

# MEDICAL MARIHUANA FACILITY LICENSE



OFFICE OF THE WARREN CITY CLERK  
 PAUL WOJNO  
 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% penalty for renewal applications recieved 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...*

<b>REQUIREMENTS:</b>
<input type="checkbox"/> Copy of Applicant / Facility Owner's Driver's License or State ID *
<input type="checkbox"/> Copy of Facility Manager's Driver's License or State ID (if applicable) *

<b>OFFICE USE ONLY</b>	LICENSE EXPIRES:
DEPARTMENT APPROVAL:	
POLICE APPROVAL:	DATE:
BUILDING APPROVAL:	DATE:
Issued by _____	Computer Entry <input type="checkbox"/> Paper License <input type="checkbox"/>
LAST YEAR'S LICENSE NO. _____	FEE \$ _____
	LATE FEES \$ _____
	CHECK # _____
<b>MEDICAL MARIJUANA FACILITY LICENSE NO.</b> _____	RECEIPT # _____

**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.

<b>NAME:</b>	<b>* DATE OF BIRTH:</b>	<b>* PHONE:</b>
<b>ADDRESS:</b>		
street	city	state      zip

<b>NAME:</b>	<b>* DATE OF BIRTH:</b>	<b>* PHONE:</b>
<b>ADDRESS:</b>		
street	city	state      zip

<b>NAME:</b>	<b>* DATE OF BIRTH:</b>	<b>* PHONE:</b>
<b>ADDRESS:</b>		
street	city	state      zip

<b>NAME:</b>	<b>* DATE OF BIRTH:</b>	<b>* PHONE:</b>
<b>ADDRESS:</b>		
street	city	state      zip

<b>NAME:</b>	<b>* DATE OF BIRTH:</b>	<b>* PHONE:</b>
<b>ADDRESS:</b>		
street	city	state      zip

<b>NAME:</b>	<b>* DATE OF BIRTH:</b>	<b>* PHONE:</b>
<b>ADDRESS:</b>		
street	city	state      zip

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

<b>NAME:</b>	<b>DATE OF BIRTH:</b>	<b>PHONE:</b>
<b>ADDRESS:</b>		
street	city	state zip
<b>JOB TITLE:</b>		

<b>NAME:</b>	<b>DATE OF BIRTH:</b>	<b>PHONE:</b>
<b>ADDRESS:</b>		
street	city	state zip
<b>JOB TITLE:</b>		

<b>NAME:</b>	<b>DATE OF BIRTH:</b>	<b>PHONE:</b>
<b>ADDRESS:</b>		
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<b>JOB TITLE:</b>		

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street	city	state zip
<b>JOB TITLE:</b>		

<b>NAME:</b>	<b>DATE OF BIRTH:</b>	<b>PHONE:</b>
<b>ADDRESS:</b>		
street	city	state zip
<b>JOB TITLE:</b>		

**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:**

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**\* 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.*

**FACILITY OWNER:**  
(APPLICANT)

**FACILITY MANAGER:**  
(IF APPLICABLE)

<b>Signed:</b> _____	<b>Signed:</b> _____
<b>Print:</b> _____	<b>Print:</b> _____
<b>Title:</b> _____	<b>Title:</b> _____
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 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 for such license, shall have been paid (Applies to Warren businesses only) / THIS LICENSE IS NOT TRANSFERABLE & NON-REFUNDABLE**

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