



The Commonwealth of Massachusetts  
 Executive Office of Health and Human Services  
 Department of Public Health  
 Bureau of Health Care Safety and Quality  
**Medical Use of Marijuana Program**  
 99 Chauncy Street, 11<sup>th</sup> Floor, Boston, MA 02111

CHARLES D. BAKER  
 Governor

KARYN E. POLITO  
 Lieutenant Governor

MARYLOU SUDDERS  
 Secretary

MONICA BHAREL, MD, MPH  
 Commissioner

Tel: 617-660-5370  
[www.mass.gov/medicalmarijuana](http://www.mass.gov/medicalmarijuana)

**REGISTERED MARIJUANA DISPENSARY  
 REGISTRATION RENEWAL APPLICATION**

**Corporation**

The applicant corporation's legal name, trade name, and any other name under which the entity does business (if any): [ ]

Certificate of Registration Number:

[ ]

Address:

[ ]

[ ]

City: [ ] State: [ ] Zip: [ ]

CEO (Chief Executive Officer)/Executive Director (ED)

First Name: [ ] Last Name: [ ]

**Contact Person**

First Name: [ ] Last Name: [ ]

Title: [ ]

Telephone: ( ) - FAX: ( ) - E-Mail: [ ]

Contact Person Address (if different):

[ ]

[ ]

City: [ ] State: [ ] Zip: [ ]

**Registered Marijuana Dispensary Locations**

**Address of Dispensary Site** \_\_\_\_\_

**Address of Cultivation Site** \_\_\_\_\_

**Address of Processing Site** \_\_\_\_\_

**Registration Fee**

Enclose a bank/cashier's check or money order made payable to the "Commonwealth of Massachusetts" in the amount of \$50,000. Personal checks will not be accepted.

\$50,000 bank/cashier's check attached.

**Authorized Signature**

This application must be signed by an authorized signatory of the non-profit corporation.

**Required Signatures**

Signed under the pains and penalties of perjury, the authorized signatory agrees that all information included in this application is complete and accurate.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Print Name:

Print Title:

I hereby attest that the corporation has provided the Department of Public Health with updates in compliance with 105 CMR 725.100(F)(4), including regarding information that the corporation submitted on its initial application for a certificate of registration, and has ensured the accuracy of all information submitted to the Department.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Print Name:

Print Title: