



MEDICAL MARIJUANA DISPENSARY REGISTRATION CERTIFICATE APPLICATION

DISPENSARY PRINCIPAL OFFICERS AND BOARD MEMBERS INFORMATION FORMS

Provide the following information for each principal officer and board member listed above. Use as many sheets as needed.

Last Name:	First Name:	MI:	PO <input type="checkbox"/> BM <input type="checkbox"/>
Date of Birth:			
Residence Address*: <i>*This must be an Arizona address and cannot be a P.O. Box.</i>			
City:	County:	State:	Zip:
Has this individual served as a principal officer or board member for a dispensary that has had their dispensary registration certificate revoked? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Is this individual a physician currently providing written certifications for qualifying patients? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Is this individual a law enforcement officer? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Is this individual employed by or a contractor of ADHS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Has a copy of this individuals signed and dated Medical Marijuana Dispensary Principal Officer or Board Member Attestation Form been submitted with this application? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Has a copy of this individual's fingerprints on a fingerprint card been submitted with this application? YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>			
<i>If applicable, what is this individual's designated caregiver or dispensary agent registry identification number if issued within the previous six months?</i>			
Last Name:	First Name:	MI:	PO <input type="checkbox"/> BM <input type="checkbox"/>
Date of Birth:			
Residence Address*: <i>*This must be an Arizona address and cannot be a P.O. Box.</i>			
City:	County:	State:	Zip:
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