OFFICE OF CANNABIS POLICY
DEPARTMENT OF ADMINISTRATIVE AND FINANCIAL SERVICES

Maine Medical Use of Cannabis Program
Designated Long-Term Care Facility
Registration Certificate Application

A long-term care facility (LTCF) designated by a qualifying patient, or qualified patients, must apply for a designated LTCF registration certificate with the Maine Medical Use of Cannabis Program (MMUCP) using this form.

Section 1. Applicant information.			
Section 1(a). Entity Information.			
Business Legal Name:		Federal EIN:	
Business Type: ☐ Corporation ☐ LLP ☐ Limited Liability Company ☐ LLLP ☐ General Partnership ☐ Non-Profit Entity ☐ Limited Partnership ☐ Other:		Is this business entity incorporated in the State of Maine or otherwise formed or organized pursuant to the laws of the state of Maine? ☐ Yes ☐ No	
Type of LTC Facility: ☐ Hospice provider facility licensed under Title 22 chapter 1681 ☐ Nursing facility licensed under Title 22 chapter 405 ☐ Assisted living facility licensed under Title 22 chapter 1663 or 1664 ☐ Program licensed under Title 22 chapter 1663			
Physical Address:	City:	State:	Zip:
Section 1(b). Designated LTC Facility Contact Information.			
Primary Contact Name:	Title/Relationship to Applicant:		
Phone:	E-mail Address:		
Mailing Address:	City:	State:	Zip:
Section 1(c): Acknowledgement and signature.			
By signing below, I acknowledge that I understand that the applicant and its agents, officers, directors and employees are responsible for knowing and complying with all state laws and rules governing the Maine Medical Use of Cannabis Program. I further understand and agree to provide documents, if requested, to clarify or support information provided in this application and supporting documents. I understand and agree that federal, state and local officials or other persons and organization may verify the information I have given. Additionally, I affirm that if I have given incorrect or incomplete information in this application, the application for a dispensary registration certificate may be denied. I understand the questions and requirements of this application and the consequences of providing inaccurate, incomplete, or falsified information in this application and attachments hereto. I certify that all answers and supporting information provided in this application are true, accurate and complete to the best of my abilities and knowledge.			
Authorized Agent Signature:		Date:	

Section 2: Designated long-term care facility ownership and personnel. OCP reserves the right to request additional information to clarify the nature of the interests and responsibilities of the individuals and entities listed in Section 2.	
Section 2(a): Ownership. This section to be completed with information pertaining to the ownership the business entity listed in Section 1(a). The percentage of ownership must equal 100%, unless the business entity listed in Section 1(a) is a non-profit entity, in which case skip to Section 2(b).	
Owner Name:	% of Ownership:
Owner Name:	% of Ownership:
Owner Name:	% of Ownership:
Owner Name:	% of Ownership:

Section 2(b): Individual Officers or Directors. This section to be completed with information pertaining to all officers, directors, managers, shareholders, board members, partners, or other individuals holding a management position or ownership interest in the business entity listed in Section 1(a). Use additional pages if necessary.

Each individual listed in this Section is required to obtain a registry identification card (fee will be waived) and to submit to a criminal history record check pursuant to Title 22 § 2425-B every two years.

Name:	RIC#: RIC		
Role/Title:	Background check within last 24 months? ☐ Yes ☐ No		
Mailing Address:	City:	State:	Zip:
Name:	RIC#: RIC		
Role/Title:	Background check within last 24 months? ☐ Yes ☐ No		
Mailing Address:	City:	State:	Zip:
Name:	RIC#: RIC		
Role/Title:	Background check within last 24 months? ☐ Yes ☐ No		
Mailing Address:	City:	State:	Zip:
Name:	RIC#: RIC		
Role/Title:	Background check within last 24 months? ☐ Yes ☐ No		
Mailing Address:	City:	State:	Zip:
Name:	RIC#: RIC		
Role/Title:	Background check within last 24 months? ☐ Yes ☐ No		
Mailing Address:	City:	State:	Zip:

Section 2(c): Staff Persons. This section is to be completed with information pertaining to all staff persons of the facility who will be assisting a qualified patient with the patient's medical use of cannabis, not already listed above.

Each individual listed in this Section is required to obtain a registry identification card (fee will be waived) and to submit to a criminal history record check pursuant to Title 22 § 2425-B every two years.

Name:	RIC#: RIC
Role/Title:	Background check within last 24 months? ☐ Yes ☐ No
Name:	RIC#: RIC
Role/Title:	Background check within last 24 months? ☐ Yes ☐ No
Name:	RIC#: RIC
Role/Title:	Background check within last 24 months? ☐ Yes ☐ No

Section 3. Required documentation. Provide the following documents with this application.

- Copy of the partnership agreement, limited liability company agreement, bylaws, or operating agreement, as appropriate, for the business entity provided in Section 1(a)
- Copy of the partnership agreement, limited liability company agreement, bylaws, or operating agreement, as appropriate, for any business entity owner listed in Section 2(a).
- Copy of the applicant's State of Maine long-term facility license.
- Copy of the Patient Designation Form for a qualified patient designating the LTC facility, redacting the patient's name.

Section 4. Affirmations. Initial to affirm your acknowledgement of each statement below.

Affirmation	**Initials**
I affirm that this entire Application, statements, attachments, and supporting documents are true and correct to the best of my knowledge and belief, and that the application is executed with the knowledge that misrepresentation or failure to reveal information requested may be deemed good cause for denial to issue a Designated Long-Term Care Facility Registration Certificate by the Department.	
I understand and acknowledge that the applicant and its agents, officers, directors and employees are responsible for knowing and complying with all state laws and rules governing the MMUCP.	
I understand the Department does not mail out a renewal application; and therefore, I am responsible for obtaining and submitting a complete application to renew my certification no less than 30 days prior to its expiration.	
I understand that Designated Long-Term Care Facility Registration Certificates are valid for one year from the date of issuance and shall be renewed on forms provided by the Department.	
I understand I am responsible for notifying the Office of Cannabis Policy, in writing, upon any change in mailing address, phone number or email address, since all correspondence will be sent to my last known address or email address. Failure to notify the Office of Cannabis Policy could result in not receiving my physical registry identification certificate and other correspondence.	
I understand that new officers or directors or staff persons of the facility who will be assisting a qualified patient with the patient's medical use of cannabis may not begin such role unless they are 21 years of age, have obtained a registry identification card, have submitted to a criminal records background check with the Department and are found not have a disqualifying drug offense.	
I understand that a Designated Long-Term Care Facility Registration Certificate issued by the Office of Cannabis Policy is a revocable privilege, and that the burden of proving an Applicant's qualifications for a Designated Long-Term Care Registration Certificate rests at all times with the Applicant.	
I understand that the applicant and the staff of the facility may obtain, store and administer medical cannabis and cannabis products only for those qualified patients for which they have a patient designation form on file for.	
I understand that the applicant and the staff of the facility may not cultivate cannabis plants for patients.	
I understand that applicant must have a current Patient Designation Form from a qualified patient designating the long-term care facility to maintain registration eligibility.	
I affirm that the applicant has a policy consistent with the assistance being provided for the designating qualified patient or patients medical use of cannabis.	

Section 5. Criminal Background Check Fees. This application will not be considered complete until the annual fee is remitted by the applicant.

Criminal Background Check Fees: **$31.00 X** **= $**

*Please enter the number of individuals in Section 2 that you checked "No" to them having received a background check in the last 24 months.

Please submit a bank/cashier's check or money order(s) made payable to: "Treasurer, State of Maine." Include the applicant name on the payment. **All fees are non-refundable.**