MEDICAL MARIHUANA FACILITY

BUSINESS LICENSE APPLICATION
OFFICE OF THE CITY CLERK
ONE CITY SQUARE, SUITE 205
WARREN, MI 48093-2393
(586) 574-4557 / FAX (586) 574-4556

FEE: $50.00 ANNUALLY
LICENSE EXPIRES ONE YEAR FROM DATE OF ISSUANCE
10% late fee for renewal applications received after this date

I hereby apply for a license to operate a medical marihuana facility within the City of Warren in compliance with the Code of Ordinances of the City of Warren. (Ordinance No. 30-1020, Appendix A of Zoning Ordinances, Section 17.02 (aa))

** 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.

FACILITY NAME: PHONE:

FACILITY ADDRESS: Warren, 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)* *****

OFFICE USE ONLY

DEPARTMENT APPROVAL:

POLICE: ☐ BUILDING: ☐

Issued by: Computer Entry ☐ Paper License ☐

LICENSE EXPIRES: ____________________ FEE $ 50.00

LATE FEE $ ________

MEDICAL MARIHUANA FACILITY LICENSE NO. ____________________

☐ 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 medical marihuana facility or legal entity which operates the medical 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 medical marihuana facility.

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

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

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

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

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

NAME:	*** DATE OF BIRTH:**		*** PHONE:**
ADDRESS:			
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 MEDICAL MARIHUANA FACILITY:** **all information will be witheld from disclosure unless compelled by law*

NAME:	DATE OF BIRTH:	PHONE:
ADDRESS:		
street	city	state zip
JOB TITLE:		

NAME:	DATE OF BIRTH:	PHONE:
ADDRESS:		
street	city	state zip
JOB TITLE:		

NAME:	DATE OF BIRTH:	PHONE:
ADDRESS:		
street	city	state zip
JOB TITLE:		

NAME:	DATE OF BIRTH:	PHONE:
ADDRESS:		
street	city	state zip
JOB TITLE:		

NAME:	DATE OF BIRTH:	PHONE:
ADDRESS:		
street	city	state zip
JOB TITLE:		

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 medical marihuana facility complies with the locational requirements set forth in the City of Warren 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 Warren 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 may be revoked if the application for a medical marihuana facility Certificate of Compliance is denied or revoked by the Building and Inspection Division.

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 ________	**Subscribed and sworn to before me this ________**
day of _________________________, 20________.	**day of _________________________, 20________.**
, Notary Public	, Notary Public
County, Michigan	County, Michigan
My Commission Expires: ______________	My Commission Expires: ______________

*** In accordance with the Warren Code of Ordinances mandated in Section 18-9: 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 Compliance from the Building Department**