

Bureau of Medical Marijuana: Medical Marijuana Organization Contact Confirmation Card

As per your Duty to Report requirement under 1141.38 (a)(1), Medical Marijuana Organizations are required to ensure the Bureau of Medical Marijuana has current contact information for your business and facility location/s.

Permit Number: Click or tap here to enter text.

Permit Name: Click or tap here to enter text.

Primary Business Contact Information

The primary business contact is an executive member of the organization who can be contacted for high priority, and potentially sensitive, business requests and updates. Business address information should match the address of the permit holder.

The table below includes the information we have on record. Please correct any inaccurate information and add any missing information.

Name: Click or tap here to enter text.	Position: Click or tap here to enter text.
Email: Click or tap here to enter text.	Phone Number: Click or tap here to enter text.
Mailing Street Address: Click or tap here to enter text.	
City: Click or tap here to enter text.	State: Click or tap here to enter text.
Zip Code: Click or tap here to enter text.	

Facility Contact Information

The facility contact is someone who is on site at the facility most days, who is able to answer questions about the facility and who has authority within the facility. The facility address listed should be the physical address of the facility and/or the associated USPS address for this facility.

Please provide contact information for the following facility:

Facility Name*: _____

* Note - the facility names are used by the DOH to uniquely identify the facility and cannot be updated.

Facility Address: _____

Facility County: _____

Name: Click or tap here to enter text.	Position: Click or tap here to enter text.
Email: Click or tap here to enter text.	Phone Number: Click or tap here to enter text.
Mailing Street Address (if different from Facility Address): Click or tap here to enter text.	
City: Click or tap here to enter text.	State: Click or tap here to enter text.
Zip Code: Click or tap here to enter text.	

Date of form submission: Click or tap here to enter text. **Printed name of submitter:** Click or tap here to enter text.

Check this box to certify that the person completing this form is affiliated with the Medical Marijuana Organization for whom the form is being submitted.