Financial Compliance Section
Cannabis Regulatory Agency
P.O. Box 30205 Lansing, MI 48909
Telephone: (517) 284-8599
CRA-AFS@michigan.gov

REMOVAL OF AUTHORIZED CONTACT
MEDICAL ANNUAL FINANCIAL STATEMENT (AFS)

Licensee Information

Licensee legal name	Licensee prequalification record number (e.g., ERG-000000)
AFS Fiscal Year FEIN	Phone 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 medical 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 medical AFS. Further, licensee understands that this person will no longer have authority to submit documentation regarding the licensee's medical 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 medical AFS does not remove them as a contact person on the licensee's application, license records, or adult-use AFS, 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 associated rules. I understand that falsified or fraudulent information could subject the licensee to disciplinary action as provided in the MMFLA and associated rules, up to and including license revocation.

Signature: **Date:**

Printed Name:

Notary

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

_____ (Notary Public Signature) _____ (Notary Public Printed Name)

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

My commission expires: _____.