



Ohio Medical Marijuana Control Program



Medical Marijuana Dispensary Change in Ownership or Name Application

Pursuant to Rule [3796:6-2-12](#) of the Ohio Administrative Code, only a dispensary that has engaged in medical marijuana dispensing under a certificate of operation for a continuous twelve-month period is eligible to apply for a change of ownership. Any change in ownership, business or tradename of a medical marijuana dispensary requires (1) Submission of the Dispensary Change in Ownership or Name Application and (2) Payment of the required fee of \$5,000. Please follow the steps below to submit a request for a change in ownership.

1. Log into the licensed dispensary’s eLicense account.
2. From the license tile, select “OPTIONS” then “SUBMIT ADDITIONAL DOCUMENTATION”.
3. Upload and submit the completed Dispensary Change in Ownership or Name Application.

Once the completed Application is received, a \$5,000 fee will be applied to the dispensary’s eLicense cart. The primary point of contacts will be notified via e-mail—at the addresses provided in Sections C & D (separate individuals must be identified for these sections)—to process payment.

The Application will be reviewed after the Change in Ownership or Name Application fee is paid. Please be aware that the Board may contact licensees for additional information. The \$5,000 application fee applies only to the Change in Ownership or Name Application. Should the application be granted, the applicant will be required to pay a Dispensary Certificate of Operation fee of \$70,000.

Section A – Current Licensee Information

A-1. Name of Dispensary:	A-2. Dispensary License No.:
A-3. Dispensary Address:	
A-4. City:	A-5. State:
A-4. Zip Code:	A-5. Phone Number:
A-6. Anticipated Date of Ownership Change:	

Section B – Change Information

B-1. Type of Change: <input type="checkbox"/> Ownership <input type="checkbox"/> Name (DBA) <input type="checkbox"/> Ownership & Name (DBA)
B-2. New Business Name (if applicable):



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B-3. New Trade Name/DBA Name (If applicable):
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Section C – Primary Contact for Current Owner		
C-1. First Name:	C-2. Middle Name:	C-3. Last Name:
C-4. Address:		C-5. City:
C-6. State:	C-7. Zip Code:	C-8. Phone Number
C-9. Email Address:		
C-10. Current Dispensary Organization Type (Select One):		
If "Other" explain:		
C-11. State Where Formation Documents Filed:	C-12. Date of Business Formation:	
C-13. Business Name on Formation Documents:		
C-14. Federal Employer ID Number (EIN):		
C-15. Ohio Unemployment Compensation Account Number:		
C-16. Ohio Department of Taxation Number:		
C-17. Ohio Workers' Compensation Policy Number:		



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I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921., 3715., 3719., 3796., 4752., AND 4729. OF THE OHIO REVISED CODE THAT I AM AUTHORIZED TO SIGN THIS APPLICATION ON BEHALF OF THE ENTITY LISTED IN SECTION C OF THIS APPLICATION. I HEREBY CERTIFY 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., 4752., AND 4729. OF THE OHIO REVISED CODE AND ALL RELATED LAWS AND RULES.

I FULLY UNDERSTAND, ACKNOWLEDGE, AND AGREE THAT SUBMISSION OF THIS APPLICATION WITH THE STATE OF OHIO BOARD OF PHARMACY CONSTITUTES EXPRESS WRITTEN CONSENT FOR AN AUTHORIZED BOARD AGENT TO ENTER AND PERFORM AN ON-SITE INSPECTION OF THE LICENSED DISPENSARY IN ACCORDANCE WITH RULE 3796:6-2-06 OF THE OHIO ADMINISTRATIVE CODE.

This form must be signed in ink by an individual defined as an "owner" under [rule 3796:6-2-03 of the Ohio Administrative Code](#). Digital signatures will NOT be accepted.

SIGNATURE OF CURRENT OWNER	DATE SIGNED
PRINTED NAME OF CURRENT OWNER	

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 _____.

<i>Sworn to and signed before me this date:</i>
<i>Date</i>
<i>Signature of Notary</i> <p style="text-align: center;">(SEAL)</p>



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Section D – Primary Contact for Proposed Dispensary Business Owner		
D-1. First Name:	D-2. Middle Name:	D-3. Last Name:
D-4. Address:		D-5. City:
D-6. State:	D-7. Zip Code:	D-8. Phone Number
D-9. Email Address:		
D-10. Current Dispensary Organization Type (Select One):		
If "Other" explain:		
D-11. State Where Formation Documents Filed:	D-12. Date of Business Formation:	
D-13. Business Name on Formation Documents:		
D-14. Federal Employer ID Number (EIN):		
D-15. Ohio Unemployment Compensation Account Number:		
D-16. Ohio Department of Taxation Number:		
D-17. Ohio Workers' Compensation Policy Number:		



Section E –Legal and Disciplinary Questions

To be completed on behalf of the entity identified in questions D-10 through D-17. Individuals are required to provide responses in section F.

E-1. Has the Entity or any of its affiliates been the subject of an action resulting in sanctions, disciplinary actions or civil monetary penalties or fines being imposed relating to a registration, license, provisional license or any other authorization to cultivate, process, or dispense medical marijuana or equivalent thereof in any state?

Yes

No

E-1.1. If 'Yes', please explain:

E-2. Has the Entity or any of its affiliates been the subject of a civil or administrative action relating to a registration, license, provisional license or authorization to cultivate, process, or dispense medical marijuana or equivalent thereof in any state?

Yes

No

E-2.1. If 'Yes', please explain:

E-3. Has criminal, civil, or administrative action been taken against the Entity or any of its affiliates for obtaining a registration, license, provisional license or other authorization to operate as a cultivator, processor, or dispensary of medical marijuana, or equivalent thereof in any jurisdiction by fraud, misrepresentation, or the submission of false information?

Yes

No

E-3.1. If 'Yes', please explain:

E-4. Has criminal, civil, or administrative action been taken against the Entity or any of its affiliates under the laws of Ohio or any other state, the United States or a military, territorial or tribal authority, relating to any of the Proposed Owner's prospective associated key employee of the Proposed Owner's, profession or occupation?

Yes

No

E-4.1. If 'Yes', please explain:



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If yes to any question above, provide the following:

Name of Case	Case Number	Nature of Charge or Complaint	Date of Charge or Complaint	Disposition	Name and Address of the Administrative Agency Involved (If applicable)	Court Name (If Applicable) (Specify Federal, State and/or local Jurisdictions)



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I FULLY UNDERSTAND, ACKNOWLEDGE, AND AGREE THAT SUBMISSION OF THIS APPLICATION WITH THE STATE OF OHIO BOARD OF PHARMACY CONSTITUTES EXPRESS WRITTEN CONSENT FOR AN AUTHORIZED BOARD AGENT TO ENTER AND PERFORM AN ON-SITE INSPECTION OF THE LICENSED DISPENSARY IN ACCORDANCE WITH RULE 3796:6-2-06 OF THE OHIO ADMINISTRATIVE CODE.

This form must be signed in ink by an individual fitting the definition of "owner" under [rule 3796:6-2-03 of the Ohio Administrative Code](#). Digital signatures will NOT be accepted.

SIGNATURE OF PROPOSED OWNER	DATE SIGNED
PRINTED NAME OF PROPOSED OWNER	

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 ____.

<i>Sworn to and signed before me this date:</i>
<i>Date</i>
<i>Signature of Notary</i>
<i>(SEAL)</i>



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The State Board of Pharmacy requires that all dispensary owners, as defined under [rule 3796:6-2-03 of the Ohio Administrative Code](#), be licensed as an Associated Key Employee. *See also*, [Ohio Adm. Code 3796:6-2-07](#). Generally, ownership requirements must be met only by those with at least a ten percent ownership interest in a dispensary. The State of Ohio Board of Pharmacy, however, may require an owner or person who exercises substantial control over an Applicant, but who has less than a ten percent ownership interest, to comply with statutory and regulatory ownership requirements.

“Prospective Associated Key Employees” include any and all natural persons who are owners, officers, board members of a dispensary Applicant; persons who have a financial interest in a dispensary Applicant; and/or persons who exercise substantial control over a dispensary Applicant. Exercising control includes the power to influence management and operational decision-making. For purposes of this application an individual is a “prospective associated key employee” irrespective of that individual’s ownership interest.

If applying for a change of Ownership, the following Addendum must be completed by EACH Prospective Associated Key Employee and uploaded with the above application.

Section F – PAKE Addendum		
F-1. First Name:	F-2. Middle Name:	F-3. Last Name:
F-4. Address:		F-5. City:
F-6. State:	F-7. Zip Code:	F-8. Phone Number:
F-9. Email Address:		
F-10. Date of Birth:	F-11. Social Security Number:	F-12. Occupation:
F-13. Title in the Proposed Owner’s business:	F-14. Proposed Owner’s business-related compensation:	
F-15. Number of shares or membership units owned:	F-16. Types of shares or membership units owned:	
F-17. Percent interest in Proposed Owner’s business:	F-18. Voting Percentage:	



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F-19. Proposed Role (Select One):

If "Other", explain:

F-20. Attachments:

- Verification of Identity: (1) Unexpired, valid state-issued driver's license, (2) Unexpired, valid photographic identification issued by the Ohio Bureau of Motor Vehicles or the equivalent from another state; or (3) Unexpired, valid United States Passport.**
- Tax Authorization Form: Each employee with an aggregate ownership interest of ten percent or more in the Proposed Owner's business must attach a copy of the Tax Authorization Form. The State of Ohio Board of Pharmacy may, in its discretion, require an owner or person who exercises substantial control over a dispensary, but who has less than ten percent ownership interest, to comply with statutory and regulatory ownership requirements. (ORC 3796.10; OAC 3796:6-2-02)**



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Section G – PAKE Legal and Compliance

G-1. Has the individual served, or are they currently serving as an owner, officer, board member, or employee of another medical marijuana entity in the State of Ohio or elsewhere in the United States?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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G-2. If yes, please provide the entity Name and Address:

G-3. Has this individual had ownership or financial interest, or do they currently have ownership or financial interest of another medical marijuana entity in the State of Ohio or the United States?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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G-4. If yes, please provide the entity Name and Address:

G-5. Has this individual ever been convicted of, or are charges pending for, a disqualifying offense? Include instances in which a court granted intervention in lieu of treatment (also known as treatment in lieu of conviction, ILC, or TLC), or other diversion programs. Offenses must be reported regardless of whether the case has been sealed, as described in section 2953.32 of the Revised Code, or the equivalent thereof in another jurisdiction.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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G-6. If yes, please provide the following:

Defendant	Name of Case & Case Number	Nature of Charge or Complaint	Date or Charge or Complaint	Disposition	Court Name (Specify Federal, State and/or Local Jurisdiction)

G-7. Has the individual ever been convicted of, or are charges pending for, any other felony offense under state or federal law?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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G-8. If yes, please provide the following:

Defendant	Name of Case & Case Number	Nature of Charge or Complaint	Date or Charge or Complaint	Disposition	Court Name (Specify Federal, State and/or Local Jurisdiction)



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G-11. Has this individual ever been disciplined by the State of Ohio Board of Pharmacy or any other licensing body?		Yes <input type="checkbox"/>	No <input type="checkbox"/>			
G-12. If yes, please provide the following:						
Name	License Number	Name & Address of Licensing Body	Nature of Charge or Complaint	Date of Charge or Complaint	Disposition	Name and Address of the Licensing Body Involved
Please respond to the following statements by selecting "Yes" or "No". Unless otherwise indicated, the individual must provide further information "Yes" is selected:						
G-13. Has the individual ever been denied a license by the appropriate issuing body of any federal, state or jurisdiction, or is such action pending?		Yes <input type="checkbox"/>	No <input type="checkbox"/>			
G-14. Has the individual ever been the subject of an investigation or disciplinary action by the appropriate issuing body of any federal, state or jurisdiction that resulted in the surrender, suspension, revocation, or probation of the individual's license or registration?		Yes <input type="checkbox"/>	No <input type="checkbox"/>			
G-15. Has the individual ever been the subject of a disciplinary action by the appropriate issuing body of any federal, state jurisdiction that was based in whole or in part, on the Proposed Owner's prescribing, dispensing, diverting, administering, storing, personally furnishing, compounding, supplying, or selling a controlled substance or other dangerous drug (i.e. prescription drug), or is any such action pending?		Yes <input type="checkbox"/>	No <input type="checkbox"/>			
G-16. By selecting "Yes," this individual agrees to be enrolled in the Retained Applicant Fingerprint Database (Rapback) should this application be approved.		Yes <input type="checkbox"/>	No <input type="checkbox"/>			
G-17. Has the individual been the subject of an action resulting in sanctions, disciplinary actions, or civil monetary penalties being imposed relating to any registration, license, provisional license or any other authorization to cultivate, process, or dispense medical marijuana in any state?		Yes <input type="checkbox"/>	No <input type="checkbox"/>			
G-18. Has the individual been the subject of a civil or administrative action relating to any registration, license, provisional license or authorization to cultivate, process, or dispense medical marijuana in any state?		Yes <input type="checkbox"/>	No <input type="checkbox"/>			
G-19. Has the individual been accused of obtaining any registration, license, provisional license or other authorization to operate as a cultivator, processor, or dispensary of medical marijuana in any jurisdiction by fraud, misrepresentation, or the submission of false information?		Yes <input type="checkbox"/>	No <input type="checkbox"/>			
G-20. Has any civil or administrative action been taken against the individual under the laws of Ohio or any other state, the United States or a military, territorial or tribal authority, relating to the individual's profession or occupation?		Yes <input type="checkbox"/>	No <input type="checkbox"/>			
G-21. If Yes, please provide the following:						



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Name	License Number	Name & Address of Licensing Body	Nature of Charge or Complaint	Date of Charge or Complaint	Disposition	Name and Address of the Licensing Body Involved

By selecting "Yes," the Proposed Owner understands and attests to the following statements:		
G-22. One or more of the Proposed Owner's Prospective Associated Key Employees is a physician who has a certificate to recommend medical marijuana or who intends to apply for a certificate to recommend medical marijuana under section 4731.30 of the Revised Code.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
G-23. One or more of the Proposed Owner's Prospective Associated Key Employees has an ownership, investment interest, or a compensation arrangement with a laboratory licensed under Chapter 3796. of the Revised Code or an Applicant for a license to conduct laboratory testing.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
G-24. One or more agreements have been entered between the person and/or entity identified in D-1 through D-18 and any entity awarded a provisional dispensary license or certificate of operation in the State of Ohio (e.g., purchase option agreement; membership interest purchase agreement; consulting agreement; licensing agreement; loan agreement, etc.).	Yes <input type="checkbox"/>	No <input type="checkbox"/>
G-25. Operating Agreement/Table of Organization: Attach all operating agreements and tables of organization of the entity identified in D-1 through D-18 for the previous 24 months.		
G-26. License Limit Verification: If you answered "Yes" to G-24, attach all agreements entered between the person and/or entity identified in D-1 through D-18 and any entity awarded a provisional dispensary license or certificate of operation in the State of Ohio (e.g., purchase option agreement; membership interest purchase agreement; consulting agreement; licensing agreement; loan agreement, etc.).		

This form must be manually signed in ink. Digital signatures will **NOT** be accepted.

SIGNATURE OF PAKE	DATE
PRINTED NAME OF PAKE	

Attestation and Release Authorization

This form must be signed by an individual who may legally sign for the Proposed Owner identified in section D 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 accepted.** Scan and attach a copy of the complete, notarized form, in PDF format with a completed Dispensary Change in Ownership or Name Application. Failure to do so may result in delay and/or cause the application to be abandoned.



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Name:	Title:	
Phone Number:	E-mail:	
<p>I attest that I am authorized to sign this application on the behalf of the Applicant identified in section D (the Applicant) of this application. I understand that the burden of establishing the Applicant's eligibility to be approved as a dispensary owner 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 an application containing any false or misleading information and that all statements contained in the application are true.</p> <p>I understand that a background investigation will be conducted by the State of Ohio Board of Pharmacy pursuant to its statutory duty to investigate the character, honesty, integrity and suitability of myself, any and all Prospective Associated Key Employees identified in section D of 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 Attestation and Release Authorization to expressly authorize and permit the State of Ohio Board of Pharmacy to obtain any and all information it deems necessary, and accept any risk of adverse impacts as a consequence of any investigation or lawful release of public records.</p> <p>The rights and powers herein are granted to facilitate the background investigation being conducted by the State of Ohio 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 of Ohio Board of Pharmacy, its agents and employees, and me. I hereby acknowledge that no such relationship exists.</p> <p>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 of Ohio Board of Pharmacy.</p> <p>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 SIGN 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.</p> <p>I FULLY UNDERSTAND, ACKNOWLEDGE, AND AGREE THAT SUBMISSION OF THIS APPLICATION WITH THE STATE OF OHIO BOARD OF PHARMACY CONSTITUTES EXPRESS WRITTEN CONSENT FOR AN AUTHORIZED BOARD AGENT TO ENTER AND PERFORM AN ON-SITE INSPECTION OF THE LICENSED DISPENSARY IN ACCORDANCE WITH RULE 3796:6-2-06 OF THE OHIO ADMINISTRATIVE CODE.</p>		
SIGNATURE OF INDIVIDUAL	DATE	DATE OF BIRTH OR SOCIAL SECURITY NUMBER



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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)

<i>Sworn to and signed before me this date:</i>
<i>Date</i>
<i>Signature of Notary</i>
(SEAL)



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Tax Authorization Form

This form must be completed by *each* Prospective Associated Key Employee with an aggregate ownership interest of ten percent or more in the Proposed Dispensary identified in Section D of this Application. Print and sign this form with an original, wet-ink signature. **Electronic or digital signatures are not accepted.** Scan and attach a copy of the signed form, in PDF format, as described on the first page of this Application. The State of Ohio Board of Pharmacy may, in its discretion, require an owner or person who exercises substantial control over a proposed dispensary, but who has less than a ten percent ownership interest, to comply with statutory and regulatory ownership requirements. (3796:6-2-03)

Business Name of Applicant	
I hereby authorize the Ohio Department of Taxation and any of its agents and/or employees to release information to the State of Ohio Board of Pharmacy including information relating to the undersigned individual as well as information regarding any business disclosed on the Application related to this tax authorization form for which the undersigned individual has an ownership interest. These records and information shall be limited to information obtained and maintained by the Ohio Department of Taxation and shall not contain any federal tax information as defined in the Internal Revenue Code, 26 U.S. Code § 6103, and received by the Internal Revenue Service. I expressly waive the confidentiality provisions of the Ohio Revised Code, which would otherwise prohibit disclosure, and agree to hold the Ohio Department of Taxation and the State of Ohio Board of Pharmacy harmless with respect to the disclosure herein. I certify under the penalties of perjury that I am the taxpayer identified below.	
PRINTED NAME OF AUTHORIZED REPRESENTATIVE	SOCIAL SECURITY NUMBER
SIGNATURE	DATE

Subscribed and sworn to before me this _____ day of _____, 20 ____.

<i>Sworn to and signed before me this date:</i>
<i>Date</i>
<i>Signature of Notary</i>
<i>(SEAL)</i>