



**MEDICAL MARIJUANA PROGRAM  
DOCUMENTATION OF PROPERTY OWNERSHIP (v. 1.0)**

To be completed by the owner of the physical address of the proposed medical marijuana dispensary.

**APPLICANT INFORMATION**

Name of Entity Applying for a Dispensary Registration Certificate

Street Address of Proposed Dispensary Registration Certificate

Ste., Unit, etc. #

City

County

State

Zip Code

Legal Description of the Property and/or Assessor's Parcel Number

**PROPERTY OWNER INFORMATION**

Name of Owner of the Physical Address of the Proposed Medical Marijuana Dispensary

Name of Authorized Legal Representative of Owner of the Physical Address of the Proposed Medical Marijuana Dispensary, if Applicable

Phone Number (XXX) XXX-XXXX

Email Address

**PROPERTY OWNER AUTHORIZATION**

Select **One** Box Below, Sign, and Date

The entity applying for a Dispensary Registration Certificate is the owner of the physical address of the proposed medical marijuana dispensary.

OR

The owner of the physical address of the proposed medical marijuana dispensary gives permission to the entity applying for a Dispensary Registration Certificate to operate a medical marijuana dispensary at the physical address.

\_\_\_\_\_  
Signature of Property Owner or Authorized Legal Representative

\_\_\_\_\_  
Date Signed

**NOTARIZATION INFORMATION**

State of \_\_\_\_\_, County of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, before me personally appeared

\_\_\_\_\_, whose identity was proven to me on the basis of satisfactory evidence to be the person who he or she claims to be, and acknowledged that he or she signed the above document.

(Seal)  
(Affix Seal Here)

\_\_\_\_\_  
Notary Public (Notary Public Signature)