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

CONTACT AUTHORIZATION

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 authorizes the individual below to be the contact person that the Cannabis Regulatory Agency (Agency) can discuss any and all information regarding the medical AFS.

Contact Name: ____

Email Address: ____

Phone Number: ____

☐ Licensee understands this person will receive all communication from the Agency regarding the licensee's medical AFS report until the licensee submits an official request to cease communication with this person.

☐ By signing this form, the licensee is acknowledging all supplemental applicants have been made aware and approve of this designation.

☐ The individual responsible for completing this form also has full 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____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: ____.