## Medical Marijuana Dispensary Permit Application

You may apply for one dispensary permit in this application for any of the Medical Marijuana Regions listed below. A separate application must be submitted for each primary dispensary location sought by the applicant. Please see the Medical Marijuana Organization Permit Application Instructions for a table of the counties within each Medical Marijuana Region and the number of dispensary permits to be issued in each Medical Marijuana Region. The primary dispensary location may be in any county within the Medical Marijuana Region. An applicant has the option of listing two additional dispensary locations on the permit application but is not required to do so. The second and third dispensary locations must be within the same Medical Marijuana Region as the primary dispensary location. The second and third dispensary locations are not permitted to be in the same county as the primary dispensary location. In addition, the second and third dispensary locations are not permitted to be in the same county.

**Please check one of the following to indicate the Medical Marijuana Region, and specify the county, for which you are applying for a dispensary permit:**

[ ]  Northwest [ ]  Northcentral [ ]  Northeast

[ ]  Southwest [ ]  Southcentral [ ]  Southeast

County 1 (Primary Dispensary Location): Text Here

County 2 (if applicable): Text Here

County 3 (if applicable): Text Here



## Medical Marijuana Dispensary Permit Application

## Part A - Applicant Identification and Dispensary Information

## **(Scoring Method: Pass/Fail)**

For this part, the applicant is required to provide contact information for the business or individual applying for a dispensary permit, the primary dispensary location, along with any second or third dispensary locations that are being sought under the application.

### Section 1 – Applicant Name, Address and Contact Information

**Business or Individual Name and Principal Address**

|  |
| --- |
| **Business Name, as it appears on the applicant’s certificate of incorporation, charter, bylaws, partnership agreement or other legal business formation documents:**TEXT HERE |
| **Other trade names and DBA (doing business as) names:**TEXT HERE |
| **Business Address:** TEXT HERE |
| **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |

[ ] **Primary Contact –** (Please note:If an initial permit fee needs to be refunded, the check will be made payable to the business name provided above, in care of the primary contact, at the primary contact’s mailing address provided below.)

|  |
| --- |
| **Name:** TEXT HERE |
| **Address:** TEXT HERE |
| **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |

### Section 2 – Dispensary Information

The applicant is required to provide a primary dispensary location. The applicant may include a second or third location under this application. A second or third location may be added to a dispensary permit at a later date through the filing of an application for additional dispensary location.

|  |  |  |
| --- | --- | --- |
| By checking “Yes,” you affirm that you possess the ability to obtain in an expeditious manner the right to use sufficient land, buildings and other premises and equipment to properly carry on the activity described in the medical marijuana dispensary permit application, and any proposed location for a dispensary. | [ ] Yes | [ ] No |

Primary Dispensary Location (please indicate dispensary name as you would like it to appear on the dispensary permit)

|  |
| --- |
| **Facility Name:** TEXT HERE |
| **Address:** TEXT HERE |
| **City:** TEXT HERE | **State: PA** | **Zip Code:** 55555 |
| **County:** TEXT HERE | **Municipality:** TEXT HERE |
| Please provide a description of the public access to the dispensary location, including any local public transportation that may be available:Please limit your response to no more than 5,000 words. |

Second Dispensary Location

|  |
| --- |
| **Facility Name:** TEXT HERE |
| **Address:** TEXT HERE |
| **City:** TEXT HERE | **State: PA** | **Zip Code:** 55555 |
| **County:** TEXT HERE | **Municipality:** TEXT HERE |
| Please provide a description of the public access to the dispensary location, including any local public transportation that may be available:Please limit your response to no more than 5,000 words. |

Third Dispensary Location

|  |
| --- |
| **Facility Name:** TEXT HERE |
| **Address:** TEXT HERE |
| **City:** TEXT HERE | **State: PA** | **Zip Code:** 55555 |
| **County:** TEXT HERE | **Municipality:** TEXT HERE |
| Please provide a description of the public access to the dispensary location, including any local public transportation that may be available:Please limit your response to no more than 5,000 words. |

## Part B – Diversity Plan

## **(Scoring Method: 100 Points)**

In accordance with section 615 of the Act (35 P.S. § 10231.615), an applicant shall include with its application a diversity plan that promotes and ensures the involvement of diverse participants and diverse groups in ownership, management, employment, and contracting opportunities. Diverse Participants include individuals from diverse racial, ethnic and cultural backgrounds and communities; women; veterans; and individuals with disabilities. Diverse Groups include the following businesses that have been certified by a third-party certifying organization or that have been verified by the Department of General Services Bureau of Diversity, Inclusion and Small Business Opportunities: a disadvantaged business, minority-owned business, and women-owned business as those terms are defined in 74 Pa. C.S. § 303(b); and a service-disabled veteran-owned small business or veteran-owned small business as those terms are defined in 51 Pa. C.S. § 9601.

## Section 3 – Diversity Plan

|  |  |  |
| --- | --- | --- |
| By checking “Yes,” the applicant affirms that it has a diversity plan that establishes a goal of opportunity and access in employment and contracting by the medical marijuana organization. The applicant also affirms that it will make a good faith effort to meet the diversity goals outlined in the diversity plan. Changes to the diversity plan must be approved by the Department of Health in writing. By checking “Yes,” the applicant agrees to report participation level and involvement of Diverse Participants and Diverse Groups in the form and frequency required by the Department, and to provide any other information the Department deems appropriate regarding ownership, management, employment, and contracting opportunities by Diverse Participants and Diverse Groups. |  [ ]  Yes[ ]  Yes | [ ]  No[ ]  No |

|  |
| --- |
| Diversity Plan – Equal opportunity and access in employment (75 points)In narrative form, describe a plan that establishes a goal of diversity in ownership, management, and employment to ensure that diverse participants and diverse groups are afforded equality of opportunity. to the extent available, include the following:1. The diversity status of the Principals, Operators, Financial Backers, and Employees of the Medical Marijuana Organization.
2. An official affirmative action plan for the Medical Marijuana Organization.
3. Internal diversity goals adopted by the Medical Marijuana Organization.
4. A plan for diversity-oriented outreach or events the Medical Marijuana Organization will conduct to support its diversity goals in ownership, management, and employment.
5. Any materials from the Medical Marijuana Organization’s mentoring, training, or professional development programs for diverse groups.
6. Any other information that demonstrates the Medical Marijuana Organization’s commitment to workforce and employment diversity practices.
7. A workforce utilization report including the following information for each job category within the Medical Marijuana Organization:
	1. The total number of persons employed in each job category,
	2. The total number of men employed in each job category,
	3. The total number of women employed in each job category,
	4. The total number of veterans employed in each job category,
	5. The total number of service-disabled veterans employed in each job category, and
	6. The total number of members of each racial minority employed in each job category.
8. A narrative description of your ability to record and report on the components of the diversity plan.

Please limit your response to no more than 5,000 words. |

|  |
| --- |
| Diversity Plan – Equal opportunity and access in contracting (25 points)Indicate the total percentage of revenues that the Medical Marijuana Organization will pay to Diverse Groups as contractors of the Medical Marijuana Organization for the full permit term. The percentage of revenues will be used to calculate a score for Equal opportunity and access in contracting as detailed in the Medical Marijuana Permit Application – Diversity Plan Scoring Matrix. List the total anticipated dollar amount of those revenues to be paid to Diverse Groups as contractors of the Medical Marijuana Organization for the full permit term. Provide the name of each Diverse Group and a valid certificate issued by a third-party certifying organization (Unified Certification Program (UCP), Woman’s Business Enterprise National Council (WBENC), National Minority Supplier Development Council (NMSDC), United States Small Business Administration (SBA) 8(a) Program, or Vets First Verification Program (vetbiz.gov)) or a valid Small Diverse Business verification issued by the Department of General Services, Bureau of Diversity, Inclusion and Small Business Opportunities to demonstrate the entity is a Diverse Group. Provide the percentage of revenues the Medical Marijuana Organization will pay to each Diverse Group and the total anticipated dollar amount of revenues the Medical Marijuana Organization will pay to each Diverse Group. A Medical Marijuana Organization will only receive points in this section for the percentage of revenues it will pay to entities with proof of Diverse Group status provided with the application. Points for this section will be based upon the following formula:Total percentage of revenues that the Medical Marijuana Organization will pay to Diverse Groups as contractors ÷ 4 = Equal Opportunity and Access in Contracting score. |

## Part C – Applicant Information

## **(Scoring Method: Pass/Fail)**

For this part the applicant is required to provide contact information for the principals, financial backers, operators and employees.

## Section 4 – Principals, Financial Backers, Operators and Employees

**A. Please list all Principals, Financial Backers and Operators**

|  |
| --- |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** TEXT HERE |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** TEXT HERE |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** TEXT HERE |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** TEXT HERE |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** TEXT HERE |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** TEXT HERE |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** TEXT HERE |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |

If more space is required, please submit additional information on other individuals in a separate document titled “Principals, Financial Backers and Operators (Contd.)” in accordance with the attachment file name format requirements and include it with the attachments.

**B. Please list all Employees**Please provide the following information for any employees that have been hired to date to work for the applicant. If no employees are currently employed, please leave this section blank.

|  |
| --- |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** TEXT HERE |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** TEXT HERE |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** TEXT HERE |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** TEXT HERE |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** TEXT HERE |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |

If more space is required, please submit additional information on other individuals in a separate document titled “Employees (Contd.)” in accordance with the attachment file name format requirements and include it with the attachments.

## Section 5 – Moral Affirmation

|  |  |  |
| --- | --- | --- |
| By checking “Yes,” you affirm that each principal, financial backer, operator and employee listed in this permit application is of good moral character. |  [ ]  Yes | [ ]  No |

## Section 6 – Compliance with Applicable Laws and Regulations

|  |  |  |
| --- | --- | --- |
| By checking “Yes,” you affirm that you, as well as the principals, financial backers, operators and employees listed in this permit application are able to continuously comply with all applicable Commonwealth laws and regulations relating to the operation of a medical marijuana dispensary. | [ ] Yes | [ ] No |

## Section 7 – Civil and Administrative Action

|  |
| --- |
| For the statements below:* By checking “Yes,” you affirm the statement
* If you check “No,” you must state your reasoning in “Schedule A” below
 |
| **Civil and Administrative Action** | **Yes** | **No** |
| The applicant has never responded to an action resulting in sanctions, disciplinary actions or civil monetary penalties being imposed relating to a registration, license, permit or any other authorization to grow, process or dispense medical marijuana in any state. |[ ] [ ]
| The applicant has never responded to a civil or administrative action relating to a registration, license, permit or authorization to grow, process or dispense medical marijuana in any state. |[ ] [ ]
| The applicant has never been accused of obtaining a registration, license, permit or other authorization to operate as a grower, processor or dispensary of medical marijuana in any jurisdiction by fraud, misrepresentation, or the submission of false information. |[ ] [ ]
| No civil or administrative action has been taken against the applicant under the laws of the Commonwealth or any other state, the United States or a military, territorial or tribal authority relating to a principal, operator, financial backer or employee of the applicant’s profession, or occupation or fraudulent practices, including fraudulent billing practices. |[ ] [ ]

|  |
| --- |
| **Schedule A: Civil and Administrative Action**  |
| **Defendant** | **Name of Case & Docket #** | **Nature of Charge or Complaint** | **Date of Charge or Complaint** | **Disposition** | **Name and Address of the Administrative Agency Involved, and the Tribunal or Court** |
| TEXT HERE | TEXT HERE | TEXT HERE | TEXT HERE | TEXT HERE | TEXT HERE |
| TEXT HERE | TEXT HERE | TEXT HERE | TEXT HERE | TEXT HERE | TEXT HERE |
| TEXT HERE | TEXT HERE | TEXT HERE | TEXT HERE | TEXT HERE | TEXT HERE |
| TEXT HERE | TEXT HERE | TEXT HERE | TEXT HERE | TEXT HERE | TEXT HERE |

## Part D – Plan of Operation

## **(Scoring Method: 675 Points)**

A Plan of Operation is required for all dispensary permit applications. The Plan of Operation must include a timetable outlining the steps the applicant will take to become operational within six months from the date of issuance of a permit. The plan of operation must also describe how the applicant’s proposed business operations will comply with statutory and regulatory requirements necessary for the continued operation of the facility.

## Plan of Operation

**What must be covered in a Plan of Operation?**Applicants must identify how they will comply with relevant laws and temporary regulations regarding:

* Security and Surveillance
* Employee qualifications and training
* Transportation of medical marijuana and medical marijuana products
* Storage of medical marijuana products
* Inventory management
* Recordkeeping
* Prevention of unlawful diversion of medical marijuana and medical marijuana products
* A timetable outlining the steps required for the applicant to become operational within six months from the date of issuance of a dispensary permit

|  |  |  |
| --- | --- | --- |
| By checking “Yes,” you affirm that you are able to continuously maintain effective security, surveillance and accounting control measures to prevent diversion, abuse and other illegal conduct regarding medical marijuana and medical marijuana products. |  [ ]  Yes | [ ] No |

## Section 8 – Operational Timetable

|  |
| --- |
| If issued a permit, please describe the steps and timeframes for becoming fully operational as a dispensary within six months from the date of issuance of a dispensary permit. Specifically, please provide the steps you will take to begin the process for the handling, storing, and transporting of medical marijuana and medical marijuana products. |
| **Activity** | **Estimated Date** |
| TEXT HERE | TEXT HERE |
| TEXT HERE | TEXT HERE |
| TEXT HERE | TEXT HERE |
| TEXT HERE | TEXT HERE |
| TEXT HERE | TEXT HERE |
| TEXT HERE | TEXT HERE |
| TEXT HERE | TEXT HERE |

If more space is required for the Operational Timetable, please submit additional information in a separate document titled “Operational Timetable (Contd.)” in accordance with the attachment file name format requirements and include it with the attachments.

## Section 9 – Employee Qualifications, Description of Duties and Training

|  |
| --- |
| 1. Please provide a description of the duties, responsibilities, and roles of each principal, financial backer, operator and employee.
 |
| 1. TEXT HERE
 |
| 1. TEXT HERE
 |
| 1. TEXT HERE
 |
| 1. TEXT HERE
 |
| 1. TEXT HERE
 |
| 1. TEXT HERE
 |
| 1. TEXT HERE
 |
| 1. TEXT HERE
 |

|  |
| --- |
| 1. Please describe the qualifications of each principal and employee.
 |
| 1. TEXT HERE
 |
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|  |
| --- |
| 1. Please describe the steps the applicant will take to assure that each principal and employee will meet the two-hour training requirement under the Act and temporary regulations.
 |
| 1. TEXT HERE
 |
| 1. TEXT HERE
 |
| 1. TEXT HERE
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| 1. TEXT HERE
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| 1. TEXT HERE
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| 1. TEXT HERE
 |
| 1. TEXT HERE
 |
| 1. TEXT HERE
 |

If more space is required for any of the above three components of Section 9 (A, B and C), please submit additional information in a separate document titled “Employee Qualifications, Description of Duties and Training (Contd.)” in accordance with the attachment file name format requirements and include it with the attachments.

|  |  |  |
| --- | --- | --- |
| 1. **Licensed Medical Professionals at Facility**
 | **Yes** | **No** |
| By checking “Yes,” you affirm that licensed medical professionals at the dispensary will adhere to the following: If you check “No” to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and temporary regulations. |  |  |
| A physician or a pharmacist will be present at the primary dispensary location listed in this permit application at all times during the hours the primary dispensary facility is open to dispense or to offer to dispense medical marijuana to patients and caregivers. |[ ] [ ]
| If the applicant is operating any dispensaries in addition to the primary dispensary location listed under the permit, and a physician or pharmacist is not present onsite at the additional dispensary or dispensaries, a physician assistant or a certified registered nurse practitioner will be present onsite at each of the other dispensaries instead of a physician or pharmacist. |[ ] [ ]
| Any physician, pharmacist, physician assistant or certified registered nurse practitioner employed by a dispensary will, prior to assuming any duties at the dispensary facility, successfully complete a four-hour training course developed by the Department. |[ ] [ ]

Please provide an explanation of any responses above that were answered as a “No” and how you will meet these requirements by the time the department determines you to be operational under the Act and temporary regulations:

Please limit your response to no more than 5,000 words.

## Section 10 – Security and Surveillance

A dispensary must have security and surveillance systems, utilizing commercial-grade equipment, to prevent unauthorized entry and to prevent and detect diversion, theft, or loss of any medical marijuana or medical marijuana products.

|  |
| --- |
| Please provide a summary of your proposed security and surveillance equipment and measures that will be in place at your proposed facility and site. These measures should cover, but are not limited to, the following: general overview of the equipment, measures and procedures to be used, alarm systems, surveillance system, storage, recording capability, records retention, premises accessibility, and inspection/servicing/alteration protocols.Please limit your response to no more than 5,000 words. |

## Section 11 – Transportation of Medical Marijuana

|  |  |  |
| --- | --- | --- |
| 1. **Transportation**
 | **Yes** | **No** |
| By checking “Yes,” you affirm that any delivery of medical marijuana to any other medical marijuana organization or approved laboratory within the Commonwealth will adhere to the following: If you check “No” to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and temporary regulations. |  |
| * Medical marijuana will only be delivered between 7 a.m. and 9 p.m.
 |[ ] [ ]
| * Medical marijuana will not be transported to any location outside of this Commonwealth.
 |[ ] [ ]
| * A global positioning system will be used to ensure safe, efficient delivery of the medical marijuana to a medical marijuana organization.
 |[ ] [ ]
| In addition to having a transport vehicle staffed with a delivery team consisting of at least two individuals, the applicant affirms the following: |  |
| * At least one delivery team member will remain with the vehicle at all times that the vehicle contains medical marijuana.
 |[ ] [ ]
| * Each delivery team member shall have access to a secure form of communication with the dispensary, such as a cellular telephone, at all times that the vehicle contains medical marijuana.
 |[ ] [ ]
| * Upon demand, each delivery team member shall produce an identification badge or card to the Department or its authorized agents, law enforcement or other Federal, State, or local government officials if necessary to perform the government officials’ functions and duties.
 |[ ] [ ]
| * Each delivery team member will have a valid driver’s license.
 |[ ] [ ]
| * While on duty, a delivery team member will not wear any clothing or symbols that may indicate ownership or possession of medical marijuana.
 |[ ] [ ]
| * Medical marijuana stored inside the transport vehicle may not be visible from the outside of the transport vehicle.
 |[ ] [ ]
| * A delivery team shall proceed in a transport vehicle from the dispensary, where the medical marijuana is loaded, directly to the medical marijuana organization, where the medical marijuana is unloaded, without unnecessary delays. Notwithstanding the foregoing, a transport vehicle may make stops at multiple facilities, as appropriate, to deliver medical marijuana.
 |[ ] [ ]
| * Any vehicle accidents, diversions, losses, or other reportable events that occur during transport of medical marijuana must be immediately reported to the Department either through a designated phone line established by the Department or by electronic communication with the Department in a manner prescribed by the Department.
 |[ ] [ ]
| * The Department shall be notified daily of the dispensary’s delivery schedule, including routes and delivery times, either through a designated phone line established by the Department or by electronic communication with the Department in a manner prescribed by the Department.
 |[ ] [ ]
| * A transport vehicle is subject to inspection by the Department or its authorized agents, law enforcement or other Federal, State or local government officials if necessary to perform the government officials’ functions and duties.
 |[ ] [ ]
| * A transport vehicle may be stopped and inspected along its delivery route or at any medical marijuana organization.
 |[ ] [ ]
| * If a third-party contractor is used, the contractor must comply with all the transportation requirements listed in the Act and temporary regulations.
 |[ ] [ ]
| 1. **Transport Manifest**
 | **Yes** | **No** |
| By checking “Yes” to any statement, you affirm that the transport manifest (printed or electronic) that accompanies every transport vehicle will contain the following information and meet the following requirements: If you check “No” to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and temporary regulations. |  |
| * The name, address and permit number of the medical marijuana organization receiving the delivery, and the name of and contact information for a representative of the medical marijuana organization.
 |[ ] [ ]
| * The quantity, by weight or unit, of each medical marijuana harvest batch, harvest lot or process lot contained in the transport, along with the identification number for each harvest batch, harvest lot or process lot.
 |[ ] [ ]
| * The date and approximate time of departure.
 |[ ] [ ]
| * The date and approximate time of arrival.
 |[ ] [ ]
| * The transport vehicle’s make, model, and license plate number.
 |[ ] [ ]
| * The identification number of each member of the delivery team accompanying the transport.
 |[ ] [ ]
| * When a delivery team delivers medical marijuana to multiple medical marijuana organizations, the transport manifest must correctly reflect the specific medical marijuana in transit; each recipient will also provide the dispensary with a printed receipt for the medical marijuana received.
 |[ ] [ ]
| * All medical marijuana being transported must be packaged in shipping containers and labeled in accordance with §§ 1151.34 and 1161.28 (relating to packaging and labeling of medical marijuana; and labels and safety inserts).
 |[ ] [ ]
| • Separate copies of the transport manifest will be provided to each recipient receiving the medical marijuana product described in the transport manifest. To maintain confidentiality, a dispensary may prepare separate manifests for each recipient. |[ ] [ ]
| * The applicant acknowledges that, upon request, a copy of the printed transport manifest, and any printed receipts for medical marijuana being transported, will be provided to the Department or its authorized agents, law enforcement, or other Federal, State, or local government officials if necessary to perform the government officials’ functions and duties.
 |[ ] [ ]

Please provide an explanation of any responses above that were answered as a “No” and how you will meet these requirements by the time the department determines you to be operational under the Act and temporary regulations:

Please limit your response to no more than 5,000 words.

|  |
| --- |
| 1. Please describe your plan regarding the transportation of medical marijuana and medical marijuana products. For example, explain whether you plan to maintain your own transportation operation as part of the facility operation, or whether you will use a third-party contractor. If you choose to use your own transportation operation, please provide the number and type of vehicles that will be used to transport medical marijuana and medical marijuana products, the training that will be provided to employees that will transport medical marijuana and medical marijuana products, and any additional measures you will take to prevent diversion during transport. If you will be using a third-party contractor for transporting medical marijuana and medical marijuana products, please explain the steps you will take to guarantee the third-party contractor will be compliant with the transportation requirements under the Act and temporary regulations:

Please limit your response to no more than 5,000 words. |

## Section 12 – Storage of Medical Marijuana

|  |  |  |
| --- | --- | --- |
| 1. **Storage Requirements**
 | **Yes** | **No** |
| By checking “Yes” to any statement, you affirm that the plan of operation will address the below statements:If you check “No” to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and temporary regulations. |  |
| * There will be separate, locked, limited access areas for the storage of medical marijuana that is expired, damaged, deteriorated, mislabeled, contaminated, recalled, or whose containers or packaging have been opened or breached, until the medical marijuana is returned to a grower/processor, destroyed or otherwise disposed of, as required by § 1151.40 (relating to the management and disposal of medical marijuana waste).
 |[ ] [ ]
| * All storage areas will be maintained in a clean and orderly condition and free from infestation by insects, rodents, birds, and pests.
 |[ ] [ ]
| * A separate and secure area for temporary storage of medical marijuana that is awaiting disposal will be established.
 |[ ] [ ]

Please provide an explanation of any responses above that were answered as a “No” and how you will meet these requirements by the time the Department determines you to be operational under the Act and temporary regulations:

Please limit your response to no more than 5,000 words.

1. Please describe your plans regarding the storage of medical marijuana and medical marijuana products within your facility:

 Please limit your response to no more than 5,000 words.

## Section 13 – Labeling of Medical Marijuana Products

|  |  |  |
| --- | --- | --- |
| 1. **Labeling Requirements**
 | **Yes** | **No** |
| By checking “Yes” to any statement, you affirm that the applicant will implement a quality control process to ensure that the label does not bear any of the following: |  |
| * Any resemblance to the trademarked, characteristic or product-specialized packaging of any commercially available food or beverage product.
 |[ ] [ ]
| * Any statement, artwork or design that could reasonably lead an individual to believe that the package contains anything other than medical marijuana.
 |[ ] [ ]
| * Any seal, flag, crest, coat of arms, or other insignia that could reasonably mislead an individual to believe that the product has been endorsed, manufactured, or approved for use by any State, county or municipality or any agency thereof.
 |[ ] [ ]
| * Any cartoon, color scheme, image, graphic or feature that might make the package attractive to children.
 |[ ] [ ]

## Section 14 – Inventory Management

|  |  |  |
| --- | --- | --- |
| 1. **Electronic Tracking System**
 | **Yes** | **No** |
| By checking “Yes,” the applicant acknowledges the obligation to use the electronic tracking system prescribed by the Department containing the requirements in section 701 of the Act (35 P.S. § 10231.701). |[ ] [ ]
| By checking “Yes,” the applicant acknowledges that an electronic tracking system that is approved by the Department will be deployed to log, verify and monitor the receipt of medical marijuana product from a grower/processor, the verification of the validity of an identification card presented by a patient or caregiver, the dispensing of medical marijuana product to a patient or caregiver, the disposal of medical marijuana waste and the recall of defective medical marijuana. |[ ] [ ]

|  |  |  |
| --- | --- | --- |
| 1. **Inventory Management**
 | **Yes** | **No** |
| By checking “Yes” to any statement, you affirm that each dispensary will maintain the following inventory data in its electronic tracking system:If you check “No” to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and temporary regulations. |  |
| * Medical marijuana received from a grower/processor.
 |[ ] [ ]
| * Medical marijuana dispensed to a patient or caregiver.
 |[ ] [ ]
| * Damaged, defective, expired, or contaminated medical marijuana awaiting return to a grower/processor or awaiting disposal.
 |[ ] [ ]
| * Inventory controls and procedures will be established for the conducting of monthly inventory reviews and annual comprehensive inventories of medical marijuana at the facility.
 |[ ] [ ]
| * The written or electronic record will include the date of the inventory, a summary of the inventory findings, and the employee identification numbers and titles or positions of the individuals who conducted the inventory.
 |[ ] [ ]

Please provide an explanation of any responses above that were answered as a “No” and how you will meet these requirements by the time the department determines you to be operational under the Act and temporary regulations:

Please limit your response to no more than 5,000 words.

1. Please describe your approach regarding the implementation of an inventory management process. This approach must also include a process that provides for the recall of medical marijuana products and the management of medical marijuana product returns from you to the originating grower/processor:

Please limit your response to no more than 5,000 words.

## Section 15 – Diversion Prevention

|  |
| --- |
| 1. Please provide a summary of the procedures that you will implement at each proposed facility for the prevention of the unlawful diversion of medical marijuana and medical marijuana products, along with the process that will be followed when evidence of theft/diversion is identified:

Please limit your response to no more than 5,000 words. |

## Section 16 – Sanitation and Safety

|  |
| --- |
| 1. Please provide a summary of the intended sanitation and safety measures to be implemented at each proposed facility listed in the permit application. These measures should cover, but not be limited to, the following: a written process for contamination prevention, pest protection procedures, medical marijuana product handler restrictions, and hand-washing facilities.

Please limit your response to no more than 5,000 words. |

## Section 17 – Recordkeeping

|  |
| --- |
| 1. Please provide a summary of your recordkeeping plan at each proposed facility listed in the permit application. This plan should cover, but is not limited to, records of inventory and all dispensing transactions:

Please limit your response to no more than 5,000 words. |

## Part E – Applicant Organization, Ownership, Capital and Tax Status

## **(Scoring Method: 75 Points)**

## Section 18 – Organizational Structure

|  |
| --- |
| **Applicant’s Form of Organization** |
| **Check One**[ ]  **C-Corporation**  [ ]  **S-Corporation** [ ]  **Limited Liability Company**[ ]  **Sole Proprietorship** [ ]  **Partnership** [ ]  **Limited Liability Partnership**[ ]  **Limited Liability Limited Partnership** [ ]  **Non-Profit Organization** [ ]  **Other (explain):** TEXT HERE |

|  |
| --- |
| **Applicant’s Organization Documents** |
| **State of Incorporation or Registration:** TEXT HERE | **Date of Formation:** MM/DD/YYYY |
| **Business Name on Formation Documents:** TEXT HERE |

|  |
| --- |
| **Applicant’s Identification Numbers** |
| **Federal Employer ID number:** a refund cannot be processed without the applicant’s Federal Employer ID NumberTEXT HERE | **PA Unemployment Compensation Account Number:**TEXT HERE |
| **PA Department of Revenue Tax number (if applicant is currently doing business in Pennsylvania):**TEXT HERE | **PA Workers’ Compensation Policy Number (if applicant is currently doing business in Pennsylvania):**TEXT HERE |

|  |  |  |
| --- | --- | --- |
| By checking “Yes,”the applicant affirms that workers’ compensation insurance will be obtained by the time the Department determines you to be operational under the Act and temporary regulations. |  [ ]  Yes | [ ]  No |

## Section 19 – Business History and Capacity to Operate

|  |
| --- |
| Describe your business history and your ability and plan to maintain a successful and financially sustainable operation:Please limit your response to no more than 5,000 words. |

## Section 20 – Current Officers

Provide the position, title in the applicant’s business, and address information for all current officers, directors, partners or trustees.

|  |
| --- |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** Text Here. |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
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If more space is required, please submit additional information on other officers in a separate document titled “Current Officers (Contd.)” in accordance with the attachment file name format requirements and include it with the attachments.

## Section 21 – Ownership

In this section, list all persons with a controlling interest in the business, defined as follows:

(1)  For a publicly traded company, voting rights that entitle a person to elect or appoint one or more of the members of the board of directors or other governing board, or the ownership or beneficial holding of 5% or more of the securities of the publicly traded company.

(2)  For a privately held entity, the ownership of any security in the entity.

Complete the appropriate section(s) below:

1. For C-corporations, S-corporations, LLCs and LLLCs

|  |
| --- |
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| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Stock type or class:**TEXT HERE | **Number of shares held:**TEXT HERE | **Date Acquired:** MM/DD/YYYY | **Percentage of outstanding voting stock:**TEXT HERE | **Terms, conditions, rights and privileges:**TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
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If more space is required, please submit additional information on other owners of the corporation in a separate document titled “Corporate Ownership (Contd.)” in accordance with the attachment file name format requirements and include it with the attachments.

1. For partnerships and LLPs

|  |
| --- |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
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| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Partner Type:**[ ]  **General/Full Partner**[ ]  **Limited Partner**[ ]  **Dormant/Silent Partner**[ ]  **Other**: TEXT HERE | **Percentage of ownership:**TEXT HERE | **Partnership participation from:**MM/DD/YYYY | **Description of participation in operation of the applicant:**TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
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| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
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| **Partner Type:**[ ]  **General/Full Partner**[ ]  **Limited Partner**[ ]  **Dormant/Silent Partner**[ ]  **Other**: TEXT HERE | **Percentage of ownership:**TEXT HERE | **Partnership participation from:**MM/DD/YYYY | **Description of participation in operation of the applicant:**TEXT HERE |
| **Name and Residential Address** |
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If more space is required, please submit additional information on other partners in a separate document titled “partner Ownership(Contd.)” in accordance with the attachment file name format requirements and include it with the attachments.

1. Other persons holding an interest in the proposed site or facility

List any other persons holding an interest in the proposed site or facility, that are otherwise not disclosed in sections A or B.

|  |
| --- |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
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| **Address Line 1:** TEXT HERE | **Address Line 2:** Text Here. |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Nature, type, terms and conditions of the interest in the applicant:**TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** Text Here. |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Nature, type, terms and conditions of the interest in the applicant:**TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** Text Here. |
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| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Nature, type, terms and conditions of the interest in the applicant:**TEXT HERE |
| **Name and Residential Address** |
| **First Name:** TEXT HERE | **Middle Name:** TEXT HERE | **Last Name:** TEXT HERE | **Suffix:** 55555 |
| **Occupation:** TEXT HERE | **Title in the applicant’s business:** TEXT HERE |
| **Also known as:** TEXT HERE | **Date of birth:** MM/DD/YYYY |
| **Address Line 1:** TEXT HERE | **Address Line 2:** Text Here. |
| **Address Line 3:** TEXT HERE | **City:** TEXT HERE | **State:** WW | **Zip Code:** 55555 |
| **Phone:** TEXT HERE | **Fax:** TEXT HERE | **Email:** TEXT HERE |
| **Nature, type, terms and conditions of the interest in the applicant:**Text Here. |

If more space is required, please submit additional information on other persons holding an interest in the proposed site or facility in a separate document titled “Other Persons Holding an Interest(Contd.)” in accordance with the attachment file name format requirements and include it with the attachments.

## Section 22 – Capital Requirements

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| Provide an estimated spending plan to be used for you to become operational within six months from the date of issuance of the permit:Please limit your response to no more than 5,000 words. |

## Part F – Community Impact

## **(Scoring Method: 100 Points)**

## Section 23 – Community Impact

|  |
| --- |
| please be advised, Letters of Recommendation or Support will not be considered when evaluating this application. Please refer to the Permit Application Instructions for the Community Impact Scoring Matrix. Provide a summary of how the applicant intends to have a positive impact on the community where its operations are proposed to be located:Please limit your response to no more than 5,000 words. |