionate Use Act*") ("CUA"), *Senate Bill 420* (also known as the *Medical Marijuana Program Act*) ("MMPA"), the California Attorney General's *Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use* (August 2008)("AG Guidelines") and interpreting case law. ("California medical marijuana laws"). The Collective prides itself in its commitment to complying with California medical marijuana laws and in being a model collective, serving the multiple goals of providing high quality medicine in a safe, secure, and professional manner.

Please fill out the membership registration form in clear, legible writing.

Last Name: ____ Member Number: ____________

First Name: ____ Date of Registration: __________

Middle Name/Initial: ______________ Date of Birth: __________

California Driver's License No.:___________________________ Telephone Number: _________________

Email Address: _______________________________________

I learned about to Collective from: ________________________ Preferred Medication: _____________________

Complete this section only if you have a medical cannabis ID card issued by a Department of Public Health, ("DPHS") County Health Department or other agency pursuant to California *Health & Safety Code* §11362.7 et seq.

NOTICE: The Collective Must Retain a Copy of your DPHS Card for or records.

Card Issued by County: ________________________________ Expiration Date: ______________

Card Verified by: ______________________________________ Card No: ____________________

Physician Recommendation Information

NOTICE: The Collective Must Retain a Copy of Physician Recommendation
And a Copy of your Photographic Identification

Recommendation copied by:__________________________________ Expiration Date: ___________

Recommendation verified by:_________________________________ Verified [ ] Yes [ ] No

Physician Name:____ Verification Date: __________