

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.

<input type="checkbox"/> Courier	<input type="checkbox"/> Cultivation Center Tier <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	<input type="checkbox"/> Internet Retailer	<input type="checkbox"/> Manufacturer Type <input type="checkbox"/> 1 <input type="checkbox"/> 2	<input type="checkbox"/> Retailer
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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

<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Partner	<input type="checkbox"/> Corporate Officer	<input type="checkbox"/> Managing Member	<input type="checkbox"/> General Partner
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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:	_____
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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

Does 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