

MEDICAL MARIJUANA



Registration Application Form [Agency Name]

Phone: ###-###-#### Fax: ###-###-####

Type of Action

- New Medical Marijuana Facility
- Medical Marijuana Facility Registration Renewal (Registration #: _____)

Facility Information

Facility Legal Name: _____

Facility DBA Name (if applicable): _____

Facility Physical Address: _____
Street City County ZIP

Mailing Address (if different): _____
Street City ZIP

Phone: _____ Email: _____

Fax: _____ Website: _____

Secretary of State Business Registration #: _____

May OHA publish and make public the location of this facility? Yes No

Person Responsible for Facility (PRF) Information

Name of PRF: _____

Home Address: _____
Street City State Zip

Mailing Address (if different): _____
Street City ZIP

Phone: _____ Fax: _____ Email: _____

ODL or Oregon ID Card #: _____

I certify the information on this application is true and correct to the best of my knowledge. I understand my application may be returned as incomplete, denied, or the facility's registration revoked for making false statements in connection with this application for registration I have reviewed and understand the facility rules in OAR 333, Division 008. By signing this application I attest that I have legal authority to act on behalf of the facility and business named above and that if the facility is registered I am accountable for any intentional or unintentional action of its owners, officers, managers, employees or agents, with or without my knowledge, violate ORS 475.314 or OAR 333-008-1000 to 333-008-XXXX.

Signature of PRF: _____ Date: _____

Printed Name of PRF: _____

DRAFT

Additional application requirements:

- Application Attachments
 - Security system preliminary information (alarms, cameras, locks, floorplan)
 - Fee payment
- Separate Form
 - Background check request
 - Fingerprint submission
 - Background check fee
- Mailed Separately
 - Proof of residency
 - Zoning document from governmental entity
 - Maps

DRAFT