Office Use Only

License No.	Date Accepted	Accepted By	Hearing Date
Fees Paid $	From To	Issue Date	From To

Date Approved by ABC Board	Board Initials							
Date Denied by ABC Board	Board Initials							

MEDICAL CANNABIS BUSINESS LICENSE APPLICATION

SECTION I | APPLICATION TYPE

Select one.

☐ New ☐ Transfer (with sale of entity or stock) ☐ Transfer (without sale) ☐ Transfer to New Location

SECTION II | LICENSE TYPE

Select one. If selecting Cultivation Center or Manufacturer, you must also select a tier or type.

☐ Courier	☐ Cultivation Center Tier ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6	☐ Internet Retailer	☐ Manufacturer Type ☐ 1 ☐ 2	☐ Retailer

Are you seeking a conditional license? ☐ Yes ☐ No

SECTION III | ENDORSEMENTS (RETAILERS ONLY)

Select all that apply. Please note that a Safe-Use Treatment Facility endorsement is required to obtain a Summer Garden endorsement.

☐ Delivery ☐ Education Tasting ☐ Safe-Use Treatment Facility ☐ Summer Garden

SECTION IV | APPLICANT INFORMATION

Type of Entity ☐ Corporation (for-profit) ☐ Corporation (non-profit)

Business Entity Name

Business Entity Mailing Address City ST Postal Code

Will you be the true and actual owner of the business? If no, explain below and attach affidavit. ☐ Yes ☐ No

Do you currently hold or have you previously held a medical cannabis or adult-use cannabis license in DC or elsewhere? ☐ Yes ☐ No

Provide an explanation below if you checked yes to the above questions.

SECTION V |PRIMARY POINT OF CONTACT INFORMATION

First Name Last Name

Title

Mailing Address *(If different from above)* City ST Postal Code

Phone No. Mobile No. Email

SECTION VI |PROPOSED FACILITY INFORMATION

Trade Name

Facility Address

No. of Floors for Licensed Facility Area _____ No. of Floors for Storage for Licensed Facility Area _____

Safe-Use Treatment Facility *(Retailers Only, if applicable)*

Total Indoor Capacity _____ Total Indoor Seating Capacity _____ Total Summer Garden Capacity _____ Total Summer Garden Seating Capacity _____ Total Occupancy Load _____

No. of Safe Use Treatment Rooms _____

SECTION VII | PROPOSED HOURS

Enter general hours of operation and hours for each endorsement/permitted activity. The latter may not exceed the stated hours of operation.

Hours of Operation

	Hours of Operation
Sunday	Start:_____ am/pm End:_____ am/pm
Monday	Start:_____ am/pm End:_____ am/pm
Tuesday	Start:_____ am/pm End:_____ am/pm
Wednesday	Start:_____ am/pm End:_____ am/pm
Thursday	Start:_____ am/pm End:_____ am/pm
Friday	Start:_____ am/pm End:_____ am/pm
Saturday	Start:_____ am/pm End:_____ am/pm

Hours Open to the Public *(Retailers Only)*

	Hours Open to the Public
Sunday	Start:_____ am/pm End:_____ am/pm
Monday	Start:_____ am/pm End:_____ am/pm
Tuesday	Start:_____ am/pm End:_____ am/pm
Wednesday	Start:_____ am/pm End:_____ am/pm
Thursday	Start:_____ am/pm End:_____ am/pm
Friday	Start:_____ am/pm End:_____ am/pm
Saturday	Start:_____ am/pm End:_____ am/pm

Delivery *(Retailers and Internet Retailers Only)*

	Hours of Delivery
Sunday	Start:_____ am/pm End:_____ am/pm
Monday	Start:_____ am/pm End:_____ am/pm
Tuesday	Start:_____ am/pm End:_____ am/pm
Wednesday	Start:_____ am/pm End:_____ am/pm
Thursday	Start:_____ am/pm End:_____ am/pm
Friday	Start:_____ am/pm End:_____ am/pm
Saturday	Start:_____ am/pm End:_____ am/pm

Safe-Use Treatment Facility *(Retailers Only, if applicable)*

	Hours of Service/Consumption
Sunday	Start:_____ am/pm End:_____ am/pm
Monday	Start:_____ am/pm End:_____ am/pm
Tuesday	Start:_____ am/pm End:_____ am/pm
Wednesday	Start:_____ am/pm End:_____ am/pm
Thursday	Start:_____ am/pm End:_____ am/pm
Friday	Start:_____ am/pm End:_____ am/pm
Saturday	Start:_____ am/pm End:_____ am/pm

Summer Garden *(Retailers Only, if applicable)*

	Hours of Service/Consumption
Sunday	Start:_____ am/pm End:_____ am/pm
Monday	Start:_____ am/pm End:_____ am/pm
Tuesday	Start:_____ am/pm End:_____ am/pm
Wednesday	Start:_____ am/pm End:_____ am/pm
Thursday	Start:_____ am/pm End:_____ am/pm
Friday	Start:_____ am/pm End:_____ am/pm
Saturday	Start:_____ am/pm End:_____ am/pm

Summer Garden *(Retailers Only, if applicable)*

	Hours of Recorded Music
Sunday	Start:_____ am/pm End:_____ am/pm
Monday	Start:_____ am/pm End:_____ am/pm
Tuesday	Start:_____ am/pm End:_____ am/pm
Wednesday	Start:_____ am/pm End:_____ am/pm
Thursday	Start:_____ am/pm End:_____ am/pm
Friday	Start:_____ am/pm End:_____ am/pm
Saturday	Start:_____ am/pm End:_____ am/pm

SECTION VIII|PROPOSED BUSINESS INFORMATION

Will any other business be conducted on the premises? ☐ Yes ☐ No

Will any portion of the premises be used for a private residence or a lodging? ☐ Yes ☐ No

If yes to the above, will there be interior access from the living quarters to the licensed premises? ☐ Yes ☐ No

Does any other ABCA licensed medical cannabis business or employee thereof, or any other individual or corporation have any financial interest directly in this business or any other business holding an ABCA license? ☐ Yes ☐ No

Will you be utilizing hazardous materials, flammable and combustible liquids, compressed gases, cryogenic fluids, or extraction equipment? (Manufacturers only) ☐ Yes ☐ No

Provide an explanation below if you checked yes to any of the above questions. Attach additional pages as needed.

I/we understand that I/we have one-year from ABC Board approval to submit to ABCA: (1) a lease or similar documentation, (2) a security plan, (3) a certificate of occupancy, (4) a permanent medical cannabis facility license application, (5) any remaining or additional owed license or endorsement fees, and any other documentation requested by the Board, and that failure to submit these documents within this timeframe will result in the Conditional License being cancelled by the ABC Board. *(Conditional License Applicants Only)* ☐ Yes ☐ No

What types of medical cannabis products are you requesting approval to manufacture? (Manufacturers only)

What is the size in square feet of your mature plant grow canopy area? (Cultivation Centers only) _____

Enter the name, address, and distance in feet for each ABCA licensed Medical Cannabis Retailer within 400 feet of the proposed licensed premises. (Retailers only)

Retailer	Name	Address	Distance

Enter the name, address, and distance in feet for each of the below facility types within 300 feet of the proposed licensed premises.

	Name	Address	Distance
School			
School			
School			
Recreation Center			

How were the above distances measured? _____

Detail how you will ensure that all employees receive regular training on DC laws, medical cannabis use, security, and theft prevention. Specify any ABC Board approved medical cannabis certified training providers being utilized. Attached supporting documentation, if necessary.

Detail your knowledge of DC and federal law related to medical cannabis. Attach supporting documentation, if necessary.

Detail the source of funds being used to acquire or develop the proposed medical cannabis facility. Attach supporting documentation.

LANDLORD AFFIDAVIT

This authorization form must be completed by the owner of the property that is being leased for the proposed medical cannabis facility location.

First Name | Last Name

Title *(if applicable)*

Business Name *(if applicable)*

Mailing Address | City | ST | Postal Code

Phone No. | Mobile No. | Email

Address of the Proposed Leased Property | City | ST | Postal Code

Are you the true owner and actual owner of the property?	☐ Yes	☐ No
Do you currently hold or have you previously held a medical cannabis business license in DC?	☐ Yes	☐ No
Do you have any direct or indirect financial interest in the medical cannabis business license?	☐ Yes	☐ No
Does another cannabis business have any direct or indirect financial interest in the property or business, including money, equipment, furniture, fixtures, or property either given, rented or loaned?	☐ Yes	☐ No

Provide an explanation below if you checked yes to any of the above questions. Attach additional sheets as needed.

Certification

◯ I hereby certify under penalty of perjury that the information on this affidavit and any attachments are true and correct.

Signature | Date

BUSINESS INFORMATION RELEASE AUTHORIZATION

This authorization form must be completed for your business entity. The signatory must be the President or Vice President if your business entity is a for-profit or non-profit Corporation.

Failure to complete this form may result in delays of obtaining your license and may result in the license being denied if this information cannot otherwise be obtained.

☐ I authorize any agent from the Alcoholic Beverage and Cannabis Administration, to obtain any information, relating to the business entity's activities, financial or lending institutions, credit bureaus, consumer reporting agencies and retail business establishments, or individuals. This information may include all aspects of the business entity.

☐ I release any individual, including records custodians, from all liability for damages that may result to me because of compliance, or any attempts to comply, with this authorization. This release is binding, now and in the future, on my heirs, assignees, associates and personal representative(s) of any nature. Copies of the authorization that show my signature are as valid as the original release signed by me.

☐ I hereby certify under penalty of perjury that the foregoing information is true and correct. I further, hereby, authorize the ABC Board or its employees to investigate any and all of the information provided by me in this application.

Full Legal Name

Title FEIN

Entity Name

Address City ST Postal Code

Signature Date

PERSONAL INFORMATION RELEASE AUTHORIZATION

This authorization form must be completed by each Sole Proprietor, Partner(s), Corporate Officers, Directors of Corporation, Managing Member(s), and General Partner(s).

Failure to complete this form may result in delays of obtaining your license and may result in the license being denied if this information cannot otherwise be obtained.

I authorize any agent from the Alcoholic Beverage and Cannabis Administration, to obtain any information, relating to my activities, from employers, criminal justice agencies, financial or lending institutions, credit bureaus, consumer reporting agencies and retail business establishments, or individuals. This information may include, but is not limited to, my residential, personal, or criminal history record and financial and credit information.

I further authorize release of my criminal history from criminal justice agencies for the purposes of determining my eligibility for a liquor license as either a licensee and/or investor. I understand that the information released is for official use by the Alcoholic Beverage and Cannabis Administration, and that these users may re--disclose this information as authorized by law.

I release any individual, including records custodians, from all liability for damages that may result to me because of compliance, or any attempts to comply, with this authorization. This release is binding, now and in the future, on my heirs, assignees, associates and personal representative(s) of any nature. Copies of the authorization that show my signature are as valid as the original release signed by me.

I hereby certify under penalty of perjury that the foregoing information is true and correct. I further, hereby, authorize the ABC Board or its employees to investigate any and all of the information provided by me in this application.

First and Last Name SSN No. (XXX-XX-XXXX)

Other Names

☐ Sole Proprietor	☐ Partner	☐ Corporate Officer	☐ Managing Member	☐ General Partner

Home Address City ST Postal Code

Mobile Phone Email

Applicant Signature Date

PERSONAL HISTORY AFFIDAVIT

This affidavit must be completed by Sole Proprietor, Partner(s), Corporate Officer(s), Director(s), Managing Member(s), General Partner(s), Investor(s), or any person or any officer in an entity that has an ownership interest of one (1) percent.

Application Type ☐ New ☐ Transfer (with sale of entity or stock) ☐ Transfer (without sale: change location)

Entity Name | Trade Name

Licensed Premises Address | City | ST | Postal Code

Licensed Premises Phone | Licensed Premises Email

Applicant First and Last Name | Title

Home Address | City | ST | Postal Code

Mobile Phone | Email

Date of Birth | Place of Birth (City, State, Country)

Are you eligible to work in the U.S.? ☐ Yes ☐ No

Document Type ☐ U.S. Passport ☐ Drivers License ☐ Naturalization Papers ☐ Work Permit ☐ Green Card ☐ Visa

Credential No:		Expiration Date:	

Have you ever:

- Applied for or received a cannabis business license in DC or any state or territory? ☐ Yes ☐ No
- Had any cannabis business suspended or revoked in DC or any state or territory? ☐ Yes ☐ No

Do you or any member of your immediate family hold an ABCA license (alcohol or cannabis) or have any financial interest, directly or indirectly, in any alcohol or cannabis establishment in DC? ☐ Yes ☐ No

If yes to any of the above, provide an explanation below.

◯ I hereby certify under penalty of perjury that the information in this application is true and correct.

Applicant Signature | Date

SUMMARY OF SHARES/PERCENTAGES OF INTEREST

This form must be completed by all persons that own stock or own 1 percent interest or more in the entity.

Entity Name Trade Name

First and Last Name	Title	Email Address	No. of Shares	% of Interest

☐ I hereby certify under penalty of perjury that the information in this application is true and correct.

First and Last Name Signature Date

First and Last Name Signature Date

First and Last Name Signature Date

First and Last Name Signature Date

First and Last Name Signature Date

First and Last Name Signature Date

First and Last Name Signature Date