



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

REMOVAL OF AUTHORIZED CONTACT PERSON
(To be completed and submitted by the medical facility licensee)

Do not sign until notary is present

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

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 removal of authorized contact person.
2. I hereby request that the Marijuana Regulatory Agency (Agency) remove _____ as a contact person for the medical facility licensee. I understand that this person will no longer have access to medical facility licensing records of the licensee. Further, I understand that this person will no longer receive communications regarding the medical facility licensee and will no longer be able to contact the Agency on the licensee's behalf.

 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: _____.