CITY AND COUNTY OF SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
ENVIRONMENTAL HEALTH SECTION
1390 MARKET ST. STE 210 SAN FRANCISCO, CA 94102
ph 415-252-3800 fax 415-252-3894

APPLICATION FOR PERMIT TO OPERATE A MEDICAL CANNABIS DISPENSARY

Date of Application_____

Dispensary Address:_____ Disp. zip code_____

Dispensary Name:_____ Disp. Phone _____

Dispensary Operational Structure (circle one) **Nonprofit Collective** **Nonprofit Cooperative***
*** must be registered w/ State**

Dispensary Owner_____

Legal Ownership Structure (circle one) **Non-profit Corporation*** **Sole Proprietor** **Partnership**
Corporation* **Cooperative*** **Other_____**
(*submit a copy of Articles of Incorporation)

Applicant/Operator(s)*	**Age**	**ID# and ID type**	**Home address**
1)_____	____	_____	_____
_____ (title, if corporate)		_____ (ID type)	_____
2)_____	____	_____	_____
_____ (title, if corporate)		_____ (ID type)	_____

**** must submit valid proof of medical cannabis patient or caregiver status.***

(attach additional forms if necessary)

Manager(s)*_____

Has any owner/operator or manager been convicted of a felony?(circle one) Yes No. If yes, list felony(s) and explain on the back of this form. Please note that all owners/operators and managers listed on this form must submit to a criminal background check.

CALIFORNIA FIRE CODE REQUIRES A <u>PLACE OF ASSEMBLY</u> PERMIT IF FACILITY CAN ACCOMMODATE 50 OR MORE PERSONS

Cannabis will be (circle all that apply): Grown on site Smoked on site Vaporized on site

SIGNATURE(S) OF APPLICANT(S)

X_____ **X**_____

X_____ **X**_____

For Office Use Only

Planning referral_____/_____ **Fire Dept referral_____/_____**
Background Check_____/_____ ,_____/_____ **Seller's permit #_____**
DBI referral _____/_____ **Bus. Reg. Cert. # _____**
MOD referral_____/_____ **Facility ID# _____**
Permit revocation check _____ **DPH Hearing Date _____**