COLLECTIVE NAME _____ MEMBER SOURCE #_____

MEDICAL MARIJUANA MEMBER SOURCE AGREEMENT

I am a cultivator of medicinal marijuana as a patient [ ] or caregiver [ ] and I agree to be a member source and to contribute *marijuana / concentrated cannabis* *cultivated at the following location:*

_____

Street Address (NO PO Box) City State Zip

_____ **I understand pursuant to San Diego County Code Section 21.2505(8) (B), the location of my cultivation of marijuana is subject to inspection by the appropriate law enforcement, fire agencies and/or code enforcement agencies. I agree to allow Sheriff's Licensing personal access to my cultivations site, *without delay*, upon request.**

_____ **I understand that my marijuana cultivation site must comply with all local ordinances and state laws governing the cultivation of medical marijuana in accordance with HS11362.5 - HS11362.83**

_____ **I understand that this form will be maintained at the collective facility and that the information contained herein will be provided to law enforcement.**

_____ **I understand that cultivation, possession, transportation and distribution of marijuana is illegal according to federal law.**

_____ **I understand that as a member source and pursuant to California State law, I am only allowed to grow the amount of marijuana required for my current medical needs (H&S11362.77).**

_____ **I understand that I may provide my excess marijuana to the collective for dissemination among the collective members and that I may be reasonably compensated for the overhead expenses related to my cultivation of medicinal marijuana.**

_____ **I agree to notify the collective facility immediately if there is any change to my address or phone number, my status as a member source, or the location of my cultivation.**

_____ **I understand that a violation of any of the above expectations may result in a Notice of Violation to the collective and termination of my status as a member source for the collective.**

_____ _____

Full Name **Date of Birth**

_____

Residence Address (NO PO Box) City State Zip

(_____)_____

Telephone

I have read and agree to the above terms and conditions of being a Member Source for a collective facility. I certify, *under penalty of perjury* that all information provided is true and correct.

_____ _____ _____ _____

Signature (Member Source) Date Signature (Witness) Date