Medical Marijuana Program

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E-mail: dcp.mmp@ct.gov • **Website:** www.ct.gov/dcp/mmp

Expansion or Reduction of a Dispensary Facility or Dispensary Department Form

INSTRUCTIONS: You must complete all portions of this application. This application must be accompanied by a check or money order in the amount of $1000.00, made payable to: "*Treasurer, State of Connecticut*." Upon approval, the applicant will be required to pay an additional $1,500.00. **All application fees are non-refundable.**

Section A: Business Information

1. Legal Name of Applicant:		
2. Trade Name of Applicant:		
3. Applicant's Business Address:		
4. City:	5. State:	6. Zip Code:
7. Name of Primary Contact:	8. Primary Contact Title:	
9. Primary Contact E-mail Address:	10. Primary Contact Telephone Number:	

Section B: Dispensary Facility Information

11. Dispensary Facility Address:	12. Dispensary Facility License No.:	
13. City:	14. State: CT	15. Zip Code:
16. Telephone Number:	17. Fax Number:	

Section C: Changes to Dispensary Facility or Dispensary Department

18. Type of Change:
○ Expansion ○ Reduction

19. Proposed Start Date:	20. Proposed Completion Date:

21. Description of Project:

22. Please provide the following information as part of your application:

- A blueprint, or floor plan drawn to scale, of the proposed area of the dispensary facility or dispensary department.
- Copies of all licenses and/or permits required by the town necessary to complete work.
- List of all individuals who will be working at the site for the proposed time frame.
- Attach a detailed description of the security plan to be in place during this project to prevent against theft, diversion and/or loss.

Section D: Changes to Dispensary Department Hours

23. State the proposed dispensary department hours of operation for each day, excluding holidays. The dispensary department is where marijuana will be sold.

Monday _____ to _____ Friday _____ to _____

Tuesday _____ to _____ Saturday _____ to _____

Wednesday _____ to _____ Sunday _____ to _____

Thursday _____ to _____

Section E: Changes to Dispensary Facility Hours

24. State the proposed dispensary facility hours of operation for each day, excluding holidays. The dispensary facility includes areas where non-marijuana products and services will be offered.

Monday _____ to _____ Friday _____ to _____

Tuesday _____ to _____ Saturday _____ to _____

Wednesday _____ to _____ Sunday _____ to _____

Thursday _____ to _____

I hereby certify that the above information is correct and complete.

I fully understand that if I knowingly make a statement that is untrue and which is intended to mislead the Department of Consumer Protection or any person designated by the Department in the performance of their official function, I will be in violation of Section 53a-157b of the Connecticut General Statutes. As the duly authorized representative of the applicant, I hereby make the above certifications on behalf of the applicant.

25. Signature: ►	26. Printed Name:	27. Date Signed:

For Department Use Only.

28. Date Received:	☐ Approved ☐ Disapproved	Assigned Drug Control Agent Name:	Date of Action: