Attestation and Release Authorization

(Attachment to Application Section F-1.2)

This form must be signed by an individual who may legally sign for the Applicant and who can verify the information provided in this application is true, correct, and complete. The form must be printed and signed with an original, wet-ink signature. Electronic or digital signatures are not acceptable.

Scan and attach a copy of the completed, notarized form, in PDF format, in response to Question F-1.2 of the online Application. Failure to do so may cause the application to be abandoned.

NAME	TITLE
PHONE (INCLUDING AREA CODE)	E-MAIL

I attest that I am authorized to pursue this application on the behalf of the Applicant identified in section A-1 of this application. I understand that the burden of proving the Applicant's qualifications to be awarded a provisional dispensary license at all times rests with the Applicant. I attest that the Applicant has not improperly secured any advantage against any other applicant or any person or persons interested in obtaining a provisional license from the Ohio Medical Marijuana Control Program. I further attest that the Applicant has not submitted a sham application and that all statements contained in the application are true.

I attest that this application is based on the legal requirements set forth in Ohio Revised Code and Ohio Administrative Code as well as performance expectations detailed in this application. The responses to this application are not based on details of any other potentially related application. The State Board of Pharmacy is not responsible for the accuracy of any information regarding this application that was gathered through a source different from the instruction provided in the Application Instructions, Application, Q&A, or Informational Webinar (if applicable).

I attest that I will not knowingly permit any public official, public employee, or contractor doing business with a public entity who has any responsibilities related to this application or the evaluation of this application to acquire an interest in anything or any entity under the Applicant's control. The Applicant will disclose to the State knowledge of any such person who acquires an incompatible or conflicting personal interest related to this application. The Applicant will take steps to ensure that such a person does not participate in any action affecting the evaluation of this application. This will not apply when the State has determined, in light of the personal interest disclosed, that person's participation in any such action would not be contrary to the public interest.

I understand that a background investigation will be conducted by the State Board of Pharmacy pursuant to its statutory duty to investigate the applicant and suitability of myself, any and all Prospective Associated Key Employees identified in this application, and any entity with which I am or one of the listed Prospective Associated Key Employees is associated. I further understand and agree that I am voluntarily executing this Release Authorization to expressly authorize and permit the State Board of Pharmacy to obtain any and all information it deems necessary, and accept any risk of adverse impacts as a consequence of any application review, investigation or lawful release of public records.

The rights and powers herein are granted to facilitate the background investigation being conducted by the State Board of Pharmacy at my request and on behalf of the Applicant and is not otherwise intended to create or establish a legal or fiduciary relationship between the State Board of Pharmacy, its agents and employees, and me. I hereby acknowledge that no such relationship exists.

I authorize and request every person, firm, company, corporation, board, association, or institution of any kind, and every Federal, state, or local government entity, including but not limited to every court, law enforcement agency, criminal justice agency or probation department, without exception, both foreign and domestic, to whom this Release Authorization is presented having any knowledge, information, documents, forms, photographs, computer files, accounts, ledgers or other items about, relating to or concerning the Applicant to fully discuss with and answer any inquiry made by any duly authorized representative of the State Board of Pharmacy.

I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921., 3715., 3719., 3796., AND 4729. OF THE OHIO REVISED CODE THAT I AM AUTHORIZED TO PURSUE THIS APPLICATION ON BEHALF OF THE ENTITY LISTED IN THIS APPLICATION AND THAT THIS APPLICATION IS TRUE, CORRECT, AND COMPLETE. I HEREBY ACKNOWLEDGE THAT IF THE LICENSE APPLIED FOR IS GRANTED, THE LICENSE-HOLDER SHALL SUBMIT TO THE JURISDICTION OF THE STATE OF OHIO BOARD OF PHARMACY AND TO THE LAWS OF THIS STATE FOR THE PURPOSE OF ENFORCEMENT OF CHAPTERS 2925., 3715., 3719., 3796., AND 4729. OF THE OHIO REVISED CODE AND ALL RELATED LAWS AND RULES.

I FULLY UNDERSTAND THAT SUBMISSION OF THIS APPLICATION WITH THE STATE BOARD OF PHARMACY CONSTITUTES PERMISSION FOR ENTRY AND ON-SITE INSPECTION BY AN AUTHORIZED BOARD AGENT IN ACCORDANCE WITH RULE 3796:6-2-06 OF THE OHIO ADMINISTRATIVE CODE.

SIGNATURE OF INDIVIDUAL	**DATE**	**DATE OF BIRTH OR SOCIAL SECURITY NUMBER**

A photocopy, facsimile or other electronic version of this document shall be accepted as an original signature.

Subscribed and sworn to before me this___day of_____, 20___.

(SEAL)

_____
NOTARY PUBLIC