



MARIHUANA FACILITY

BUSINESS LICENSE APPLICATION

OFFICE OF THE CITY CLERK

300 W. 13 MILE RD.

MADISON HEIGHTS, MI 48071

(248) 583-0826 / FAX (248) 588-0204

**FEE: \$5000.00/LICENSE TYPE ANNUALLY
LICENSE EXPIRES ON DECEMBER 31st**

RENEWALS ARE DUE NOVEMBER 1st

I hereby apply for a license to operate a marihuana facility within the City of Madison Heights in compliance with the Code of Ordinances of the City of Madison Heights. (Article XVI and Article XVII, Appendix A of Zoning Ordinances, Article IV and IX)

** an asterisk denotes information that will be kept confidential to the extent allowed by law*

NEW RENEWAL

APPLICATION MUST BE COMPLETED IN FULL (4 PAGES)

A.

MEDICAL PROCESSING MEDICAL PROVISIONING MEDICAL TRANSPORT MEDICAL COMPLIANCE

FACILITY TYPE (check all that apply):

ADULT-USE PROCESSING ADULT-USE RETAIL ADULT-USE TRANSPORT ADULT-USE COMPLIANCE

FACILITY NAME:

PHONE:

FACILITY ADDRESS:

Madison Heights, MI

street

city

state

zip

APPLICANT / FACILITY

OWNER NAME:

PHONE:

* APPLICANT / FACILITY

OWNER HOME ADDRESS:

street

city

state

zip

* DATE OF BIRTH: / /

EMAIL ADDRESS:

FACILITY MANAGER NAME:

PHONE:

(individual responsible for overall operating)

(If different from Medical Marihuana applicant/facility owner)

* FACILITY MANAGER

HOME ADDRESS:

street

city

state

zip

* DATE OF BIRTH: / /

EMAIL ADDRESS:

FACILITY LANDLORD NAME:

PHONE:

please continue on to the next page...

REQUIREMENTS:

- Copy of Applicant / Facility Owner's Driver's License or State ID *
- Copy of Facility Manager's Driver's License or State ID (if applicable) *
- Copy of all findings from inspections, investigations and audits conducted by the state department of licensing and regulatory affairs and any other state department or agency pertaining to applicants, licensees, proposed medical marihuana facilities, and adult-use marihuana facility operations

OFFICE USE ONLY

DEPARTMENT APPROVAL:

POLICE: _____ BUILDING: _____ TREASURY: _____

Issued by:

DATE:

LICENSE NO. (S) _____

& TYPE: _____

FEE: No. License types x \$5000 =

LICENSE(s) EXPIRE: _____

PAID

OTC

MAIL

B.**1) APPLICANT ENTITY TYPE:** SOLE PROPRIETORSHIP CORPORATION LIMITED LIABILITY COMPANY PARTNERSHIP OTHER: _____**2) PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH INDIVIDUAL HAVING ANY OF THE FOLLOWING:**

(1) the actual power to control the operation, management or policies of the marihuana facility or legal entity which operates the marihuana facility, (2) ownership of a financial interest of ten (10) percent or more of a business or of any class of voting securities of a business, or (3) holding an office (e.g., president, vice president, secretary, treasurer, managing member, managing director, etc.) in a legal entity which operates the marihuana facility.

NAME:	* DATE OF BIRTH:		* PHONE:	
	street	city	state	zip

NAME:	* DATE OF BIRTH:		* PHONE:	
	street	city	state	zip

NAME:	* DATE OF BIRTH:		* PHONE:	
	street	city	state	zip

NAME:	* DATE OF BIRTH:		* PHONE:	
	street	city	state	zip

NAME:	* DATE OF BIRTH:		* PHONE:	
	street	city	state	zip

NAME:	* DATE OF BIRTH:		* PHONE:	
	street	city	state	zip

please continue on to the next page...

*** 3) PLEASE LIST ALL PERSONS WHO WILL BE EMPLOYED EITHER PART-TIME OR FULL-TIME AT THE MARIHUANA FACILITY:** * *all information will be withheld from disclosure unless compelled by law*

NAME:	DATE OF BIRTH:	PHONE:
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ADDRESS:	street	city	state	zip
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JOB TITLE:	
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NAME:	DATE OF BIRTH:	PHONE:
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ADDRESS:	street	city	state	zip
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JOB TITLE:	
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ADDRESS:	street	city	state	zip
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JOB TITLE:	
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ADDRESS:	street	city	state	zip
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JOB TITLE:	
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NAME:	DATE OF BIRTH:	PHONE:
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ADDRESS:	street	city	state	zip
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JOB TITLE:	
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4) FOR PERSONS IDENTIFIED IN SUBSECTIONS A, B-2, AND B-3, PLEASE LIST ANY ASSUMED NAMES OR ALIASES THEY HAVE BEEN KNOWN BY IN THE LAST FIVE YEARS:

please continue on to the next page...

*** 5) WHO IS THE PRIMARY CONTACT FOR QUESTIONS CONCERNING THIS APPLICATION?:**

Name: _____

Title: _____ Phone: _____

Email: _____

CERTIFICATION: By signing the following, I/we agree and certify:

- (A) To supplement the information contained in this application within 10 business days of any change in application information.
- (B) That the location of the marihuana facility complies with the locational requirements set forth in the City of Madison Heights Code of Ordinances.
- (C) That the information contained herein is true, complete, and accurate.
- (D) To provide any other information that may be requested to assist the City of Madison Heights with the review of this application or issuance of this license

I/we understand that the failure to provide the information and documentation required by this application may result in the denial of this application. This license(s) may be revoked if the application for a marihuana facility Certificate of Occupancy is denied or revoked by the Building Department.

*This application must be signed by each individual identified in response to **Section A**, it must also be notarized.*

STOP! Sign only in front of a Notary:

FACILITY OWNER:
(APPLICANT)

FACILITY MANAGER:
(IF APPLICABLE)

Signed: _____

Signed: _____

Print: _____

Print: _____

Title: _____

Title: _____

Subscribed and sworn to before me this _____
day of _____, 20 _____. _____

Subscribed and sworn to before me this _____
day of _____, 20 _____. _____

, Notary Public

, Notary Public

County, Michigan

County, Michigan

My Commission Expires: _____

My Commission Expires: _____

* In accordance with the Madison Heights Code of Ordinances mandated in Section 7-27: No license shall be issued or renewed under the provisions of this chapter or any other ordinance of the city until any and all personal property taxes, levied and assessed against such person by the city which may be due and payable at the time of the filing of the application

* Note: New dwelling or new owner must obtain a new Certificate of Occupancy from the Building Department