Temescal Wellness, Inc.
New Caregiver Form

Designated Caregiver Information

Name

FIRST ______________________ LAST ______________________

Mailing Address

ADDRESS LINE 1 ______________________

ADDRESS LINE 2 ______________________

CITY/TOWN ______________ ZIP CODE ______________

Phone Numbers

HOME ______________________

MOBILE ______________________

OTHER (OPTIONAL) ______________________

Registration Information

NH CAREGIVER REGISTRATION NUMBER ______________________

/ /

EXPIRATION DATE (MM/DD/YYYY)

Additional Information

EMAIL ADDRESS ______________________

/ /

DATE OF BIRTH (MM/DD/YYYY)

Preferred method of contact: ☐ HOME # ☐ MOBILE # ☐ EMAIL ☐ TEXT

Caregiver Questions (Please check the appropriate box)

Do you wish to subscribe to our newsletter for updates? ☐ YES ☐ NO

Temescal Wellness, Inc.
New Caregiver Form

Patient #1 and #2 Information

Patient #1 Information

FIRST AND LAST NAME

Mailing Address

ADDRESS

CITY/TOWN ZIP CODE

Registration Information

NH PATIENT REGISTRATION NUMBER

/ /

EXPIRATION DATE (MM/DD/YYYY)

Phone Numbers

HOME

MOBILE

Additional Information

EMAIL ADDRESS

/ /

DATE OF BIRTH (MM/DD/YYYY)

Preferred method of contact:

- [ ] HOME #
- [ ] MOBILE #
- [ ] EMAIL
- [ ] TEXT

Patient #2 Information (if applicable)

FIRST AND LAST NAME

Mailing Address

ADDRESS

CITY/TOWN ZIP CODE

Registration Information

NH PATIENT REGISTRATION NUMBER

/ /

EXPIRATION DATE (MM/DD/YYYY)

Phone Numbers

HOME

MOBILE

Additional Information

EMAIL ADDRESS

/ /

DATE OF BIRTH (MM/DD/YYYY)

Preferred method of contact:

- [ ] HOME #
- [ ] MOBILE #
- [ ] EMAIL
- [ ] TEXT

Temescal Wellness, Inc.
New Caregiver Form

Patient #3 and #4 Information

Patient #3 Information (if applicable)

FIRST AND LAST NAME

Mailing Address

ADDRESS

CITY/TOWN   ZIP CODE

Registration Information

NH PATIENT REGISTRATION NUMBER

/ /

EXPIRATION DATE (MM/DD/YYYY)

Phone Numbers

HOME

MOBILE

Additional Information

EMAIL ADDRESS

/ /

DATE OF BIRTH (MM/DD/YYYY)

Preferred method of contact:

☐ HOME # ☐ MOBILE # ☐ EMAIL ☐ TEXT

Patient #4 Information (if applicable)

FIRST AND LAST NAME

Mailing Address

ADDRESS

CITY/TOWN   ZIP CODE

Registration Information

NH PATIENT REGISTRATION NUMBER

/ /

EXPIRATION DATE (MM/DD/YYYY)

Phone Numbers

HOME

MOBILE

Additional Information

EMAIL ADDRESS

/ /

DATE OF BIRTH (MM/DD/YYYY)

Preferred method of contact:

☐ HOME # ☐ MOBILE # ☐ EMAIL ☐ TEXT

Temescal Wellness, Inc.
New Caregiver Form

Patient #5 (if applicable) Information

Name

FIRST

LAST

Mailing Address

ADDRESS LINE 1

ADDRESS LINE 2

CITY/TOWN

ZIP CODE

Phone Numbers

HOME

MOBILE

OTHER (OPTIONAL)

Registration Information

NH PATIENT REGISTRATION NUMBER

/ /

EXPIRATION DATE (MM/DD/YYYY)

Additional Information

EMAIL ADDRESS

/ /

DATE OF BIRTH (MM/DD/YYYY)

Preferred method of contact:

☐ HOME # ☐ MOBILE # ☐ EMAIL ☐ TEXT

Temescal Wellness, Inc.
New Caregiver Form

Acknowledgements

Please __initial__ next to each acknowledgment below as well as sign and date the form:

- I ATTEST THAT I WILL NOT ENGAGE IN THE DIVERSION OF CANNABIS. I UNDERSTAND THAT FRAUDULENT DISTRIBUTION OR RESALE OF THERAPEUTIC CANNABIS IS A CLASS B FELONY. ___________
- I UNDERSTAND THAT MY REGISTRATION CARD DOES NOT ALLOW ME TO CULTIVATE CANNABIS FOR ANY PURPOSE. ___________
- I UNDERSTAND THAT I MAY NOT POSSESS MORE THAN 2 OUNCES OF USABLE CANNABIS PER PATIENT. ___________
- I UNDERSTAND CANNABIS HAS NOT BEEN ANALYZED OR APPROVED BY THE FDA, INCLUDING CANNABIS AND CANNABIS PRODUCTS PRODUCED AND DISPENSED BY TEMESCAL WELLNESS, INC. ___________
- I UNDERSTAND THERE IS LIMITED INFORMATION ON THE SIDE EFFECTS OF CANNABIS, INCLUDING CANNABIS AND CANNABIS PRODUCTS PRODUCED AND DISPENSED BY TEMESCAL WELLNESS, INC. ___________
- I UNDERSTAND THERE MAY BE HEALTH RISKS ASSOCIATED WITH USING CANNABIS, INCLUDING CANNABIS AND CANNABIS PRODUCTS PRODUCED AND DISPENSED BY TEMESCAL WELLNESS, INC. ___________
- I UNDERSTAND CANNABIS SHOULD BE KEPT AWAY FROM CHILDREN AND STORED IN A LOCKED BOX AT HOME. ___________
- I UNDERSTAND CANNABIS SHOULD BE TRANSPORTED IN A LOCKED CONTAINER IN THE CARGO PORTION OF A VEHICLE. ___________
- I UNDERSTAND THAT WHEN UNDER THE INFLUENCE OF CANNABIS, DRIVING AND OPERATING HEAVY MACHINERY IS PROHIBITED. ___________
- I UNDERSTAND I MAY NOT DISTRIBUTE CANNABIS TO ANY OTHER INDIVIDUAL, AND MUST RETURN UNUSED, RECALLED, EXCESS, OR CONTAMINATED PRODUCT(S) PURCHASED AT TEMESCAL WELLNESS INC. TO A TEMESCAL WELLNESS INC. DISPENSARY FOR DISPOSAL. ___________

Temescal Wellness, Inc.
New Caregiver Form

Acknowledgements (continued)

Please initial next to each acknowledgment below as well as sign and date the form:

- I UNDERSTAND THAT AS A DESIGNATED CAREGIVER I AM NOT PERMITTED TO USE THERAPEUTIC CANNABIS, UNLESS I AM ALSO A QUALIFYING PATIENT, AND MAY BE SUBJECT TO CRIMINAL PENALTIES IF I DO SO. ______

- UNDERSTAND THAT AS A DESIGNATED CAREGIVER I AM NOT PERMITTED TO POSSESS ANY CANNABIS FOR PURPOSES OTHER THAN ITS THERAPEUTIC USE AS PERMITTED BY RSA 126-X. ______

- I UNDERSTAND THAT I MAY NOT BE IN POSSESSION OF THERAPEUTIC CANNABIS IN ANY OF THE FOLLOWING LOCATIONS:

  (1) THE BUILDING AND GROUNDS OF ANY PRESCHOOL, ELEMENTARY, OR SECONDARY SCHOOL, WHICH ARE LOCATED IN AN AREA DESIGNATED AS A DRUG FREE ZONE;
  (2) A PLACE OF EMPLOYMENT, WITHOUT THE WRITTEN PERMISSION OF THE EMPLOYER;
  (3) ANY CORRECTIONAL FACILITY; ______
  (4) ANY PUBLIC RECREATION CENTER OR YOUTH CENTER; OR
  (5) ANY LAW ENFORCEMENT FACILITY.

- I UNDERSTAND THAT IN THE EVENT OF MY QUALIFYING PATIENT'S DEATH, I WILL, WITHIN FIVE DAYS OF HIS OR HER DEATH:

  (1) **NOTIFY THE PROGRAM** OF HIS OR HER DEATH; AND
  (2) EITHER REQUEST THAT THE LOCAL LAW ENFORCEMENT AGENCY REMOVE ANY REMAINING CANNABIS OR DISPOSE OF THE REMAINING CANNABIS IN A MANNER THAT IS SPECIFIED IN RSA 126-X:2, XIV. ______

- I AUTHORIZE MY INFORMATION TO BE SHARED BETWEEN TEMESCAL WELLNESS, INC. FACILITIES. ______

Agreement Signature

______________________ PRINT NAME

______________________ SIGN NAME

______________________ DATE OF SIGNATURE

Designated Caregiver Waiver

The enclosed waiver constitutes a Declaration regarding Registered Qualifying Patients and their Designated Caregivers on behalf of the therapeutic use of cannabis by individuals in the State of New Hampshire.

Registered Qualifying Patient or Personal Caregiver acknowledges the following:

- TEMESCAL WELLNESS, INC. ("TWI") IS OPERATING UNDER HE-C 400 AS A REGISTERED ALTERNATIVE TREATMENT CENTER ONLY.

- TWI HAS INDICATED A WARNING THAT:

  1. THE THERAPEUTIC USE OF CANNABIS HAS NOT BEEN ANALYZED OR APPROVED BY THE FDA.
  2. THERE IS LIMITED INFORMATION ON SIDE EFFECTS OF CANNABIS.
  3. THERE MAY BE HEALTH RISKS ASSOCIATED WITH USING CANNABIS.
  4. CANNABIS SHOULD BE KEPT AWAY FROM CHILDREN.

- TWI MAKES NO REPRESENTATION AS TO THE SAFETY OF ANY CANNABIS OBTAINED WITHIN.

- TWI HAS INDICATED THAT THE USE OF ANY CANNABIS OBTAINED AT TWI IS AT ONE'S OWN RISK.

- REGISTERED QUALIFYING PATIENT OR DESIGNATED CAREGIVER AGREES TO HOLD HARMLESS AND INDEMNIFY TWI FOR ANY POSSIBLE DAMAGES OR LOSSES.

- REGISTERED QUALIFYING PATIENT OR DESIGNATED CAREGIVER AGREES THAT TWI SHALL NOT BE NAMED IN ANY LAWSUIT ARISING FROM ITS DISPENSATION OF CANNABIS.

- REGISTERED QUALIFYING PATIENT OR DESIGNATED CAREGIVER UNDERSTANDS AND ASSUMES THE RISK OF ALL POTENTIAL HARMS THAT COULD BE CAUSED BY CANNABIS INCLUDING BUT NOT LIMITED TO: ANXIETY; LOW/HIGH BLOOD PRESSURE; LIGHTHEADEDNESS, FAINTING, LOSS OF BALANCE, DROWSINESS INCLUDING ANY INJURIES ASSOCIATED THEREWITH; DEMOTIVATION; INCREASED APPETITE AND WEIGHT GAIN; SLOWER REFLEXES OR OTHER COGNITIVE OBSTRUCTIONS; AGGRAVATION OF PRE-EXISTING MENTAL OR PHYSICAL DISORDERS; AND ADDICTION.

- REGISTERED QUALIFYING PATIENT OR DESIGNATED CAREGIVER AGREES TO COMPLY WITH ALL STATUTES, ORDINANCES, AND RULES RELATED TO THE THERAPEUTIC USE OF CANNABIS, INCLUDING THOSE ESTABLISHED IN NEW HAMPSHIRE RSX 126–X.

Designated Caregiver Waiver (continued)

Registered Qualifying Patient or Personal Caregiver acknowledges the following:

- REGISTERED QUALIFYING PATIENT OR DESIGNATED CAREGIVER UNDERSTANDS UNDER NEW HAMPSHIRE LAW, THE REGISTRATION CARD ONLY PROTECTS HIM OR HER FROM ARREST FOR POSSESSING LIMITED AMOUNTS OF CANNABIS IN NEW HAMPSHIRE. IN STATES OUTSIDE OF NEW HAMPSHIRE, PLEASE CONSULT AN ATTORNEY IN THAT STATE TO LEARN ABOUT ANY APPLICABLE RESTRICTIONS.
- POSSESSING AND USING CANNABIS IN ANY FORM IS A FEDERAL CRIME. YOUR RISK OF FEDERAL PROSECUTION INCREASES ON FEDERAL LAND, WHICH INCLUDES NATIONAL PARKS AND FEDERALLY SUBSIDIZED HOUSING.
- TWI DOES NOT CLAIM TO BE ABLE TO DIAGNOSE, TREAT, PRESCRIBE FOR, OR PREVENT ANY HUMAN DISEASE, AILMENT, PAIN, INJURY, OR CONDITION.
- TWI DOES NOT SUGGEST, RECOMMEND, PRESCRIBE, OR ADMINISTER ANY FORM OF TREATMENT, OPERATION, OR HEALING FOR THE INTENDED PALLIATION, RELIEF, OR CURE OF ANY PHYSICAL OR MENTAL DISEASE, AILMENT, INJURY, OR CONDITION.
- TWI DOES NOT MAINTAIN AN OFFICE FOR THE PURPOSE OF EXAMINING OR TREATING PERSONS AFFLICTED WITH DISEASE, INJURY, OR DEFECT OF BODY OR MIND.
- I SWEAR AND AFFIRM UNDER PENALTY OF PERJURY THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS.

Agreement Signature

PRINT NAME: ______________________

SIGN NAME: ______________________

DATE OF SIGNATURE: ______________________