

Medical Marijuana Business Change

(Submit this form **before** making any changes to corporate structure, ownership structure or financial interest with any individual.)

Section 1 — Current business information

Business name (as registered by the secretary of state):		MMD or MMPS number:	
Mailing address:			
City:		State:	ZIP:
Primary PRP or primary PRD name:			
Phone number:		Email address:	

Section 2 — Proposed business change

Describe the proposed change. If it involves the financial interest change of an individual, include that person's full legal name. You may attach documents to provide more information:

Section 3 — Required documentation

You must submit this form and any criminal background check documents and fees, if applicable, **before** making the change proposed. If you do not submit this form according to the rules, you may be subject to civil penalties or your registration may be suspended or revoked.

The Oregon Medical Marijuana Program will review the form and other submitted information. The change will be approved if it would not result in an application denial under OAR 333-008-1060 or 333-008-1670, or serve as the basis of a registration suspension or revocation. The registrant may proceed with the proposed change *only* after receiving the program's written approval.

If the change is the financial interest of any individual in the business, the following items **must** also be submitted with this form:

- A **Medical Marijuana Individual History** form ([OHA 9251](#)) for each new individual listed
- A copy of a government issued photo ID for each new individual listed
- Background check application and fee (*please follow the instructions on Oregon Health Authority web page at <https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/Pages/background-check.aspx>*)
- Proof the proposed business entity has filed an application to register as a business with the Oregon Office of the Secretary of State
- Please attach a list of all individuals who have a financial interest in the business.

Section 4 — Signature (*required*)

I understand the program cannot review this form unless I submit the information required under OAR 333-008-2030.

I certify I am the primary person responsible for the dispensary (primary PRD) or primary person responsible for the processing site (primary PRP) as defined under OAR 333-008-1010 and OAR 333-008-1610.

By signing below, I certify the information on this form is true and correct to the best of my knowledge. I understand if any of the statements on this form are found to be false, the program may deny, suspend or revoke my registration.

Signature (<i>required</i>)	Printed name	Date / /
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Oregon Medical Marijuana Program, P.O. Box 14450, Portland, OR 97293
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