MEDICAL CANNABIS FACILITY APPLICANT INFORMATION SHEET

Primary Point of Contact

First Name | Last Name | Suffix

Title (Enter "N/A" if not applicable)

Entity (Enter "N/A" if not applicable)

Street Address | Suite | City | State | Postal Code

Mobile Number | Email

Alternate Point of Contact

First Name | Last Name | Suffix

Title (Enter "N/A" if not applicable)

Entity (Enter "N/A" if not applicable)

Street Address | Suite | City | State | Postal Code

Mobile Number | Email

Facility

Registration Type: ☐ Cultivation Center | $11,000 ☐ Dispensary | $16,000 ☐ Testing Laboratory | $7,500

Trade Name

Entity or Sole Proprietor

Street Address | Suite | City | State | Postal Code