DIVIDEND CAPITAL®

INDUSTRIAL PROPERTY TRUST™

_____
Brokerage Account Number

Physician Certification Form

The undersigned physician hereby certifies, under penalties of perjury as follows:

1. The undersigned is a physician duly licensed and in good standing to practice medicine in the State of _____.

2. In the course of my medical practice, I have examined _____ for the purpose of determining whether he/she is disabled within the meaning of Section 72(m)(7) of the Internal Revenue Code of 1986, as amended (the "Code") and the regulations promulgated there under.

3. Pursuant to Section 72(m)(7) of the Code, I understand that an individual shall be considered to be disabled if: he/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or to be of long-continued and indefinite duration. In determining whether an individual's impairment makes him/her unable to engage in any substantial gainful activity, primary consideration shall be given to the nature and severity of his/her impairment. Consideration shall also be given to other factors such as the individual's education, training and work experience. The substantial gainful activity to which Section 72(m)(7) refers is the activity, or a comparable activity, in which the individual customarily engaged prior to the arising of the disability (or prior to retirement if the individual was retired at the time the disability arose).

4. Based upon my medical examination, I certify that, in my professional medical opinion, [INSERT NAME OF PATIENT]:_____

☐ is disabled within the meaning of Section 72(m)(7) of the Code. This is an initial determination of disability.

☐ was initially determined to be disabled within the meaning of Section 72(m)(7) of the Code on or as of _____, 20_____.

SIGNATURE OF NOTARY

Executed this _____ day of _____, 20 _____.

Signature: _____

Signature: _____, M.D.

State of _____)
) ss.
County of _____)

The foregoing instrument was acknowledged before me this _____ day of _____, 20_____,

by _____.

Witness my hand and official seal.

Signature: _____ Printed Name: _____

My Commission Expires: _____

You may mail this completed form to:

Direct Overnight Mail:
Dividend Capital — Industrial Property Trust
C/O DST Systems Inc.
430 W. 7th Street, Suite 219079
Kansas City, MO 64105

P.O. Box:
Dividend Capital
P.O. Box 219079
Kansas City, MO 64121-9079

Dividend Capital — Industrial Property Trust Contact Information:

Phone	**Web Site**	**E-mail**
866.DCG.REIT (324.7348)	industrialpropertytrust.com	operations@dividendcapital.com

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