**MEDICAL MARIJUANA ORGANIZATION PERMIT APPLICATION, CLINICAL REGISTRANT**

Attachments

The following attachments A through K must be submitted in conjunction with a Medical Marijuna Grower/Processor or Dispensary Permit Application. Attachment L must be completed in conjuction with any application where the applicant files multiple applications and the applicant wishes to designate priorities. Instructions for each attachment are at the beginning of each attachment.

**Attachment A:** Signature Page

**Attachment B:** Organizational Documents

**Attachment C:** Property Title, Lease, or Option to Acquire Property Location

**Attachment D:** Site and Facility Plan

**Attachment E:** Personal Identification

**Attachment F:** Affidavit of Business History

**Attachment G:** Affidavit of Criminal Offense

**Attachment H:** Tax Clearance Certificates

**Attachment I:** Affidavit of Capital Sufficiency

**Attachment J:** Sample Medical Marijuana Product Label (for Grower/Processor applicants only)

**Attachment K:** Release Authorization

**Attachment L:** Applicant Prioritization of Multiple Applications

## Attachment A: Signature Page

Instructions:

**This attachment is the signature page for your application.**

* Please review the application
* By checking the appropriate boxes, indicate the sections that are included in your submission
* Print this attachment
* Sign the document
* Scan this sheet and save it as a file called “Attachment A,” using the appropriate file name format

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| --- | --- | --- |
| By checking “Yes,” you acknowledge that you have read the Medical Marijuana Organization Permit Application Instructions before completing an application for a medical marijuana organization permit. | Yes | No |

The applicant hereby submits this application for a Medical Marijuana Organization Permit to the Pennsylvania Department of Health, which consists of the completed application and attachments listed below:

Fees:

Application Fee

Permit Fee

Application:

Completed Application, including Completed Application for Approval of a Clinical Registrant

Redacted Application

Written statement signed by an applicant representative stating that all redactions made by the applicant constitute trade secret or confidential proprietary information as defined under the Right-to-Know Law

Other Attachments:

Attachment B: Organizational Documents

Attachment C: Property Title, Lease, or Option to Acquire Property Location

Attachment D: Site and Facility Plan

Attachment E: Personal Identification

Attachment F: Affidavit of Business History

Attachment G: Affidavit of Criminal Offense

Attachment H: Tax Clearance Certificates

Attachment I: Affidavit of Capital Sufficiency

Attachment J: Sample Medical Marijuana Product Label (for Grower/Processor applicants only)

Attachment K: Release Authorization

Attachment L: Applicant Priorities for Multiple Applications

Background Checks:

The applicant has requested background checks, as described in the instructions.

Additional attachments:

Please list any other electronic documents submitted as part of this application:

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| --- | --- | --- |
| File Name | Name of Document | Purpose |
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**A false statement made in this application is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).**

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Signature Title in Applicant’s Business Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

**A false statement made in this application is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Signature Title in Applicant’s Business Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

**A false statement made in this application is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Signature Title in Applicant’s Business Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name

A photocopy, facsimile or other electronic version of this document shall be accepted as an original signature.

## Attachment B: Organizational Documents

Instructions:

* Attach certified copies of the applicant’s certificate of incorporation, partnership agreement, charter or other such documentation. If the applicant is not organized in Pennsylvania, attach certified copies of documentation that show that the applicant is authorized to do business in Pennsylvania
* Complete this cover sheet. Scan this sheet and the organizational documents and save it as a PDF file called “Attachment B,” using the appropriate file name format

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

## Attachment C: Property Title, Lease, or Option to Acquire Property Location

Instructions:

* Attach one of the following:
* Evidence of the applicant’s clear legal title to or option to purchase the proposed site and facility
* A fully-executed copy of the applicant’s unexpired lease for the proposed site and facility and a written statement from the property owner that the applicant may operate a medical marijuana organization on the proposed site for, at a minimum, the term of the permit
* Other evidence that shows that the applicant has a location to operate its medical marijuana organization
* Complete this cover sheet. Scan this sheet and the appropriate document(s) and save it as a PDF file called “Attachment C,” using the appropriate file name format

|  |  |  |
| --- | --- | --- |
| Business Name, as it appears on the applicant’s certificate of incorporation, charter, bylaws, partnership agreement or other official documents: | | |
| Trade names and DBA (doing business as) names: | | |
| Principal Business Address: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | Email: |

## Attachment D: Site and Facility Plan

Instructions:

* Applicants must show that they can expeditiously obtain a site and facility to meet the activities described in the permit by attaching one of the following:
  + If the facility is in existence at the time the permit application is submitted, submit plans and specifications drawn to scale for the interior of the facility
  + If the facility is in existence at the time the permit application is submitted, and the applicant plans to make alterations to the facility, submit renovation plans and specifications for the interior and exterior of the facility
  + If the facility does not exist at the time the permit application is submitted, submit a plot plan that shows the proposed location of the facility and an architect’s drawing of the facility, including a detailed drawing, to scale, of the interior of the facility
* The applicant also must submit evidence that the applicant is in compliance or will be in compliance with the municipality’s zoning requirements
* Complete this cover sheet. Scan this sheet and the appropriate documents and save it as a PDF file called “Attachment D,” using the appropriate file name format

|  |  |  |
| --- | --- | --- |
| Business Name, as it appears on the applicant’s certificate of incorporation, charter, bylaws, partnership agreement or other official documents: | | |
| Trade names and DBA (doing business as) names: | | |
| Principal Business Address: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | Email: |

## Attachment E: Personal Identification

Instructions:

* For each principal, financial backer, operator and employee, attach the following:

1. A curriculum vitae or resume, maximum of two pages
2. A verification of identity satisfactory to the Department, including but not limited to the following forms of verification of identity:

* A valid and unexpired Pennsylvania Photo Driver’s License
* A valid and unexpired Pennsylvania Photo Identification Card
* A valid and unexpired Pennsylvania Photo Exempt Driver's License
* A valid and unexpired Pennsylvania Photo Exempt Identification Card
* A valid and unexpired U.S. Armed Forces Common Access Card
* A valid and unexpired U.S. passport
* **Please note:** Personal identification only needs to be supplied once for each individual, regardless of whether the individual serves in multiple capacities, such as owner and principal
* Complete this cover sheet. Scan this sheet and the curricula vitae or resume and identification documents and save as a PDF file called “Attachment E,” using the appropriate file name format

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| --- | --- | --- |
| Business Name, as it appears on the applicant’s certificate of incorporation, charter, bylaws, partnership agreement or other official documents: | | |
| Trade names and DBA (doing business as) names: | | |
| Principal Business Address: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | Email: |

## Attachment F: Affidavit of Business History

**Affidavit of Business History**

Instructions:

* Each principal or operator of the applicant must complete the Affidavit of Business History
* **Please note:** The Department will accept individual affidavits from each principal, operator, financial backer and employee or one affidavit signed by a principal or operator that includes every principal, operator, financial backer and employee
* Execute and notarize the affidavit and save as a PDF file called “Attachment F,” using the appropriate file name format. A cover sheet is not needed

State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby certifies the following:

During the 10 years preceding the submission date of the permit application, the following principal(s), operator(s), financial backer(s) and employee(s), have held a position of management or ownership of a controlling interest in any other business in this Commonwealth or any other jurisdiction involving the manufacturing or distribution of medical marijuana or a controlled substance:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of individual** | **Role (principal, operator, financial backer or employee)** | **Business name and address** | **Position of management or ownership of a controlling interest** | **Dates** |
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I hereby certify that I am authorized to execute this affidavit on behalf of the applicant and that the information contained herein is true and correct and that there is no misrepresentation, falsification or omissions in this affidavit. I am further aware that any false or misleading statement or omitted information is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Signature of Affiant and Title Date

Sworn to and subscribed before me this \_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

MY COMMISSION EXPIRES:

An electronic version of this document shall be accepted as an original signature.

## Attachment G: Affidavit of Criminal Offense

**Affidavit of Criminal Offense**

Instructions:

* Each principal or operator of the applicant must complete the Affidavit of Criminal Offense
* **Please note:** The Department will accept individual affidavits from each principal, operator, and financial backer or one affidavit signed by a principal or operator that includes every principal, operator, and financial backer. If you are unsure if a conviction must be disclosed, please list the conviction in the interest of full disclosure.
* Execute and notarize the affidavit as instructed and save as a PDF file called “Attachment G,” using the appropriate file name format. A cover sheet is not needed

State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby certifies the following by checking the boxes below:

**Principal(s):**

No principal(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.

One or more principals listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.

If one or more principal(s) listed in this permit application has been convicted of a criminal offense graded higher than a summary offense, please provide below the name(s) of the principal(s) and the offense(s) of which one or more principal(s) was convicted.

Name(s ): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Offense(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Operator(s):**

No operator(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.

One or more operator(s) listed in this permit application has been convicted of a criminal offense graded higher than a summary offense.

If one or more operator(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense, please provide below the name(s) of the operator(s) and the offense(s) of which one or more operator(s) was convicted.

Name(s ): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Offense(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Backer(s):**

No financial backer(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.

One or more financial backer(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.

If one or more financial backer(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense, please provide below the name(s) of the financial backer(s) and the offense(s) of which one or more financial backer(s) was convicted.

Name(s ): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Offense(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Signature of Affiant and Title Date

Sworn to and subscribed before me this \_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

MY COMMISSION EXPIRES:

An electronic version of this document shall be accepted as an original signature.

## Attachment H: Tax Clearance Certificates

Instructions:

* This form authorizes the Pennsylvania Department of Revenue (DOR) and the Pennsylvania Department of Labor and Industry (L&I) to review the tax records of the applicant and its principals and other persons affiliated with the applicant, as part of the permit application review by the Pennsylvania Department of Health (Department)
* Your signature on this form is required and represents a waiver of confidentiality of this information. Your signature allows DOR and L&I to provide tax information to the Department
* If the applicant’s business is not at a stage where a tax clearance certificate is available, the application may be considered to be complete if the applicant provides a copy of [PA-100, PA Enterprise Registration Form](https://www.revenue.pa.gov/FormsandPublications/FormsforBusinesses/BusinessRegistration/Documents/pa-100.pdf)
* Complete this cover sheet. Scan this sheet with the completed Application for a Tax Clearance Review and save it as a PDF file called ”Attachment H,” using the appropriate file name format

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| --- | --- | --- |
| Business Name, as it appears on the applicant’s certificate of incorporation, charter, bylaws, partnership agreement or other official documents: | | |
| Trade names and DBA (doing business as) names: | | |
| Principal Business Address: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | Email: |

Application for a Tax Clearance Review

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name listed on tax return Employer Identification Number or Social Security Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip Code

I certify that I am the individual whose tax records are to be reviewed. If the tax records are for an entity, I certify that I am an authorized signatory for the applicant.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Signature of officer or authorized signatory Telephone number Date

An electronic version of this document shall be accepted as an original signature.

## Attachment I: Affidavit of Capital Sufficiency

Instructions:

* The applicant must submit an affidavit stating that the applicant meets the capital requirements set forth in §1141.30 (relating to capital requirements)
* **Please note:** There are two affidavits available, one for a grower/processor applicant and one for a dispensary applicant
* Execute and notarize the appropriate affidavit and save as a PDF file called “Attachment I,” using the appropriate file name format. A cover sheet is not needed

## Attachment I-1: Affidavit of Capital Sufficiency for a Grower/Processor Permit Applicant

**COMMONWEALTH OF PENNSYLVANIA**

**DEPARTMENT OF HEALTH**

**AFFIDAVIT OF CAPITAL SUFFICIENCY**

State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I/WE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS PHONE

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CITY STATE ZIP CODE COUNTY

## For the following applicant:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF BUSINESS

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS PHONE

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CITY STATE ZIP CODE COUNTY

hereby certify that the Applicant named has at least $2,000,000 in capital, $500,000 of which is on deposit with one or more financial institutions, as follows (capital may include cash or securities, real estate, or other assets):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type of Capital** | **Source of Capital** | **Total Value of Capital** | **Value not encumbered by debt or other obligations** | **If on deposit, name and address of financial institution** | **If on deposit, account number** |
|  |  |  |  |  |  |
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I hereby certify that I am authorized to execute this affidavit on behalf of the applicant and that the information contained herein is true and correct and that there is no misrepresentation, falsification or omissions in this affidavit. I am further aware that any false or misleading statement or omitted information is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_

Signature of Affiant and Title Date

Sworn to and subscribed before me this \_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

MY COMMISSION EXPIRES:

An electronic version of this document shall be accepted as an original signature.

## Attachment I-2: Affidavit of Capital Sufficiency for a

## Dispensary Permit Applicant

**COMMONWEALTH OF PENNSYLVANIA**

**DEPARTMENT OF HEALTH**

**AFFIDAVIT OF CAPITAL SUFFICIENCY**

State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I/WE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS PHONE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY STATE ZIP CODE COUNTY

For the following applicant:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

NAME OF BUSINESS

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS PHONE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY STATE ZIP CODE COUNTY

hereby certify that the Applicant named has at least $150,000 on deposit with one or more financial institutions, as follows:

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Capital** | **Source of Capital** | **Name and address of financial institution** | **Account number** |
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I hereby certify that I am authorized to execute this affidavit on behalf of the applicant and that the information contained herein is true and correct and that there is no misrepresentation, falsification or omissions in this affidavit. I am further aware that any false or misleading statement or omitted information is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Affiant and Title

Sworn to and subscribed before me this \_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

MY COMMISSION EXPIRES:

An electronic version of this document shall be accepted as an original signature.

## Attachment J: Sample Medical Marijuana Product Label

Instructions: **Please note:** Attachment J is only required for Grower/Processor applicants.

* Provide a sample label for each medical marijuana product you expect to produce
* Complete this cover sheet. Scan this sheet and the sample labels and save it as a PDF file called “Attachment J,” using the appropriate file name format

|  |  |  |
| --- | --- | --- |
| Business Name, as it appears on the applicant’s certificate of incorporation, charter, bylaws, partnership agreement or other official documents: | | |
| Trade names and DBA (doing business as) names: | | |
| Principal Business Address: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | Email: |

## Attachment K: Release Authorization

Instructions:

* Execute the following release authorization
* Scan the completed, executed and notarized release authorization below and save it as a PDF file called “Attachment K,” using the appropriate file name format. No cover sheet is needed

RELEASE AUTHORIZATION

TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Do not write above this line – For Department of Health Only)

FROM: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s Name

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, by and on behalf of the undersigned applicant, have filed a permit application with the Pennsylvania Department of Health (“Department”). I certify that I am authorized by the applicant to submit this Release Authorization on its behalf and to bind the applicant to all provisions within this Release Authorization. I understand that the applicant is seeking the granting of a privilege and acknowledge that the burden of proving the applicant’s qualifications and suitability for a favorable determination is at all times the burden of the applicant.

I understand that a background investigation may be conducted by the Department pursuant to its statutory duty to investigate the character, honesty, integrity and suitability of myself and any entity with which I am associated. I further understand and agree that I am voluntarily executing this Release Authorization to expressly authorize and permit the Department to obtain any and all information it deems necessary, and accept any risk of adverse public notice, embarrassment, criticism, or other action or financial loss which may result from action with respect to this permit application.

The rights and powers herein are granted to facilitate the background investigation being conducted by the Department at my request and on behalf of the applicant and is not otherwise intended to create or establish a legal or fiduciary relationship between the Department, its agents and employees, and me. I hereby acknowledge that no such relationship exists.

1. I hereby authorize and request every person, firm, company, corporation, board, association or institution of any kind, and every Federal, state or local government entity, including but not limited to every court, law enforcement agency, criminal justice agency or probation department, without exception, both foreign and domestic, to whom this Release Authorization is presented having any knowledge, information, documents, forms, photographs, computer files, accounts, ledgers or other items about, relating to or concerning the applicant and to fully discuss with and answer any inquiry made by any duly authorized investigator of the Pennsylvania Department of Health.
2. If this Release Authorization is presented to any brokerage firm, bank, savings and loan, or other financial institution or officer of same, I hereby authorize and request any and all documents, records or correspondence pertaining to the applicant, including but not limited to past loan information, notes, checking account records, savings deposit records, safe deposit box records, passbook records and general ledger folio sheets.
3. I hereby authorize an agent of the Department to obtain and review copies of any and all documents, records or correspondence pertaining to myself and the applicant, and I hereby authorize any Federal, state or municipal agency or body, law enforcement agency or criminal justice agency or department, tax agency or authority, regulatory agency, authority or body, to make full and complete disclosure of any and all information and documents including, but not limited to, documents and information otherwise privileged or not subject to public disclosure, as well as other information on file or available concerning the applicant.
4. This Release Authorization extends to the review and copy of any information protected by law or contact from disclosure, privilege or obligation.
5. I do for the applicant, as well as for myself, my heirs, executors, administrators, successors and assigns, hereby release, remise, exonerate and forever discharge the Department, its members, agents and employees, the Commonwealth of Pennsylvania and its instrumentalities, and any agents and employees thereof, from any and all liabilities including but not limited to all manner of actions, causes of action, suits, debts, judgments, executions, claims, and demands whatsoever, known and unknown, in law or equity, which exist now or in the future against those entities and persons other than relating to a willfully unlawful disclosure or publication of material or information acquired during my investigation.
6. I do for the applicant, as well as for myself, my heirs, administrators, successors and assigns, hereby release, remise, exonerate and forever discharge every person, firm, company, corporation, board, association or institution of any kind, and every Federal, state or local government entity, including but not limited to every court, law enforcement agency, criminal justice agency or probation department, without exception, both foreign and domestic, to whom this request is presented, and any agents or employees thereof, from any and all liabilities, including but not limited to all manner of actions, causes of action, suits, debts, judgments, executions, claims and demands whatsoever, known or unknown, in law or equity, which exist now or in the future against those entities and persons to whom this request is presented, and any agents or employees thereof, arising out of or by reason of the furnishing or inspection of documents, records or other information released in compliance with a request made pursuant to, or as a result of, having been presented with, this Release Authorization.
7. The applicant agrees to indemnify and hold harmless the Department, its officials and employees and every person, firm, company, corporation, board, association or institution of any kind, and every Federal, state or local government agency, to whom this request is presented and form and against all claims, damages, losses, and expenses including reasonable attorneys’ fees arising out of or by reason of, the acts permitted and provided for in the Release Authorization.
8. I agree that a reproduction of this request by photocopy, facsimile or other similar process shall be for all intents and purposes as valid as the original.

IN WITNESS WHEREOF, I have executed this Release on this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_, 20\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Signatory

STATE OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COUNTY OF

On this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_, 20\_\_, before me, a Notary Public, personally appeared \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (known to me or satisfactorily proven) to be the person whose name is subscribed in this Release, and acknowledged that he/she executed the same for the purposes herein contained.

IN WITNESS THEREOF, I hereunto set my hand and official seal.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

MY COMMISSION EXPIRES:

An electronic version of this document shall be accepted as an original signature**.**

# Attachment L: Applicant Priorities for Multiple Applications

Instructions:

* This attachment is for applicants who are submitting multiple medical marijuana organization permit applications and for applicants submitting multiple applications for approval of a clinical registrant naming more than one Academic Clinical Research Center (ACRC). Use this attachment to indicate which Medical Marijuana Region you prefer for issuance of a permit and for prioritization of ACRCs. Not completing and providing Attachment L as part of your application indicates that you have no preference.
* If you submit this completed form more than once, the last form the Department receives will represent your prioritization. This form cannot be submitted without being part of an application
* If you elect to submit this attachment, please scan the completed form and save it as a PDF file called “Attachment L,” using the appropriate file name format.

|  |  |  |
| --- | --- | --- |
| Business Name, as it appears on the applicant’s certificate of incorporation, charter, bylaws, partnership agreement or other official documents: | | |
| Trade names and DBA (doing business as) names: | | |
| Principal Business Address: | | |
| City: | State: | Zip Code: |
| Phone: | Fax: | Email: |

1. **Priorities for Multiple Grower/Processor Permit Applications**

Please check one of the following:

The applicant would like to make the Department aware of the applicant’s priorities as listed below

The applicant has no preference regarding Medical Marijuana Regions

|  |  |
| --- | --- |
| MEDICAL MARIJUANA REGION | PRIORITY (If you intend to submit a permit application for more than one Medical Marijuana Region, please rank your preferred region from 1-6, with 1 being the highest ranking) |
| 1. Southeast | Priority \_\_ |
| 1. Northeast | Priority \_\_ |
| 1. Southcentral | Priority \_\_ |
| 1. Northcentral | Priority \_\_ |
| 1. Southwest | Priority \_\_ |
| 1. Northwest | Priority \_\_ |

1. **Priorities for Multiple Dispensary Permit Applications**

Please check one of the following:

The applicant would like to make the Department aware of the applicant’s priorities as listed below

The applicant has no preference regarding Medical Marijuana Regions

|  |  |
| --- | --- |
| MEDICAL MARIJUANA REGION | PRIORITY (If you intend to submit a permit application for more than one Medical Marijuana Region, please rank your preferred region from 1-6, with 1 being the highest ranking) |
| 1. Southeast | Priority \_\_ |
| 1. Northeast | Priority \_\_ |
| 1. Southcentral | Priority \_\_ |
| 1. Northcentral | Priority \_\_ |
| 1. Southwest | Priority \_\_ |
| 1. Northwest | Priority \_\_ |

1. **Priorities for ACRCs**

Please check one of the following:

☐ The applicant would like to make the Department aware of the applicant’s priorities as listed below

☐ The applicant has no preference regarding ACRC

|  |  |
| --- | --- |
| CERTIFIED ACRC | PRIORITY (If you intend to submit multiple applications naming more than one ACRC, please rank your preferred ACRC from 1-8, with 1 being the highest ranking) |

|  |  |
| --- | --- |
| Drexel University School of Medicine | Priority \_\_ |
| Penn State College of Medicine | Priority \_\_ |
| Lake Erie College of Osteopathic Medicine (LECOM) | Priority \_\_ |
| Philadelphia College of Osteopathic Medicine | Priority \_\_ |
| Perelman School of Medicine at the University of Pennsylvania | Priority \_\_ |
| Lewis Katz School of Medicine at Temple University | Priority \_\_ |
| University of Pittsburgh School of Medicine | Priority \_\_ |
| Sidney Kimmel Medical College at Thomas Jefferson University | Priority \_\_ |