REQUEST FOR WAIVER

Global Medical REIT Inc. Dividend Reinvestment and Direct Stock Purchase Plan

This form is to be used only by participants in the Global Medical REIT, Inc. Dividend Reinvestment and Direct Stock Purchase Plan (the "Plan") who are requesting authorization from Global Medical REIT, Inc. ("GMRE") to make an optional cash investment under the Plan in excess of the $1,000 per month investment limit specified in the Plan.

This form must be completed by any participant wishing to make an initial or optional cash investment in the Plan in excess of the $1,000 monthly maximum. In addition, a new form must be completed for each month for which the participant wishes to make an optional cash investment in excess of the $1,000 monthly maximum. This form will not be accepted by GMRE unless it is completed in its entirety. GMRE may accept or reject this request for waiver in whole or in part in its sole discretion.

The participant submitting this form hereby certifies that (a) the information contained herein is true and correct as of the date of this form and (b) the participant has received a current copy of the Prospectus relating to the Plan (the "Prospectus"). This form should be completed and returned via email to bobk@interamc.com or jamieb@globalmedicalreit.com, by 3:00 p.m. Eastern Time on the third business day before the Payment Date (defined below).

GMRE will notify you by telephone by 5:00 p.m. Eastern Time on the second business day before the Payment Date regarding whether this request for waiver is approved and the dollar amount approved and will provide instructions for funds transfer to American Stock Transfer & Trust Company, LLC ("AST"), the Plan Administrator.

Good funds on all accepted requests for waiver must be received by AST by 2:00 p.m. Eastern Time by the fifth (5th) day of each calendar month, unless the 5th falls on a non-business day, in which case payment must be received by the preceding business day (the "Payment Date").

Pricing Period Requested:	**Today's Date:**
Participant Company or Individual Name:	**Cash Investment Amount Requested:**
Individual Authorized to Transact on Account:	**Social Security Number or Tax I.D.:**
Authorized Individual Signature:	**Street Address:**
Existing Account Number or Name as it Appears on Share Certificate (if applicable):	**City:** **State:** **Zip:**
Print Name as it Should Appear on Account and/or Certificate (if applicable):	**Contact Name/Contact Phone Number:**
Contact E-mail Address:	**Contact Fax Number**
Disposition of Shares (check one box): ❑ Hold all shares in my plan account ❑ DWAC full shares to DTC#_____ ($100 fee per DWAC)	

Accepted by Global Medical REIT Inc.	
Investment Date/Pricing Period:	**Approval Date:**
Optional Cash Investment Amount Approved:	**By:**
	Name/Title: