



REMOVAL OF AUTHORIZED CONTACT
CONSOLIDATED ANNUAL FINANCIAL STATEMENT (AFS)

Licensee Information			
Licensee Legal Name		Licensee prequalification Record Number (e.g., ERG-000000 and/or AU-ER-000000)	
AFS Fiscal Year	Reporting Period	Licensee FCR Record Number (e.g., FCR-000000)	
FEIN	Phone Number	Email Address	
Mailing Address	City	State	Zip Code

Check all boxes to acknowledge the following:

- Licensee requests that the Cannabis Regulatory Agency (Agency) remove the individual below as the contact person for the licensee's AFS for the fiscal year noted above.
 Contact Name: _____
- Licensee understands that this person will no longer receive communications from the Agency regarding the licensee's AFS. Further, licensee understands that this person will no longer have authority to submit documentation regarding the licensee's AFS and will no longer be able to contact the Agency on the licensee's behalf. Licensee also understands that removal of this person as a contact for the licensee's AFS does not remove them as a contact person on the licensee's application, or license records, if authorized as a contact for those records.
- By signing this form, the licensee is acknowledging all supplemental applicants have been made aware and approve of this removal of authorized contact person.
- The individual responsible for completing this form has full authority to execute this removal of authorized contact person and the authority to submit documentation on behalf of the licensee.

Signature & Declaration

I attest the information I provided on this contact form is true and accurate and that I will comply with the requirements of the Medical Marihuana Facilities Licensing Act (MMFLA) and the Michigan Regulation and Taxation of Marihuana Act (MRTMA) and their associated rules. I understand that falsified or fraudulent information could subject the licensee to disciplinary action as provided in the MMFLA and the MRTMA and their associated rules, up to and including license revocation.

Signature: _____

Date: _____

Printed Name: _____

Notary

Subscribed and sworn to by _____ before me on _____.
(Authorized Individual Name) (Date)

(Notary Public Signature) (Notary Public Printed Name)

State of _____, County of _____. Acting in the county of _____,
(County) (State)

My commission expires: _____.