



Medical Marijuana Program

165 Capitol Avenue, Room 145, Hartford, CT 06106-1630 • (860) 713-6066

E-mail: dcp.mmp@ct.gov • Website: www.ct.gov/dcp/mmp



Modification, Remodeling, Expansion, Reduction or Other Physical, Non-Cosmetic Alteration of a Production Facility Form

INSTRUCTIONS: You must complete all portions of this application. This application must be accompanied by a check or money order in the amount of \$3,500.00, made payable to: "Treasurer, State of Connecticut." Upon approval, the applicant will be required to pay an additional \$1,500.00. **All application fees are non-refundable.**

Section A: Business Information

1. Legal Name of Applicant:		
2. Trade Name of Applicant:		
3. Applicant's Business Address:		
4. City:	5. State:	6. Zip Code:
7. Name of Primary Contact:		8. Primary Contact Title:
9. Primary Contact E-mail Address:		10. Primary Contact Telephone Number: () -

Section B: Production Facility Information

11. Production Facility Address:		12. Producer License No.:	
13. City:		14. State: CT	15. Zip Code:
16. Telephone Number: () -		17. Fax Number: () -	

Section C: Changes to Production Facility

18. Type of Change: <input type="checkbox"/> Modifications <input type="checkbox"/> Remodeling <input type="checkbox"/> Expansion <input type="checkbox"/> Reduction <input type="checkbox"/> Other: _____	
19. Proposed Start Date:	20. Proposed Completion Date:
21. Description of Project: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	



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22. Please provide the following information as part of your application:

- A blueprint, or floor plan drawn to scale, of the proposed area of the dispensary facility or dispensary department.
- Copies of all licenses and/or permits required by the town necessary to complete work.
- List of all individuals who will be working at the site for the proposed time frame.
- Attach a detailed description of the security plan to be in place during this project to prevent against theft, diversion and/or loss.

I hereby certify that the above information is correct and complete.

I fully understand that if I knowingly make a statement that is untrue and which is intended to mislead the Department of Consumer Protection or any person designated by the Department in the performance of their official function, I will be in violation of Section 53a-157b of the Connecticut General Statutes. As the duly authorized representative of the applicant, I hereby make the above certifications on behalf of the applicant.

25. Signature:



26. Printed Name:

27. Date Signed:

For Department Use Only.

28. Date Received:

- Approved
 Disapproved

Assigned Drug Control Agent Name:

Date of Action: