Medical Marijuana Program

450 Columbus Boulevard, Suite 901, Hartford, CT 06103-1840 • (860) 713-6066
Fax: (860) 706-5361 • **E-mail:** dcp.mmp@ct.gov • **Website:** www.ct.gov/dcp/mmp

Request for Change of Dispensary Facility Name 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 $100.00 dollars, made payable to: "*Treasurer, State of Connecticut*." **All application fees are non-refundable.**

Section A: Dispensary Facility Backer Information

Name (First, Middle, Last):		Title/Position:	
Home Address (including Apartment or Suite #):			
City:	State:	Zip Code:	Date of Birth:
Telephone Number:	E-mail Address:		

Section C: Previous Dispensary Facility Name

Current Dispensary Facility Name:		Dispensary Facility License No.:	
Current Dispensary Facility Address:			
City:		State: **CT**	Zip Code:
Telephone Number:	Fax Number:	E-mail Address:	

Section D: New Dispensary Facility Name

New Dispensary Facility Name:			
New Dispensary Facility Address:			
City:		State: **CT**	Zip Code:
Telephone Number:	Fax Number:	E-mail Address:	

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.

Signature: ▶	Date Signed: