



ARIZONA DEPARTMENT OF HEALTH SERVICES
MEDICAL MARIJUANA PROGRAM

MEDICAL MARIJUANA DISPENSARY
DOCUMENTATION OF PROPERTY OWNER APPROVAL FOR USE

TO BE COMPLETED BY THE OWNER OF THE PROPERTY AT THE PHYSICAL LOCATION OF THE PROPOSED DISPENSARY
IF THE PROPERTY OWNER IS NOT THE ENTITY APPLYING FOR A DISPENSARY REGISTRATION CERTIFICATE

Name of Individual or Entity Applying for a Dispensary Registration Certificate:
Street Address/City of Proposed Dispensary: OR Legal Description of the Property:
(if no street address)

As the owner (or representative of the owner) of the property at the physical location listed above:

I grant permission for the individual or entity listed above to operate a dispensary on the property at the physical location listed above.

PRINTED NAME OF PROPERTY OWNER OR REPRESENTATIVE TELEPHONE NUMBER
SIGNATURE DATE SIGNED

If signed by the representative of the property owner:

NAME OF THE PROPERTY OWNER TITLE OF THE REPRESENTATIVE