



CITY OF IMLAY CITY MARIHUANA DEPARTMENT
150 N MAIN STREET, IMLAY CITY, MI 48444
(810) 724-2135

Application for Medical Marihuana Processor, Safety, Secure Transporter
ALL APPLICATIONS MUST BE LEGIBLE AND IN BLUE OR BLACK INK

CIRCLE ONE TYPE PER APPLICATION

PROCESSOR

SAFETY

SECURE TRANSPORTER

Non-refundable application fee: \$100.00

Date Paid: _____

A COPY OF YOUR GOVERNMENT ISSUED PHOTO IDENTIFICATION IS REQUIRED TO BE SUBMITTED WITH APPLICATION

CIRCLE ONE

INDIVIDUAL

CORPORATE

Applicant Contact Information

Corporate Tax ID: _____

Name: _____ Date of Birth: _____
Last First Middle

Physical Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Mailing Address if different then physical address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Email Address: _____

Emergency Contact Information or Highest Rank Stakeholder, Shareholder, Member

Name: _____ Phone Number: _____
Last First Middle

Email Address: _____ Alternate Phone Number: _____

Proposed Facility Information

Name of proposed facility: _____

Address of proposed facility: _____

Zoning of proposed facility site: _____ Parcel Number: _____

Applicant Signature: _____ **Date:** _____

Application for Medical Marihuana Facility

Proposed Location if PROCESSOR: _____

Application for Medical Marihuana Processor, Safety, Secure Transporter

CIRCLE ONE TYPE PER APPLICATION

PROCESSOR

SAFETY

SECURE TRANSPORTER

Managerial employee of Medical Marihuana Processing, Safety, or Secure Transporter if other than applicant:

Name: _____ Date of Birth: _____
Last First Middle

Physical Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Mailing Address if different then physical address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

You must include additional stockholders, shareholder/member information on forms supplied by City Clerk

Required Documentation

- **Articles of incorporation**
- **Assumed name registration documents**
- **Internal Revenue Service SS-4 EIN confirmation letter**
- **Copy of the operating partnership agreement, if a partnership**
- **Copy of the by-laws or**
- **Shareholder list and percentage**
- **The name and address of the proposed Medical Marihuana Facility**

Additional contact information if required by City Clerk: _____

Application for Medical Marihuana Facility

Proposed Location if PROCESSOR: _____

Application for Medical Marihuana Processor, Safety, Secure Transporter Stakeholder/Shareholder/Member

APPLICATION MUST BE FILLED OUT IN LEGIBLE PRINT OR TYPE USING BLACK OR BLUE INK ONLY

Name of proposed facility: _____

Address of proposed facility: _____

Name: _____ Date of Birth: _____
Last First Middle

Physical Address: _____ City: _____

State: _____ Zip Code: _____ County: _____

Mailing Address if different then physical address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Email Address: _____

APPLICANT SIGNATURE: _____ **DATE:** _____

Application for Medical Marihuana Facility

Proposed Location if PROCESSOR: _____

REQUIRED:

For the applicant, for each Stakeholder of the applicant, an affirmation under oath as to whether they are at least eighteen (18) years of age and have never been indicted for, charged with, arrested for, or convicted of, pled guilty or nolo contendere to, forfeited bail concerning, or had expunged any criminal offense under the laws of any jurisdiction, either felony or controlled substance related misdemeanor not including traffic violation, regardless of whether the offense has been expunged, pardoned, reversed on appeal or otherwise, including the date, name and location of the court, number, the offense, the disposition, and the location and length of incarceration

NUMBER OF STAKEHOLDERS: _____

NUMBER OF SHAREHOLDERS: _____

NUMBER OF MEMBERS: _____

APPLICANT SIGNATURE: _____ **DATE:** _____

Application for Medical Marihuana Facility

Proposed Location if PROCESSOR: _____

1. A signed release authorizing the City of Imlay City Department of Public Safety to perform a criminal background check to ascertain whether the applicant, each Stakeholder of the applicant, each managerial employee and employee of the applicant meet the criteria set forth in this Charter.

City Use Only ICDPS

Comment:
Date:
Name:

2. An affidavit that the transfer of Marihuana to and from Medical Marihuana Facilities shall be in compliance with the MMMA and the Medical Marihuana Facilities Licensing Act or other applicable state laws.

City Use Only ICDPS

Comment:
Date:
Name:

3. A description of the security plan for the Medical Marihuana Facility, including, but not limited to, any lighting, alarms, barriers, recording/monitoring devices and/or security guard arrangements proposed for the facility and premises. The security plan must contain the specification details of each piece of security equipment.

City Use Only ICDPS

Comment:
Date:
Name:

4. A production testing plan that includes at a minimum a description of how and when samples for laboratory testing by a state approved Safety Compliance Facility will be selected, what type of testing will be required, and how the test results will be used.

City Use Only ICDPS

Comment:
Date:
Name:

5. A staffing plan.

City Use Only ICDPS

Comment:
Date:
Name:

Application for Medical Marihuana Facility

Proposed Location if PROCESSOR: _____

6. A facility sanitation plan to protect against any Marihuana being ingested by any person or animal, indicating how the waste will be stored and disposed of, and how any Marihuana will be rendered unusable upon disposal. Disposal by on-site burning or introduction in the sewerage system is prohibited.

ICDPS - Planning

Comment:

Date:

Name:

7. A floor plan of the Medical Marihuana Facility, as well as a scale diagram illustrating the property upon which the Medical Marihuana Facility is to be operated, including all available parking spaces, and specifying which parking spaces, if any, are handicapped accessible.

ICDPS - Planning

Comment:

Date:

Name:

8. Any proposed text or graphical materials to be shown on the exterior of the proposed Medical Marihuana Facility.

Planning

Comment:

Date:

Name:

9. Proof of an adequate premise liability and casualty insurance policy in the amount not exceeding the requirements addressed in the Medical Marihuana Facilities Licensing Act or applicable state laws, covering the Medical Marihuana Facility, available for the payment of any damages arising out of an act or omission of the applicant or its stakeholders, agents, employees or subcontractors.

Finance

Comment:

Date:

Name:

Application for Medical Marihuana Facility

Proposed Location if PROCESSOR: _____

10. An affidavit that neither the applicant nor any Stakeholder of the applicant is in default to the City. Specifically, that the applicant or Stakeholder of the applicant has not failed to pay any property taxes, special assessments, fines, fees, or other financial obligations to the City.

Finance

Comment:
Date:
Name:

11. Verification, with copies of actual bank statements, showing that the applicant has liquid funds in the applicant's name in the amount needed to complete the Medical Marihuana Facility, but in no event less than \$250,000.00, in immediate liquid, available funds.

Finance

Comment:
Date:
Name:

12. business plan that defines in detail the company's objectives and how it plans to achieve its goals.

Finance

Comment:
Date:
Name:

13. Before hiring a prospective agent or employee of the applicant, and after, the holder of the license shall conduct a background check of the prospective employee. If the background check indicated a pending charge or conviction within the past ten (10) years for a controlled substance related felony, the applicant would not hire the prospective employee or agent without written permission from the City Clerk.

Clerk

Comment:
Date:
Name:

14. One of the following: (a) proof of ownership of the entire premises wherein the Medical Marihuana Facility is to be operated; or (b) written consent from the property owner for use of the premises in a manner requiring licensure under this Charter along with copy of lease for the premises

Clerk

Comment:
Date:
Name:

Application for Medical Marihuana Facility

Proposed Location if PROCESSOR: _____

15. An affirmation under oath as to whether the applicant has ever applied for or has been granted any commercial license or certificate issued by a licensing authority in Michigan or any other jurisdiction that has been denied, restricted, suspended, revoked, or not renewed, including the licensing authority, the date each action was taken, and the reason for each action
Attorney

Clerk

Comment:
Date:
Name:

16. Complete Application Review (City Attorney)

City Use Only

Comment:
Date:
Name:

Application for Medical Marihuana Facility

Proposed Location if PROCESSOR: _____

FOR CLERK USE ONLY

Date Application Received: _____ Received By: _____

I.C.D.P.S. Completed: _____ Zoning Reviewed: _____

Finance Completed: _____ Site Plan Reviewed: _____

Planning Completed: _____ Planning Commission: _____

City Attorney: _____ City Council: _____

Comments: _____

Circle one: **Approved** **Denied**

Comments: _____

Signature: _____ Date: _____