Department of Health Use Only	
#	Received

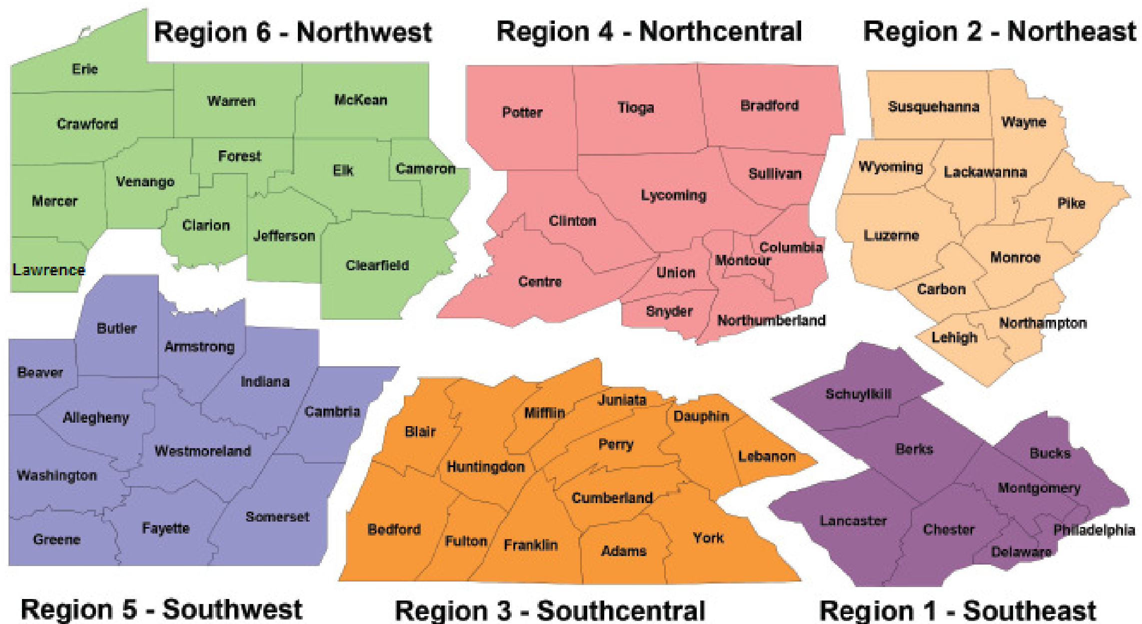
Medical Marijuana Grower/Processor Permit Application

You may apply for one grower/processor permit in this application for any of the medical marijuana regions listed below. A separate application must be submitted for each grower/processor permit sought by the applicant. Please see the Medical Marijuana Organization Permit Application Instructions for a table of the counties within each medical marijuana region.

Please check to indicate the medical marijuana region, and specify the county, for which you are applying for a grower/processor permit:

☐ Northwest	☐ Northcentral	☐ Northeast
☐ Southwest	☐Southcentral	☐ Southeast

County:



Medical Marijuana Grower/Processor Permit Application

Part A - Applicant Identification and Facility Information

(Scoring Method: Pass/Fail)

FOR THIS PART, THE APPLICANT IS REQUIRED TO PROVIDE BACKGROUND AND CONTACT INFORMATION FOR THE BUSINESS OR INDIVIDUAL APPLYING FOR A PERMIT.

Section 1 – Applicant Name, Address and Contact Information

Business or Individual Name and Principal Address

Business Name, as it appears on the applicant's certificate of incorporation, charter, bylaws, partnership agreement or other legal business formation documents:		
Other trade names and DBA (doing business as) names:		
Business Address:		
City:	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**

☐**Primary Contactor** ☐**Registered Agent for this Application**

Name:		
Address:		
City:	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**

Section 2 – Facility Information

By checking "Yes," you affirm that you possess the ability to obtain in an expeditious manner the right to use sufficient land, buildings and other premises and equipment to properly carry on the activity described in the medical marijuana grower/processor permit application, and any proposed location for a grower/processor facility.	☐ Yes	☐ No

PROPOSED GROWER/PROCESSOR FACILITY (PLEASE INDICATE THE FACILITY NAME AS YOU WOULD LIKE IT TO APPEAR ON THE PERMIT)

Facility Name:		
FacilityAddress:		
City:	**State: PA**	**Zip Code:**
County:		**Municipality:**
☐**Owned by the applicant**☐**Leased by the applicant**☐**Option for applicant to buy/lease**		
Is the facility located in a financially distressed municipality?	☐ Yes	☐ No

pennsylvania
DEPARTMENT OF HEALTH

Does the facility have an excess maintenance agreement or road use agreement with PennDOT, the local municipality, or the county?	☐ Yes	☐ No

Part B – Diversity Plan

(Scoring Method: 100 Points)

IN ACCORDANCE WITH SECTION615 OF THE ACT (35 P.S. § 10231.615), AN APPLICANT SHALL INCLUDE WITH ITS APPLICATION A DIVERSITY PLAN THAT PROMOTES AND ENSURES THE INVOLVEMENT OF DIVERSE PARTICIPANTS AND DIVERSE GROUPS IN OWNERSHIP, MANAGEMENT, EMPLOYMENT, AND CONTRACTING OPPORTUNITIES. DIVERSE PARTICIPANTS INCLUDE A PERSON, INCLUDING A NATURAL PERSON; INDIVIDUALS FROM DIVERSE RACIAL, ETHNIC AND CULTURAL BACKGROUNDS AND COMMUNITIES; WOMEN; VETERANS; INDIVIDUALS WITH DISABILITIES; CORPORATION; PARTNERSHIP; ASSOCIATION; TRUST OR OTHER ENTITY; OR ANY COMBINATION THEREOF, WHO ARE SEEKING A PERMIT ISSUED BY THE DEPARTMENT OF HEALTH TO GROW AND PROCESS OR DISPENSE MEDICAL MARIJUANA. DIVERSE GROUPS INCLUDE THE FOLLOWING BUSINESSES THAT HAVE BEEN CERTIFIED BY A THIRD-PARTY CERTIFYING ORGANIZATION: A DISADVANTAGED BUSINESS, MINORITY-OWNED BUSINESS, AND WOMEN-OWNED BUSINESS AS THOSE TERMS ARE DEFINED IN 74 PA. C.S. § 303(B); AND A SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS OR VETERAN-OWNED SMALL BUSINESS AS THOSE TERMS ARE DEFINED IN 51 PA. C.S. § 9601.

Section 3 – Diversity Plan

By checking "Yes," the applicant affirms that it has a diversity plan that establishes a goal of opportunity and access in employment and contracting by the medical marijuana organization. The applicant also affirms that it will make a good faith effort to meet the diversity goals outlined in the diversity plan. Changes to the diversity plan must be approved by the Department of Health in writing. The applicant further agrees to report participation level and involvement of Diverse Participants and Diverse Groups in the form and frequency required by the Department, and to provide any other information the Department deems appropriate regarding ownership, management, employment, and contracting opportunities by Diverse Participants and Diverse Groups.	☐ Yes	☐ No

DIVERSITY PLAN IN NARRATIVE FORM BELOW, DESCRIBE A PLAN THAT ESTABLISHES A GOAL OF DIVERSITY IN OWNERSHIP, MANAGEMENT, EMPLOYMENT AND CONTRACTING TO ENSURE THAT DIVERSE PARTICIPANTS AND DIVERSE GROUPS ARE ACCORDED EQUALITY OF OPPORTUNITY. TO THE EXTENT AVAILABLE, INCLUDE THE FOLLOWING: 1. The diversity status of the Principals, Operators, Financial Backers, and Employees of the Medical Marijuana Organization. 2. An official affirmative action plan for the Medical Marijuana Organization. 3. Internal diversity goals adopted by the Medical Marijuana Organization. 4. A plan for diversity-oriented outreach or events the Medical Marijuana Organization will

pennsylvania
DEPARTMENT OF HEALTH

conduct during the term of the permit.

5. Contracts with diverse groups and the expected percentage and dollar amount of revenues that will be paid to the diverse groups.
6. Any materials from the Medical Marijuana Organization's mentoring, training, or professional development programs for diverse groups.
7. Any other information that demonstrates the Medical Marijuana Organization's commitment to diversity practices.
8. A workforce utilization report including the following information for each job category within the Medical Marijuana Organization:
    a. The total number of persons employed in each job category,
    b. The total number of men employed in each job category,
    c. The total number of women employed in each job category,
    d. The total number of veterans in each job category,
    e. The total number of service-disabled veterans in each job category, and
    f. The total number of members of each racial minority employed in each job category.
9. A narrative description of your ability to record and report on the components of the diversity plan.

Please limit your response to no more than 5,000 words.

Part C - Applicant Background Information

(Scoring Method: Pass/Fail)

FOR THIS PART THE APPLICANT IS REQUIRED TO PROVIDE BACKGROUND AND CONTACT INFORMATION FOR THE PRINCIPALS, FINANCIAL BACKERS, OPERATORS AND EMPLOYEES.

Section 4 – Principals, Financial Backers, Operators and Employees

A. Please list Principals, Financial Backers and Operators

Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**

pennsylvania
DEPARTMENT OF HEALTH

Phone:	**Fax:**	**Email:**	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth**: MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth**: MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth**: MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth**: MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth**: MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	

If more space is required, please submit additional information on other individuals in a separate document titled "Principals, Financial Backersand Operators (Contd.)" in accordance with the attachment file name format requirements and include with the attachments.

B. Please list Employees

Please provide the following information for any employees that have been hired to date to work for the applicant listed in this application. If no employees are currently employed, please leave this section blank.

Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth**: MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth**: MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth**: MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth**: MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth**:MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	

IF MORE SPACE IS REQUIRED, PLEASE SUBMIT ADDITIONAL INFORMATION ON OTHER INDIVIDUALS IN A SEPARATE DOCUMENT TITLED "EMPLOYEES (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

Section 5 – Moral Affirmation

By checking "Yes," you affirm that each principal, financial backer, operator and employee listed in this permit application is of good moral character.	☐ Yes	☐ No

Section 6 – Compliance with Applicable Laws and Regulations

By checking "Yes," you affirm that you, as well as the principals, financial backers, operators and employees listed in this permit application are able to continuously comply with all applicable Commonwealth laws and regulations relating to the operation of a medical marijuana grower/processor facility.	☐Yes	☐No

Section 7 – Civil and Administrative Action

For the statements below:

- By checking "Yes," you affirm the statement
- If you check "No," you must state your reasoning in "Schedule A" below

Civil and Administrative Action	Yes	No
The applicant has never responded to an action resulting in sanctions, disciplinary actions or civil monetary penalties being imposed relating to a registration, license, permit or any other authorization to grow, process or dispense medical marijuana in any state.	☐	☐
The applicant has never responded to a civil or administrative action relating to a registration, license, permit or authorization to grow, process or dispense medical marijuana in any state.	☐	☐
The applicant has never been accused of obtaining a registration, license, permit or other authorization to operate as a grower, processor or dispensary of medical marijuana in any jurisdiction by fraud, misrepresentation, or the submission of false information.	☐	☐
No civil or administrative action has been taken against the applicant under the laws of the Commonwealth or any other state, the United States or a military, territorial or tribal authority relating to a principal, operator, financial backer or employee of the applicant's profession, or occupation or fraudulent practices, including fraudulent billing practices.	☐	☐

Schedule A: Civil or Administrative History Incident					
Defendant	Name of Case & Docket #	Nature of Charge or Complaint	Date of Charge or Complaint	Disposition	Name and Address of the Administrative Agency Involved, and the Tribunal or Court

Part D – Plan of Operation

(Scoring Method: 550 Points)

A PLAN OF OPERATION IS REQUIRED FOR ALL GROWER/PROCESSOR PERMIT APPLICATIONS. THE PLAN OF OPERATION MUST INCLUDE A TIMETABLE OUTLINING THE STEPS THE APPLICANT WILL TAKE TO BECOME OPERATIONAL WITHIN SIX MONTHS FROM THE DATE OF ISSUANCE OF A PERMIT. THE PLAN OF OPERATION MUST ALSO DESCRIBE HOW THE APPLICANT'S PROPOSED BUSINESS OPERATIONS WILL COMPLY WITH STATUTORY AND REGULATORY REQUIREMENTS NECESSARY FOR THE CONTINUED OPERATION OF THE FACILITY.

Plan of Operation

What must be covered in a Plan of Operation?

Applicants must identify how they will comply with relevant laws and regulations regarding:

- Security and surveillance
- Employee qualifications and training
- Transportation of medical marijuana and medical marijuana products
- Storage of seeds, immature medical marijuana plants, medical marijuana plants, medical marijuana, and medical marijuana products
- Labeling of medical marijuana products
- Inventory management, including management of returns of medical marijuana product that is expired, damaged or recalled
- Appropriate nutrient practice, using fertilizers or hydroponic solutions, and the recording of information on the use of fertilizers and growth additives
- Quality control and testing of medical marijuana and medical marijuana products for potential contamination
- Growing of medical marijuana, including a detailed summary of policies and procedures for its growth and harvest
- Recordkeeping
- Preventing unlawful diversion of medical marijuana and medical marijuana products
- Timetable outlining the steps required for the applicant to become operational within six months from the date of issuance of a permit

By checking "Yes," you affirm that youare able to continuously maintain effective security, surveillance and accounting control measures to prevent diversion, abuse and other illegal conduct regarding medical marijuana plants and medical marijuana.	☐ Yes	☐ No

Section 8 – Operational Timetable

IF ISSUED A PERMIT, PLEASE DESCRIBE BELOW THE STEPS AND TIMEFRAMES FOR BECOMING OPERATIONAL AS A

GROWER/PROCESSOR WITHIN SIX MONTHS FROM THE DATE OF ISSUANCE OF A GROWER/PROCESSOR PERMIT. SPECIFICALLY, PROVIDE THE STEPS YOU WILL TAKE TO BEGIN THE PROCESS FOR THE GROWING, HANDLING, PROCESSING, TESTING, TRANSPORTING, AND DISPOSING OF MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS.

Activity	Estimated Date

IF MORE SPACE IS REQUIRED FOR THE OPERATIONAL TIMETABLE, PLEASE SUBMIT ADDITIONAL INFORMATION IN A SEPARATE DOCUMENT TITLED "OPERATIONAL TIMETABLE (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

Section 9 – Employee Qualifications, Description of Duties and Training

A. PLEASE PROVIDE A DESCRIPTION OF THE DUTIES, RESPONSIBILITIES, AND ROLES OF EACH PRINCIPAL, FINANCIAL BACKER, OPERATOR AND EMPLOYEE.

1.
2.
3.
4.
5.
6.
7.
8.

B. PLEASE DESCRIBE THE EMPLOYEE QUALIFICATIONS OF EACH PRINCIPAL AND EMPLOYEE.
1.
2.
3.
4.
5.
6.
7.
8.

C. PLEASE DESCRIBE THE STEPS THE APPLICANT WILL TAKE TO ASSURE THAT EACH PRINCIPAL AND EMPLOYEE WILL MEET THE TWO-HOUR TRAINING REQUIREMENT UNDER THE ACTAND REGULATIONS.
1.
2.
3.
4.
5.
6.
7.
8.

IF MORE SPACE IS REQUIRED FOR ANY OF THE ABOVE THREE COMPONENTS OF SECTION 9 (A, B AND C), PLEASE SUBMIT ADDITIONAL INFORMATION IN A SEPARATE DOCUMENT TITLED "EMPLOYEE QUALIFICATIONS, DESCRIPTION OF DUTIES AND TRAINING (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

Section 10 – Security and Surveillance

A GROWER/PROCESSOR FACILITY MUST HAVE SECURITY AND SURVEILLANCE SYSTEMS, UTILIZING COMMERCIAL-GRADE EQUIPMENT, TO PREVENT UNAUTHORIZED ENTRY AND TO PREVENT AND DETECT DIVERSION, THEFT, OR LOSS OF ANY SEEDS, IMMATURE MEDICAL MARIJUANA PLANTS, MEDICAL MARIJUANA PLANTS, MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS.

PLEASE PROVIDE A SUMMARY OF YOUR PROPOSED SECURITY AND SURVEILLANCE EQUIPMENT AND MEASURES THAT WILL BE IN PLACE AT YOUR PROPOSED FACILITY AND SITE. THESE MEASURES SHOULD COVER, BUT ARE NOT LIMITED TO, THE FOLLOWING: GENERAL OVERVIEW OF THE EQUIPMENT, MEASURES AND PROCEDURES TO BE USED, ALARM SYSTEMS, SURVEILLANCE SYSTEM, STORAGE, RECORDING CAPABILITY, RECORDS RETENTION, PREMISES ACCESSIBILITY, AND INSPECTION/SERVICING/ALTERATION PROTOCOLS. Please limit your response to no more than 5,000 words.

Section 11 – Transportation of Medical Marijuana

A. Transportation	Yes	No
By checking “Yes,” you affirm that any delivery of medical marijuana to any other medical marijuana grower/processor facility, dispensary, or approved laboratory within the Commonwealth will adhere to the following: If you check “No” to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.		
• Medical marijuana will only be delivered between 7 a.m. and 9 p.m.	☐	☐
• Medical marijuana will not be transported to any location outside of this Commonwealth.	☐	☐
• A global positioning system will be used to ensure safe, efficient delivery of the medical marijuana to a medical marijuana organization or approved laboratory.	☐	☐
In addition to having a transport vehicle staffed with a delivery team consisting of at least two individuals, the applicant affirms the following:		
• At least one delivery team member will remain with the vehicle at all times that the vehicle contains medical marijuana.	☐	☐
• Each delivery team member shall have access to a secure form of communication with the grower/processor, such as a cellular telephone, at all times that the vehicle contains medical marijuana.	☐	☐

• Upon demand, each delivery team member shall produce an identification badge or card to the Department or its authorized agents, law enforcement or other Federal, State, or local government officials if necessary to perform the government officials' functions and duties.	☐	☐
• Each delivery team member shall have a valid driver's license.	☐	☐
• While on duty, a delivery team member will not wear any clothing or symbols that may indicate ownership or possession of medical marijuana.	☐	☐
• Medical marijuana stored inside the transport vehicle may not be visible from the outside of the transport vehicle.	☐	☐
• A delivery team shall proceed in a transport vehicle from the facility, where the medical marijuana is loaded, directly to the medical marijuana organization or approved laboratory, where the medical marijuana is unloaded, without unnecessary delays. Notwithstanding the foregoing, a transport vehicle may make stops at multiple facilities or approved laboratories, as appropriate, to deliver medical marijuana.	☐	☐
• Any vehicle accidents, diversions, losses, or other reportable events that occur during transport of medical marijuana must be immediately reported to the Department either through a designated phone line established by the Department or by electronic communication with the Department in a manner prescribed by the Department.	☐	☐
• The Department shall be notified daily of the grower/processor's delivery schedule, including routes and delivery times, either through a designated phone line established by the Department or by electronic communication with the Department in a manner prescribed by the Department.	☐	☐
• A transport vehicle is subject to inspection by the Department or its authorized agents, law enforcement or other Federal, State or local government officials if necessary to perform the government officials' functions and duties.	☐	☐
• A transport vehicle may be stopped and inspected along its delivery route or at any medical marijuana organization or approved laboratory.	☐	☐
• If a third-party contractor is used, the contractor must comply with all the transportation requirements listed in the Act and regulations.	☐	☐
B. Transport Manifest	**Yes**	**No**
By checking "Yes" to any statement, you affirm that the transport manifest (printed or electronic) that accompanies every transport vehicle will contain the following		

pennsylvania
DEPARTMENT OF HEALTH

information and meet the following requirements: If you check "No" to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.		
• The name, address and permit number of the medical marijuana organization or approved laboratory receiving the delivery, and the name of and contact information for a representative of the medical marijuana organization or approved laboratory.	☐	☐
• The quantity, by weight or unit, of each medical marijuana harvest batch, harvest lot or process lot contained in the transport, along with the identification number for each batch or lot.	☐	☐
• The date and approximate time of departure.	☐	☐
• The date and approximate time of arrival.	☐	☐
• The transport vehicle's make, model, and license plate number.	☐	☐
• The identification number of each member of the delivery team accompanying the transport.	☐	☐
• When a delivery team delivers medical marijuana to multiple medical marijuana organizations or approved laboratories, the transport manifest must correctly reflect the specific medical marijuana in transit; each recipient will also provide the grower/processor with a printed receipt for the medical marijuana received.	☐	☐
• All medical marijuana being transported must be packaged in shipping containers and labeled in accordance with § 1151.34 (relating to packaging and labeling of medical marijuana).	☐	☐
• Separate copies of the transport manifest will be provided to each recipient receiving the medical marijuana described in the transport manifest. To maintain confidentiality, a grower/processor may prepare separate manifests for each recipient.	☐	☐
• The applicant acknowledges that, upon request, a copy of the printed transport manifest, and any printed receipts for medical marijuana being transported, will be provided to the Department or its authorized agents, law enforcement, or other Federal, State, or local government officials if necessary to perform the government officials' functions and duties.	☐	☐

PLEASE PROVIDE AN EXPLANATION OF ANY RESPONSES ABOVE THAT WERE ANSWERED AS A "NO" AND HOW YOU WILL MEET THESE REQUIREMENTS BY THE TIME THE DEPARTMENT DETERMINES YOU TO BE OPERATIONAL UNDER THE ACT AND REGULATIONS:

Please limit your response to no more than 5,000 words.

C. PLEASE DESCRIBE YOUR PLAN REGARDING THE TRANSPORTATION OF MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS. FOR EXAMPLE, EXPLAIN WHETHER YOU PLAN TO MAINTAIN YOUR OWN TRANSPORTATION OPERATION AS PART OF THE FACILITY OPERATION, OR WHETHER YOU WILL USE A THIRD-PARTY CONTRACTOR. IF YOU CHOOSE TO USE YOUR OWN TRANSPORTATION OPERATION, PLEASE PROVIDE THE NUMBER AND TYPE OF VEHICLES THAT WILL BE USED TO TRANSPORT MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS, THE TRAINING THAT WILL BE PROVIDED TO EMPLOYEES THAT WILL TRANSPORT MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS, AND ANY ADDITIONAL MEASURES YOU WILL TAKE TO PREVENT DIVERSION DURING TRANSPORT. IF YOU WILL BE USING A THIRD-PARTY CONTRACTOR FOR TRANSPORTING MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS, PLEASE EXPLAIN THE STEPS YOU WILL TAKE TO GUARANTEE THE THIRD-PARTY CONTRACTOR WILL BE COMPLIANT WITH THETRANSPORTATION REQUIREMENTS UNDER THE ACT AND REGULATIONS.

Please limit your response to no more than 5,000 words.

Section 12 – Storage of Medical Marijuana

A. Storage Requirements	**Yes**	**No**
By checking "Yes" to any statement, you affirm that the plan of operation will address the below statements: If you check "No" to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.		
• There will be separate, locked, limited access areas for the storage of seeds, immature medical marijuana plants, medical marijuana plants, and medical marijuana that are expired, damaged, deteriorated, mislabeled, contaminated or recalled or whose containers or packaging have been opened or breached, until the seeds, immature medical marijuana plants, medical marijuana plants and medical marijuana are destroyed or otherwise disposed of, as required by § 1151.40 (relating to the management and disposal of medical marijuana waste).	☐	☐
• All storage areas will be maintained in a clean and orderly condition and free from infestation by insects, rodents, birds, and pests.	☐	☐

• A separate and secure area for temporary storage of medical marijuana that is awaiting disposal will be established.	☐	☐

PLEASE PROVIDE AN EXPLANATION OF ANY RESPONSES ABOVE THAT WERE ANSWERED AS A "NO" AND HOW YOU WILL MEET THESE REQUIREMENTS BY THE TIME THE DEPARTMENT DETERMINES YOU TO BE OPERATIONAL UNDER THE ACT AND REGULATIONS:

Please limit your response to no more than 5,000 words.

B. PLEASE DESCRIBE YOUR PLANS REGARDING THE STORAGE OF MEDICAL MARIJUANA WITHIN YOUR FACILITY:

Please limit your response to no more than 5,000 words.

Section 13 – Packaging and Labeling of Medical Marijuana

A. Packaging Requirements	**Yes**	**No**
By checking "Yes" to any statement, you affirm that you will implement a quality control process to ensure that the packaging meets all of the following: If you check "No" to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.		
• Each form of medical marijuana prepared for sale will be packaged and labeled at its facility. The original seal of a package may not be broken, except for quality control testing at an approved laboratory, for adverse loss investigations conducted by the Department, or by a dispensary that purchased the medical marijuana.	☐	☐
• Medical marijuana will be in a package that minimizes exposure to oxygen.	☐	☐
The packaged medical marijuana will be all of the following:		
• Child-resistant	☐	☐
• Tamper-proof or tamper-evident	☐	☐
• Light-resistant and opaque	☐	☐

• Resealable	☐	☐

PLEASE PROVIDE AN EXPLANATION OF ANY RESPONSES ABOVE THAT WERE ANSWERED AS A "NO" AND HOW YOU WILL MEET THESE REQUIREMENTS BY THE TIME THE DEPARTMENT DETERMINES YOU TO BE OPERATIONAL UNDER THE ACT AND REGULATIONS: Please limit your response to no more than 5,000 words.

B. Labeling Requirements	**Yes**	**No**
By checking "Yes" to any statement, you affirm that the applicant will implement a quality control process to ensure that the label does not bear any of the following: If you check "No" to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.		
• Any resemblance to the trademarked, characteristic or product-specialized packaging of any commercially available food or beverage product.	☐	☐
• Any statement, artwork or design that could reasonably lead an individual to believe that the package contains anything other than medical marijuana.	☐	☐
• Any seal, flag, crest, coat of arms, or other insignia that could reasonably mislead an individual to believe that the product has been endorsed, manufactured, or approved for use by any State, county or municipality or any agency thereof.	☐	☐
• Any cartoon, color scheme, image, graphic or feature that might make the package attractive to children.	☐	☐
Each process lot of medical marijuana will be identified with a unique identifier.	☐	☐
Prior written approval of the Department will be obtained regarding the content of any label to be affixed to a medical marijuana package.	☐	☐
By checking "Yes," you affirm that each label will:		
• Be easily readable.	☐	☐
• Be made of weather-resistant and tamper-resistant materials.	☐	☐

• Be conspicuously placed on the package.	☐	☐
• Include the name, address and permit number of the grower/processor.	☐	☐
• List the form, quantity and weight of medical marijuana included in the package.	☐	☐
• List the amount of individual doses contained within the package and the species and percentage of THC and CBD.	☐	☐
• Contain an identifier that is unique to a particular harvest batch of medical marijuana, including the number assigned to each harvest lot or process lot in the harvest batch.	☐	☐
• Include the date the medical marijuana was packaged.	☐	☐
• State the employee identification number of the employee preparing the package and packaging the medical marijuana.	☐	☐
• State the employee identification number of the employee shipping the package, if different than the employee preparing the package and packaging the medical marijuana.	☐	☐
• Contain the name and address of the dispensary to which the package is to be sold.	☐	☐
• List the date of expiration of the medical marijuana.	☐	☐
• Include instructions for proper storage of the medical marijuana in the package.	☐	☐
• Contain a warning that the medical marijuana must be kept in the original container in which it was dispensed.	☐	☐
• Contain a warning that unauthorized use is unlawful and will subject the purchaser to criminal penalties.	☐	☐
• Contain the following warning stating: This product is for medicinal use only. Women should not consume during pregnancy or while breastfeeding except on the advice of the practitioner who issued the certification and, in the case of breastfeeding, the infant’s pediatrician. This product might impair the ability to drive or operate heavy machinery. Keep out of reach of children.	☐	☐

PLEASE PROVIDE AN EXPLANATION OF ANY RESPONSES ABOVE THAT WERE ANSWERED AS A "NO" AND HOW YOU WILL MEET THESE REQUIREMENTS BY THE TIME THE DEPARTMENT DETERMINES YOU TO BE OPERATIONAL UNDER THE ACT AND REGULATIONS:
Please limit your response to no more than 5,000 words.

C. PLEASE DESCRIBE YOUR PROCESS FOR CREATING AND MONITORING THE LABELING USED FOR MEDICAL MARIJUANA PRODUCTS:
Please limit your response to no more than 5,000 words.

Section 14 – Inventory Management

A. Electronic Tracking System	**Yes**	**No**
You acknowledge that you must use the electronic tracking system prescribed by the Department containing the requirements in section 701 of the Act (35 P.S. § 10231.701).	☐	☐
You acknowledge that an electronictracking system that is approved by the Department will be deployed to log, verify, and monitor the receipt, use and sale of seeds, immature medical marijuana plants or medical marijuana plants, the funds received by a grower/processor for the sale of medical marijuana to another medical marijuana organization, the disposal of medical marijuana waste and the recall of defective medical marijuana.	☐	☐

B. Inventory Management	**Yes**	**No**
By checking "Yes" to any statement, you affirm that your grower/processor facility will maintain an accounting of, and an identifying number for, the following inventory data in the electronic tracking system prescribed by the Department: If you check "No" to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.		
• The number, weight, and type of seeds.	☐	☐
• The number of immature medical marijuana plants.	☐	☐
• The number of medical marijuana plants.	☐	☐

• The number of medical marijuana products ready for sale.	☐	☐
• The number of damaged, defective, expired, or contaminated seeds, immature medical marijuana plants, medical marijuana plants and medical marijuana products awaiting disposal.	☐	☐
• Inventory controls and procedures will be established for the conducting of monthly inventory reviews and annual comprehensive inventories of medical marijuana at the facility.	☐	☐
• Inventory reviews of medical marijuana plants in the process of growing and medical marijuana and medical marijuana products that are being stored for future sale shall be conducted monthly.	☐	☐
• Comprehensive inventories of seeds, immature medical marijuana plants, medical marijuana plants, medical marijuana and medical marijuana products shall be conducted at least annually.	☐	☐
• A written or electronic record of the inventory reviews and comprehensive inventories must be created and maintained.	☐	☐
• The written or electronic record will include the date of the inventory, a summary of the inventory findings, and the employee identification numbers and titles or positions of the individuals who conducted the inventory.	☐	☐

PLEASE PROVIDE AN EXPLANATION OF ANY RESPONSES ABOVE THAT WERE ANSWERED AS A "NO" AND HOW YOU WILL MEET THESE REQUIREMENTS BY THE TIME THE DEPARTMENT DETERMINES YOU TO BE OPERATIONAL UNDER THE ACT AND REGULATIONS:

Please limit your response to no more than 5,000 words.

C. PLEASE DESCRIBE YOUR APPROACH REGARDING THE IMPLEMENTATION OF AN INVENTORY MANAGEMENT PROCESS. THIS APPROACH MUST ALSO INCLUDE A PROCESS THAT PROVIDES FOR THE RECALL OF MEDICAL MARIJUANA AND THE MANAGEMENT OF MEDICAL MARIJUANA PRODUCT RETURNS FROM A DISPENSARY:

Please limit your response to no more than 5,000 words.

Section 15 – Management and Disposal of Medical Marijuana Waste

A. Medical Marijuana Waste	Yes	No
By checking "Yes," you affirm that medical marijuana waste will be stored, managed, and disposed of in accordance with § 1151.40(relating to management and disposal of medical marijuana waste).	☐	☐

B. PLEASE DETAIL YOUR PLAN FOR THE MANAGEMENT AND DISPOSAL OF MEDICAL MARIJUANA WASTE, IN ACCORDANCE WITH §§ 1151.22 (RELATING TO PLANS OF OPERATION) AND 1151.40 (RELATING TO MANAGEMENT AND DISPOSAL OF MEDICAL MARIJUANA WASTE):

Please limit your response to no more than 5,000 words.

Section 16 – Diversion Prevention

A. Diversion Prevention	Yes	No
You acknowledge that you have the opportunity, only within 30 days from the date the Department determines you to be operational, to import medical marijuana seeds and immature medical marijuana plants.	☐	☐

B. PLEASE PROVIDE A SUMMARY OF THE PROCEDURES THAT YOU WILL IMPLEMENT AT THE PROPOSED GROWER/PROCESSOR FACILITY AND SITE FOR THE PREVENTION OF THE UNLAWFUL DIVERSION OF SEEDS, IMMATURE MEDICAL MARIJUANA PLANTS, MEDICAL MARIJUANA PLANTS, MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS, ALONG WITH THE PROCESS THAT WILL BE FOLLOWED WHEN EVIDENCE OF THEFT/DIVERSION IS IDENTIFIED:

Please limit your response to no more than 5,000 words.

Section 17 – Growing Practice

A. Growing of Medical Marijuana	Yes	No
By checking "Yes" to any statement, you affirm that your facility will maintain the following practices for the growing of medical marijuana: If you check "No" to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time		

the Department determines you to be operational under the Act and regulations.		
• In accordance with §1151.27 (requirements for growing and processing medical marijuana), only pesticides, fungicides or herbicides that are listed and published in the *Pennsylvania Bulletin* will be used.	☐	☐
• A log of all actions taken to detect pests or pathogens, and the measures taken for control, will be maintained.	☐	☐
• Visual inspections of growing plants and harvested plant material will be performed to ensure there is no visible mold, mildew, pests, rot or grey or black plant material that is greater than an acceptable level as determined by the Department.	☐	☐
• A system to monitor, record, and regulate temperature, humidity, ventilation, lighting and water supply will be installed.	☐	☐

PLEASE PROVIDE AN EXPLANATION OF ANY RESPONSES ABOVE THAT WERE ANSWERED AS A "NO" AND HOW YOU WILL MEET THESE REQUIREMENTS BY THE TIME THE DEPARTMENT DETERMINES YOU TO BE OPERATIONAL UNDER THE ACT AND REGULATIONS:

Please limit your response to no more than 5,000 words.

B. PLEASE PROVIDE A SUMMARY OF WHICH PESTICIDES, IF ANY, WILL BE USED IN THE GROWING PROCESS:

Please limit your response to no more than 5,000 words.

C. PLEASE ALSO PROVIDE A DETAILED SUMMARY OF THE METHODS AND PROCEDURES THAT WILL BE USED FOR THE GROWING OF MEDICAL MARIJUANA AT THE PROPOSED GROWER/PROCESSOR FACILITY. FOR EXAMPLE: THE INCLUSION OF GROWING MEDIUMS OR HYDROPONICS, THE PHYSICAL CONDITION FOR MAINTAINING THE IMMATURE MEDICAL MARIJUANA PLANTS AND MEDICAL MARIJUANA PLANTS, NUTRIENT PRACTICE, PARTICULAR LIGHTING STRATEGIES, ETC.

Please limit your response to no more than 5,000 words.

Section 18 – Nutrient and Additive Practices

A. Nutrient and Growth Additive Practices	Yes	No

By checking "Yes" to any statement, you affirm that your facility will maintain the following medical marijuana nutrient and growth processes: If you check "No" to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.		
• Appropriate nutrient practices will be used.	☐	☐
• A fertilizer or hydroponic solution must be of a type, formulation and at a rate to support the healthy growth of plants.	☐	☐
• Records of the type and amounts of fertilizer and any growth additives used will be maintained.	☐	☐
• No additional active ingredients or materials will be added to the medical marijuana that alters the color, appearance, smell, taste, effect or weight of the medical marijuana, unless the grower/processor has first obtained the prior written approval of the Department.	☐	☐
• Excipients will be pharmaceutical grade, unless otherwise approved by the Department.	☐	☐

PLEASE PROVIDE AN EXPLANATION OF ANY RESPONSES ABOVE THAT WERE ANSWERED AS A "NO" AND HOW YOU WILL MEET THESE REQUIREMENTS BY THE TIME THE DEPARTMENT DETERMINES YOU TO BE OPERATIONAL UNDER THE ACT AND REGULATIONS:

Please limit your response to no more than 5,000 words.

B. PLEASE PROVIDE DETAILS OF ALL NUTRIENT AND GROWTH ADDITIVES THAT WILL BE UTILIZED AT YOUR FACILITY:

Please limit your response to no more than 5,000 words.

Section 19– Processing and Extraction

PLEASE DESCRIBE THE TECHNOLOGIES, METHODS, AND TYPES OF EQUIPMENT YOU WILL EMPLOY TO EXTRACT THE CRITICAL COMPOUNDS FROM MEDICAL MARIJUANA PLANTS TO PRODUCE THE MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS, AND THE TYPES OF MEDICAL MARIJUANA PRODUCTS THAT WILL BE PRODUCED:

Please limit your response to no more than 5,000 words.

Section 20– Sanitation and Safety

PLEASE PROVIDE A SUMMARY OF THE INTENDED SANITATION AND SAFETY MEASURES TO BE IMPLEMENTED AT YOUR PROPOSED FACILITY AND SITE. THESE MEASURES SHOULD COVER, BUT ARE NOT LIMITED TO, THE FOLLOWING: A WRITTEN PROCESS FOR CONTAMINATION PREVENTION, PEST PROTECTION PROCEDURES, MEDICAL MARIJUANA HANDLER RESTRICTIONS, HAND-WASHING FACILITIES, AND INSPECTION SCHEDULES TO ENSURE THE ACCURACY OF OPERATIONAL EQUIPMENT. Please limit your response to no more than 5,000 words.

Section 21 – Quality Control and Testing for Potential Contamination

By checking “Yes,” you affirm that quality control measures and testing efforts must be in place to track active ingredients (THC and CBD) and potential contamination of medical marijuana products.	☐ Yes	☐ No

Section 22 – Recordkeeping

PLEASE PROVIDE A SUMMARY OF THE RECORDKEEPING PLAN THAT WILL BE IN PLACE AT YOUR PROPOSED FACILITY AND SITE. THE PLAN SHOULD COVER, BUT IS NOT LIMITED TO, THE FOLLOWING: A SYSTEM FOR MONITORING, RECORDING, AND REGULATING TEMPERATURE, HUMIDITY, VENTILATION, WATER SUPPLY, AND LIGHTING THAT AFFECTS THE GROWTH OF MEDICAL MARIJUANA PLANTS, AN EQUIPMENT MAINTENANCE LOG, AND RECORDS OF INVENTORY AND ALL TRANSACTIONS. Please limit your response to no more than 5,000 words.

Part E – Applicant Organization, Ownership, Capital and Tax Status

(Scoring Method: 150 Points)

Section 23 – Organizational Structure

Applicant’s Form of Organization
Check One **☐C-Corporation☐S-Corporation☐Limited Liability Company** **☐Sole Proprietorship☐Partnership☐Limited Liability Partnership** **☐Limited Liability Limited Partnership☐Non-Profit Organization☐Other (explain):**

pennsylvania
DEPARTMENT OF HEALTH

Applicant's Organization Documents	
State of Incorporation or Registration:	**Date of Formation:** MM/DD/YYYY
Business Name on Formation Documents:	

Applicant's Identification Numbers	
Federal Employer ID number:	**PA Unemployment Compensation Account Number:**
PA Department of Revenue Tax number (if applicant is currently doing business in Pennsylvania):	**PA Workers' Compensation Policy Number (if applicant is currently doing business in Pennsylvania):**

The applicant affirms that workers' compensation insurance will be obtained by the time the Department determines you to be operational under the Act and regulations.	☐ Yes	☐ No

Section 24 – Business History and Capacity to Operate

Describe your business history and your ability and plan to maintain a successful and financially sustainable operation:
Please limit your response to no more than 5,000 words.

Section 25 – Current Officers

Provide the position, title in the applicant's business, and address information for all current officers, directors, partners or trustees.

Name and Residential Address					
First Name:		**Middle Name:**	**Last Name:**		**Suffix:**
Occupation:			**Title in the applicant's business:**		
Also known as:			**Date of birth:** MM/DD/YYYY		
Address Line 1:			**Address Line 2:**		
Address Line 3:	**City:**			**State:**	**Zip Code:**
Phone:		**Fax:**	**Email:**		
Name and Residential Address					
First Name:		**Middle Name:**	**Last Name:**		**Suffix:**
Occupation:			**Title in the applicant's business:**		
Also known as:			**Date of birth:** MM/DD/YYYY		
Address Line 1:			**Address Line 2:**		
Address Line 3:	**City:**			**State:**	**Zip Code:**
Phone:		**Fax:**	**Email:**		
Name and Residential Address					

First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth:MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	
Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth:MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	
Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth:MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	
Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth:MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	
Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth:MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	

IF MORE SPACE IS REQUIRED, PLEASE SUBMIT ADDITIONAL INFORMATION ON OTHEROFFICERS IN A SEPARATE DOCUMENT TITLED "CURRENT OFFICERS (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

SECTION 26 – OWNERSHIP

IN THIS SECTION, LIST ALL PERSONS WITH A CONTROLLING INTEREST IN THE BUSINESS, DEFINED AS FOLLOWS:

(1) FOR A PUBLICLY TRADED COMPANY, VOTING RIGHTS THAT ENTITLE A PERSON TO ELECT OR APPOINT ONE OR MORE OF THE MEMBERS OF THE BOARD OF DIRECTORS OR OTHER GOVERNING BOARD, OR THE OWNERSHIP OR BENEFICIAL HOLDING OF 5% OR MORE OF THE SECURITIES OF THE PUBLICLY TRADED COMPANY.
(2) FOR A PRIVATELY HELD ENTITY, THE OWNERSHIP OF ANY SECURITY IN THE ENTITY.

COMPLETE THE APPROPRIATE SECTION(S) BELOW:

A. FOR C-CORPORATIONS, S-CORPORATIONS, LLCS AND LLLCS

Name and Residential Address				
First Name:	Middle Name:		Last Name:	Suffix:
Occupation:			Title in the applicant's business:	
Also known as:			Date of birth: MM/DD/YYYY	
Address Line 1:			Address Line 2:	
Address Line 3:		City:	State:	Zip Code:
Phone:	Fax:		Email:	
Stock type or class:	Number of shares held:	Date Acquired: MM/DD/YYYY	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:

Name and Residential Address				
First Name:	Middle Name:		Last Name:	Suffix:
Occupation:			Title in the applicant's business:	
Also known as:			Date of birth: MM/DD/YYYY	
Address Line 1:			Address Line 2:	
Address Line 3:		City:	State:	Zip Code:
Phone:	Fax:		Email:	
Stock type or class:	Number of shares held:	Date Acquired: MM/DD/YYYY	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:

Name and Residential Address				
First Name:	Middle Name:		Last Name:	Suffix:
Occupation:			Title in the applicant's business:	
Also known as:			Date of birth: MM/DD/YYYY	
Address Line 1:			Address Line 2:	
Address Line 3:		City:	State:	Zip Code:
Phone:	Fax:		Email:	
Stock type or class:	Number of shares held:	Date Acquired: MM/DD/YYYY	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:

Name and Residential Address				
First Name:	Middle Name:		Last Name:	Suffix:
Occupation:			Title in the applicant's business:	
Also known as:			Date of birth: MM/DD/YYYY	

Address Line 1:		Address Line 2:		
Address Line 3:		City:	State:	Zip Code:
Phone:	Fax:	Email:		
Stock type or class:	Number of shares held:	Date Acquired: MM/DD/YYYY	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:
Name and Residential Address				
First Name:	Middle Name:	Last Name:	Suffix:	
Occupation:		Title in the applicant's business:		
Also known as:		Date of birth: MM/DD/YYYY		
Address Line 1:		Address Line 2:		
Address Line 3:		City:	State:	Zip Code:
Phone:	Fax:	Email:		
Stock type or class:	Number of shares held:	Date Acquired: MM/DD/YYYY	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:
Name and Residential Address				
First Name:	Middle Name:	Last Name:	Suffix:	
Occupation:		Title in the applicant's business:		
Also known as:		Date of birth: MM/DD/YYYY		
Address Line 1:		Address Line 2:		
Address Line 3:		City:	State:	Zip Code:
Phone:	Fax:	Email:		
Stock type or class:	Number of shares held:	Date Acquired: MM/DD/YYYY	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:
Name and Residential Address				
First Name:	Middle Name:	Last Name:	Suffix:	
Occupation:		Title in the applicant's business:		
Also known as:		Date of birth: MM/DD/YYYY		
Address Line 1:		Address Line 2:		
Address Line 3:		City:	State:	Zip Code:
Phone:	Fax:	Email:		
Stock type or class:	Number of shares held:	Date Acquired: MM/DD/YYYY	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:
Name and Residential Address				
First Name:	Middle Name:	Last Name:	Suffix:	
Occupation:		Title in the applicant's business:		
Also known as:		Date of birth: MM/DD/YYYY		
Address Line 1:		Address Line 2:		

Address Line 3:		City:	State:	Zip Code:
Phone:	Fax:	Email:		
Stock type or class:	Number of shares held:	Date Acquired: MM/DD/YYYY	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:

Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth:MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	

Stock type or class:	Number of shares held:	Date Acquired: MM/DD/YYYY	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:

Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth:MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	

Stock type or class:	Number of shares held:	Date Acquired: MM/DD/YYYY	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:

IF MORE SPACE IS REQUIRED, PLEASE SUBMIT ADDITIONAL INFORMATION ON OTHEROWNERS OF THE CORPORATION IN A SEPARATE DOCUMENT TITLED "OWNERS OF THE CORPORATIONS (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

B. FOR PARTNERSHIPSAND LLPS

Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth:MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	
Partner Type: ☐General/Full Partner ☐Limited Partner	Percentage of ownership:	Partnership participation from:	Description of participation in operation of the applicant:

pennsylvania
DEPARTMENT OF HEALTH

☐Dormant/Silent Partner ☐Other:		MM/DD/YYYY	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Partner Type: ☐General/Full Partner ☐Limited Partner ☐Dormant/Silent Partner ☐Other:	**Percentage of ownership:**	**Partnership participation from:** MM/DD/YYYY	**Description of participation in operation of the applicant:**
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Partner Type: ☐General/Full Partner ☐Limited Partner ☐Dormant/Silent Partner ☐Other:	**Percentage of ownership:**	**Partnership participation from:** MM/DD/YYYY	**Description of participation in operation of the applicant:**
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Partner Type: ☐General/Full Partner ☐Limited Partner ☐Dormant/Silent Partner ☐Other:	**Percentage of ownership:**	**Partnership participation from:** MM/DD/YYYY	**Description of participation in operation of the applicant:**
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**

Occupation:		**Title in the applicant’s business:**	
Also known as:		**Date of birth**:MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Partner Type: ☐**General/Full Partner** ☐**Limited Partner** ☐**Dormant/Silent Partner** ☐**Other**:	**Percentage of ownership:**	**Partnership participation from:** MM/DD/YYYY	**Description of participation in operation of the applicant:**
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant’s business:**	
Also known as:		**Date of birth**:MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Partner Type: ☐**General/Full Partner** ☐**Limited Partner** ☐**Dormant/Silent Partner** ☐**Other**:	**Percentage of ownership:**	**Partnership participation from:** MM/DD/YYYY	**Description of participation in operation of the applicant:**
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant’s business:**	
Also known as:		**Date of birth**:MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Partner Type: ☐**General/Full Partner** ☐**Limited Partner** ☐**Dormant/Silent Partner** ☐**Other**:	**Percentage of ownership:**	**Partnership participation from:** MM/DD/YYYY	**Description of participation in operation of the applicant:**
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant’s business:**	
Also known as:		**Date of birth**:MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**

Phone:	Fax:		Email:		
Partner Type: ☐General/Full Partner ☐Limited Partner ☐Dormant/Silent Partner ☐Other:	Percentage of ownership:	Partnership participation from: MM/DD/YYYY	Description of participation in operation of the applicant:		
Name and Residential Address					
First Name:	Middle Name:		Last Name:		Suffix:
Occupation:			Title in the applicant's business:		
Also known as:			Date of birth:MM/DD/YYYY		
Address Line 1:			Address Line 2:		
Address Line 3:		City:		State:	Zip Code:
Phone:	Fax:		Email:		
Partner Type: ☐General/Full Partner ☐Limited Partner ☐Dormant/Silent Partner ☐Other:	Percentage of ownership:	Partnership participation from: MM/DD/YYYY	Description of participation in operation of the applicant:		
Name and Residential Address					
First Name:	Middle Name:		Last Name:		Suffix:
Occupation:			Title in the applicant's business:		
Also known as:			Date of birth:MM/DD/YYYY		
Address Line 1:			Address Line 2:		
Address Line 3:		City:		State:	Zip Code:
Phone:	Fax:		Email:		
Partner Type: ☐General/Full Partner ☐Limited Partner ☐Dormant/Silent Partner ☐Other:	Percentage of ownership:	Partnership participation from: MM/DD/YYYY	Description of participation in operation of the applicant:		

IF MORE SPACE IS REQUIRED, PLEASE SUBMIT ADDITIONAL INFORMATION ON OTHER PARTNERS IN A SEPARATE DOCUMENT TITLED "INTEREST OF OTHER PARTNERS (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

C. OTHER PERSONS HOLDING AN INTEREST IN THE PROPOSED SITE OR FACILITY

LIST ANY OTHER PERSONS HOLDING AN INTEREST IN THE PROPOSED SITE OR FACILITY, THAT AREOTHERWISE NOT DISCLOSED IN SECTIONS A OR B.

Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:

pennsylvania
DEPARTMENT OF HEALTH

Occupation:		Title in the applicant's business:	
Also known as:		Date of birth:MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	
Nature, type, terms and conditions of the interest in the applicant:			
Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth:MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	
Nature, type, terms and conditions of the interest in the applicant:			
Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth:MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	
Nature, type, terms and conditions of the interest in the applicant:			
Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth:MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	
Nature, type, terms and conditions of the interest in the applicant:			

IF MORE SPACE IS REQUIRED, PLEASE SUBMIT ADDITIONAL INFORMATION ON OTHER PERSONS HOLDING AN INTEREST IN THE PROPOSED SITE OR FACILITY IN A SEPARATE DOCUMENT TITLED "OTHER PERSONS HOLDING AN INTEREST IN THE PROPOSED SITE OR FACILITY (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

Section 27 – Capital Requirements

Provide a summary of your available capital and an estimated spending plan to be used for you to become operational within six months from the date of the issuance of the permit:

Please limit your response to no more than 5,000 words.

Part F – Community Impact

(Scoring Method: 100 Points)

Section 28 – Community Impact

Please be advised, Letters of Recommendation or Support will not be considered when evaluating this section.

Provide a summary of how the applicant intends to have a positive impact on the community where its operations are proposed to be located:

Please limit your response to no more than 5,000 words.