



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. FACILITY TYPE (check all that apply):
MEDICAL PROCESSING MEDICAL PROVISIONING MEDICAL TRANSPORT MEDICAL COMPLIANCE

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:
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:		
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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 MARIHUANA FACILITY:** ** all information will be withheld 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:		

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JOB TITLE:		

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