

**TOWN OF RUMFORD
MEDICAL MARIJUANA-REGISTERED DISPENSARY
APPLICATION**

Application date _____ Opening date _____ Expiration date _____

New _____ Renewal _____ Annual License Fee \$3,000.00 (Non-refundable)

ALL QUESTIONS MUST BE ANSWERED IN FULL

Primary Caregiver

Primary Caregiver Name _____

Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

Mailing address _____

City _____ State _____ Zip _____

Business phone _____ Home phone _____

Cell Phone _____

Email Address _____

Location of Premise for License

Street Address _____

City _____ State _____ Zip Code _____

City Tax Map Number _____ Lot Number _____

Dimension of Property _____ Acreage of Property _____

Number of Qualified Registered Patients _____ Hours of Operation _____

Description of Security Provisions _____

List all residences, including all places of business, within the last 5 years:

Address _____ City _____ State _____ How long _____

Address _____ City _____ State _____ How long _____

Address _____ City _____ State _____ How long _____

Has applicant(s) ever been convicted of any violation of the law, other than minor traffic violations, of any State of the United States, within the past 5 years? Yes _____ No _____ (If yes, complete the following)

Name _____ Date of conviction _____

Offense _____ Location _____

Disposition _____

Has operator ever been convicted of any violation of the law, other than minor traffic violations, of any State of the United States, within the past 5 year? Yes _____ No _____ (If yes, complete the following)

Name _____ Date of conviction _____

Disposition _____ Location _____

Revocation of driver's license during the last 5 years:

<u>Date</u>	<u>Charge</u>	<u>Court</u>	<u>Disposition</u>

THE OMISSION OF FACTS OR ANY MISREPRESENTATION OF ANY OF THE
INFORMATION ON THIS APPLICATION SHALL BE SUFFICIENT GROUNDS
FOR THE REFUSAL OF SUCH LICENSE.

CERTIFICATE OF APPLICANT AND WAIVER OF CONFIDENTIALITY

****** READ CAREFULLY BEFORE SIGNING ******

I hereby authorize the release of any criminal history record information to the Town Clerk's Office or Licensing Authority. I understand that this information shall become public record, and I hereby waive any rights of privacy with respect hereto.

Signature of Applicant

Date

Documentation that must be included:

**Copy of Valid Registry Primary Caregiver Identification Card-Issued
by State of Maine**

Copy of Property Deed and demonstration of right, title or interest for use of the
property as a registered primary caregiver operation

A detailed description of the proposed cultivation and/or distribution of medical marijuana to include the number of qualified registered patients to be served, registered patient services, staffing requirements, security provisions, hours of operation, anticipated parking demand, peak hour traffic and identification of other required licenses, floor plans etc.

ADDITIONAL COMMENTS: _____

DO NOT COMPLETE BELOW THIS LINE

AUTHORIZED SIGNATURES	OCCUPANCY LOAD	APPROVED	DISAPPROVED
CODE DEPT.	_____	_____	_____
FIRE DEPT.	_____	_____	_____
POLICE DEPT.	_____	_____	_____

RECOMMENDATION _____

Site Plan

Scale of 50 feet or less to the inch

Must Contain: The Boundary lines of the Property, location of all existing and proposed buildings and structures, location of all existing and proposed parking areas and walkways and any other site improvements and the location and characteristics of all vehicular entrances and exits serving the property.

Floor Plan

Site Location Map
Scale of not greater than 1" to 100'

Must Contain: Any public or private school, church, child-care provider, youth center, park or playground located within 750 feet of proposed registered caregiver operation.