f/k/a Carter Validus Mission Critical REIT II, Inc.

CERTIFICATION REGARDING EXIGENT CIRCUMSTANCES FOR REPURCHASE

Before me, the undersigned authority, personally appeared _____ ("Stockholder"), who, after being duly sworn, deposes and says:
[Name of Current Stockholder]

1. I have personal knowledge of the facts contained in this Certification.

2. In connection with the Repurchase Request form (the "Repurchase Request") to which this Certification is attached, I submit this Certification in support of my request for a repurchase due to involuntary exigent circumstances, as follows (both items must be initialed and satisfactory evidence provided):

_____ (Initial) I have been diagnosed with a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery (the "Illness") and my life expectancy is less than twenty-four (24) months, as reflected in the attached Physician Certification completed and executed by my attending physician.

_____ (Initial) I am experiencing financial need, and if the Repurchase Request is not accepted, I will be unable to meet the basic financial obligations of support for myself and my dependents, as reflected in the following paragraphs of this Certification.

3. I ☐ am ☐ am not employed.

Employer's name:_____

Employer's address:_____

What is your monthly gross income:

from employment? _____

from other sources, including but not limited to Social Security sources, disability insurance, retirement accounts, pensions, annuities, rents and royalties, and other sources of periodic income? _____

If you are not employed, what is the date (month and year) you were last employed? _____ What was your gross monthly income when last employed? _____

4. I ☐ am ☐ am not married.

Spouse's name:_____

If you are married, is your spouse employed? ☐ Yes ☐ No

What is your spouse's monthly gross income:

from employment? _____

from other sources, including but not limited to Social Security sources, disability insurance, retirement accounts, pensions, annuities, rents and royalties, and other sources of periodic income? _____

5. I ☐ have ☐ do not have persons I personally support ("Dependents").

If yes, I have ____ (number) Dependents (excluding spouse).

For each Dependent, please provide the information below:

Name	Relationship	Age

6. What are your monthly fixed expenses?

Housing (rent, mortgage, etc.): _____

Utilities: _____

Medical: _____

Loans, charge cards, and credit accounts: _____

Transportation expenses: _____

Other expenses: _____

7. Upon request by Sila Realty Trust, Inc. (the "REIT"), I agree to execute a release authorizing my attending physician to use and disclose to the REIT my Protected Health Information (as defined in the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) with regard to the diagnosis and treatment of the Illness.

8. I am making this Certification with the intent that the REIT shall be entitled to reply upon this Certification and shall have no duty to inquire further or to make any independent verification of the representations made herein. I understand that the REIT is acting in reliance upon the representations in this Certification, which are made to induce the REIT to repurchase the shares referenced in the Repurchase Request.

9. I agree to indemnify the REIT and to hold the REIT harmless from and against any liability arising from or through the submission of the Repurchase Request, the REIT's exercise of discretion regarding the Repurchase Request, and any resulting repurchase, if applicable, including but not limited to claims by my creditors, heirs and assigns.

☐ By checking this box, I explicitly consent to the receipt of the personal information on or required by this form by the REIT and its transfer agent in the United States and to the REIT's use of the personal information on or required by this form to determine my eligibility for stock repurchase. I understand that the data protection laws in the United States to which the REIT is subject may be less protective of my privacy rights than the data protection laws in my country. I understand that I may withdraw my consent by notifying the REIT at one of the mailing addresses below, but in that case I may not be eligible for stock repurchase and my withdrawal of consent will not affect the REIT's use of my personal information up until that time or pursuant to other legal rights or permissions. If the personal information on this form belongs to someone else, such as my spouse or Dependents, I represent that either: (i) such person has provided the same consent, or (ii) I have legal authority to consent on such person's behalf, and I do so by checking this box.

I declare under penalty of perjury that the foregoing information is true and correct to the best of my information and belief. Signed, sworn and certified this _____ day of _____,_____.

Signature:_____

Print name:_____

STATE OF_____

COUNTY OF_____

SWORN TO AND SUBSCRIBED before me by means of ☐ physical presence or ☐ online notarization, this _____ day of _____,_____ by _____, who is ☐ personally known to me or who ☐ has
[Name]
produced_____ as identification.

Signature:_____

Print name:_____

Notary Public - State of_____

My Commission Number:_____

My Commission Expires:_____

[Notary Seal]

PHYSICIAN CERTIFICATION

The undersigned, who is a medical doctor, doctor of osteopathy, or other physician currently licensed to practice medicine in the State of _____, makes the following certification:

1. I am the physician who is primarily responsible for the treatment of _____ (the "Patient").

2. My office address is _____ and my telephone number is _____.

3. The Patient has been diagnosed with the following illness or condition (the "Illness") _____

_____

4. The Illness is a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery.

5. In my reasonable medical judgment, the Illness will, without treatment, be expected to cause death within less than two (2) years from the date of this Certification.

6. I am not related or subordinate to the Patient, and I am not acting as the Patient's attorney-in-fact, agent or designated health care surrogate.

7. I am not related or subordinate to the Patient, and I am not acting as the Patient's attorney-in-fact, agent or designated health care surrogate.

I HEREBY CERTIFY that the foregoing Physician's Certification represents my professional medical assessment of the Patient's diagnosis and prognosis, as of the date of this Certification.

Signed this ____ day of _____, _____

Signature of Physician: _____

Print name: _____

Title: _____

Send Completed Requests To:

Regular Mail

Sila Realty Trust, Inc.
c/o DST Systems, Inc.
P.O. Box 219359
Kansas City, MO 64121-9359

Investors: 833-404-4107

Overnight Mail

Sila Realty Trust, Inc.
c/o DST Systems, Inc.
430 W. 7th Street
Suite #219359
Kansas City, MO 64105-1407