

**Medical Marihuana Provisioning Center Facility Application**

**Mastodon Township**

1371 U.S. Hwy. 2, South, Crystal Falls, MI 49920

(906) 875-6232

[www.mastodonclerk@att.net](mailto:www.mastodonclerk@att.net)

**TYPE OF APPLILCATION:**

\_\_\_\_\_ **New Application**

\_\_\_\_\_ **Renewal Application**

**TYPE OF LICENSES:**      **Provisioning Center Facility**

**Applicant Name (must match name on State of Michigan Application):**

\_\_\_\_\_ **Individual**    \_\_\_\_\_ **Partnership**    \_\_\_\_\_ **Corporation**    \_\_\_\_\_ **LLC**    \_\_\_\_\_ **Other** \_\_\_\_\_

**State ID#** \_\_\_\_\_ **SSN/FEIN** \_\_\_\_\_ **D.O.B.** \_\_\_\_\_

**Sales Tax License #** \_\_\_\_\_ **(if applicable)**

**Business Name:**

\_\_\_\_\_

**Primary Phone Number of Applicant:**

**Secondary Phone Number of Applicant:**

\_\_\_\_\_

\_\_\_\_\_

**Email Address:**

\_\_\_\_\_

**Physical Address of Facility:**

\_\_\_\_\_

**Mailing Address (if different):**

\_\_\_\_\_

**Website Address** \_\_\_\_\_ **Business Phone:** \_\_\_\_\_

**Owner, Business and Manager Information:**

List all owners, officers, directors, general partners, managing members, stockholders, partners, managers, and members. If a holding company has an ownership interest in the licensed business, list that company and its ownership percentage as well. Attach additional pages as necessary. If a business is directly or indirectly involved, provide state of incorporation and registration.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Position: \_\_\_\_\_ D.O.B. \_\_\_\_\_ % Ownership: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Position: \_\_\_\_\_ D.O.B. \_\_\_\_\_ % Ownership: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Position: \_\_\_\_\_ D.O.B. \_\_\_\_\_ % Ownership: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Position: \_\_\_\_\_ D.O.B. \_\_\_\_\_ % Ownership: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Position: \_\_\_\_\_ D.O.B. \_\_\_\_\_ % Ownership: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Position: \_\_\_\_\_ D.O.B. \_\_\_\_\_ % Ownership: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Position: \_\_\_\_\_ D.O.B. \_\_\_\_\_ % Ownership: \_\_\_\_\_

**PROPERTY INFORMATION:**

**Business Site Address:**

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Owned _____	Registered Owner _____	Date of Purchase _____
Leased _____	Start Date _____	End Date _____

**If Leased:**

Property Owner Name: \_\_\_\_\_  
Address of Owner: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Will facility be in an existing structure? Yes \_\_\_\_\_ No \_\_\_\_\_

How many square feet: \_\_\_\_\_

Will a new structure or addition be built? Yes \_\_\_\_\_ No \_\_\_\_\_

Size: \_\_\_\_\_

Is the parcel located within 1,000 feet of any other medical marijuana facility, church, synagogue, mosque, or house of worship, public or private school, community college, university, or professional school, nursery school or child care center, public park, public library, any residentially zoned district or residential use? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, explain: \_\_\_\_\_

Property Tax Number \_\_\_\_\_

Property Zoning District \_\_\_\_\_ Legal Description of property: \_\_\_\_\_

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(Attach description if more room needed)

**BUSINESS OPERATIONS:**

**Hours of Operation:**

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Provide the name, address, and telephone number of the alarm monitoring company that will be used (if any). NOTE: The company must have a valid business license in the State of Michigan.

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Provide a list of all people with access to the surveillance camera system to be used. (Attach additional sheets if necessary).

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Please list the names and titles of all public officials or officers of any unit of government, and the spouses, parents, and children of those public officials or officers, who, directly or indirectly:

1. Own any financial interest in an applicant.
2. Have any beneficial interest in an applicant.
3. Are the creditors of an applicant.
4. Hold any debt instrument issued by an applicant.
5. Hold or have any interest in any contractual or service relationship with the applicant.

(Name of Public Official/Officer of Government Unit)	Title

Is the interest that of the public official or officer of a governmental unit: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, state the percentage/capacity of interest. \_\_\_\_\_

If no, provide the following information about the interest of the family member of the public official or officer:

Name of Family Member	Relationship	Date of Birth
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Address	Percentage/Capacity of Interest	SSN/FEIN
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Name of Family Member	Relationship	Date of Birth
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Address	Percentage/Capacity of Interest	SSN/FEIN
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Name of Family Member	Relationship	Date of Birth
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Address	Percentage/Capacity of Interest	SSN/FEIN
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**BACKGROUND INFORMATION:**

If you are currently licensed by any governmental agency to engage in any business, list each such license held, the city in which it is held and expiration date thereof.

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Have you previously operated in this Township or any other County, City or State under a Medical Marijuana/Marijuana License: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, provide details: \_\_\_\_\_

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Have any of the previously issued licenses or permits mentioned above been revoked or suspended?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, provide an explanation for the revocation/suspension \_\_\_\_\_

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Has any owner or business manager ever been convicted of a felony?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list the first and last name of the management employee, the associated criminal case number(s), the statute(s) violated, the date(s) of conviction, the date(s) of imposition of probation and/or parole, and the name and address of the sentencing court

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**OATH OF APPLICATION:**

I declare under penalty of perjury in the second degree that this application and all attachments are true, correct, and complete to the best of my knowledge. I also acknowledge that it is my responsibility and the responsibility of my agents and employees to comply with the provisions of the Michigan Marijuana Facilities Licensing Act, Public Act 281 of 2016 and the Township of Mastodon Ordinances which govern my license.

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Signature \_\_\_\_\_ Date \_\_\_\_\_

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Printed Name \_\_\_\_\_ Title \_\_\_\_\_