Medical Facilities Licensing
Marijuana Regulatory Agency
P.O. Box 30205 Lansing, MI 48909
Telephone: (517) 284-8599
MRA-Applications@Michigan.gov

AUTHORIZATION OF ADDITIONAL CONTACT PERSON

Do not sign until notary is present

Add additional pages of this form as necessary to account for multiple contact persons.

PART A (to be completed by the medical licensee):

On behalf of ______________________________, I ______________________________,
Legal Name of Medical Licensee — Name & Title of Individual Authorized to Sign on Behalf of Medical Licensee

confirm the following:

1. I am the individual responsible for submitting this form and have full authority to execute this authorization of additional contact person.
2. I authorize the Marijuana Regulatory Agency (Agency) to add ______________________________ to be a contact person for the medical facility licensee. I understand that this person will have access to the following medical facility license records of the licensee: the prequalified record, license record(s), and renewal record(s). Further, I understand that this person will retain access and is authorized to communicate with and receive communication from the Agency regarding the medical facility licensee until the licensee submits an official request to remove this person's access and cease communication with this person. The contact information for this person in provided in Part B below.

______________________________ ______________________________
Authorized Individual Signature — Date

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: ______________________________.

PART B (to be completed by the authorized contact person):

I ______________________________, confirm the following:
Name of Contact Person

1. I am the individual named in Part A above.
2. My contact information to be used in communications regarding the medical facility licensee named in Part A above is as follows:

Contact E-mail Address: ______________________________

Contact Phone Number: ______________________________

Contact Person's ACA Login User ID (if applicable): ______________________________

(IMPORTANT: ACA Login User ID is required if the contact person needs to have access to online medical facility records. Please contact the MRA if you need assistance creating an ACA account.)

______________________________ ______________________________
Contact Person Signature — Date

Subscribed and sworn to by ______________________________ before me on ______________________________.
(Contact Person Name) — (Date)

______________________________ ______________________________
(Notary Public Signature) — (Notary Public Printed Name)

State of ______________, County of ______________. Acting in the county of ______________, ________.
(county) — (state)

My commission expires: ______________________________.