



MEDICAL MARIJUANA DISPENSARY DISPENSARY INFORMATION UPDATE FORM

FIELDS MARKED WITH AN ASTERISK (\*) REQUIRE BOARD MEMBER SIGNATURE FOR CHANGES

Dispensary's Legal Name:
Dispensary's Registration Certificate ID#: CHAA #:

DESIGNATED PRINCIPAL OFFICER OR BOARD MEMBER INFORMATION

This individual will serve as the Primary Contact for the dispensary. This individual may be contacted by the Program to at the phone number provided. This individual must be a Principal Officer/Board Member, according to Department records, at the time this document is submitted.

Last Name\*: First Name\*: MI:
Phone Number\*: Dispensary Agent Registry ID#\*:

DESIGNATED EMAIL ADDRESS

The email address provided will receive official correspondence from the Department, including notice of inspection, statements of deficiencies, program updates, courtesy reminders, as well as other time sensitive information.

Dispensary's Email Address:

DESIGNATED MAILING ADDRESS

The mailing address provided will receive official correspondence from the Department, registration and approval to operate certificates, dispensary agent cards, as well as other important and/or time sensitive information.

Dispensary's Mailing Address\*:
City\*: County\*: State\*: Zip Code\*:

MEDICAL DIRECTOR

Last Name: First Name: MI:
License #: License Type: MD DO NMD MD(H)

DISPENSARY HOURS OF OPERATION

Empty box for dispensary hours of operation.

Principal Officer/Board Member Signature(s):

Signature lines for Principal Officer/Board Member with labels: Print Name, Title, Signature, Date Signed.