



## City of Southfield

26000 Evergreen Rd. • P.O. Box 2055 • Southfield, MI 48037-2055 • [www.cityofsouthfield.com](http://www.cityofsouthfield.com)

Dear Applicant,

When applying for a Medical Marijuana Facility or an Adult Use Marihuana Establishment license with the City of Southfield please have the following when you return your application to the Clerk's office.

- Application Fee: \$5000
- Fingerprints
- Application- filled out and notarized
- Police Background Check Application (filled out by owner)
- Copy of Driver's License (Front and Back)
- Proof of corporation registration (if applicable);
- Deed/lease/option agreement;
- Property owner's authorization (if applicable);
- Diagram of proposed licensed premise;
- Lighting plan;
- Security plan;
- Proof of insurance;
- Staffing plan;
- Contact information.
- Social Equity Statement(for Adult Use Marihuana Establishments)

The City of Southfield Medical Marijuana License or Adult Use Marihuana Establishment Application must be filled out by each applicant and returned to the City Clerk's Office. Once all the information required is received an investigation will begin. The investigation cannot begin until all documents are received and all necessary fees are paid.

Once your application is received you will be contacted by a representative from the Police Department and Fire Department to conduct their investigation. Inspectors from the Building Department and Planning will also be coming out to do inspections. You will be contacted by the City Clerk's Office once a decision regarding your application has been made. If you have any questions do not hesitate to contact us at (248)796-5150.

### APPLICATION RECEIPT – CITY CLERK'S OFFICE

Application received by: \_\_\_\_\_ Date received: \_\_\_\_\_  
Fee paid: \$ \_\_\_\_\_ Date: \_\_\_\_\_  
City Clerk's approval: \_\_\_\_\_ Date: \_\_\_\_\_  
License/permit number: \_\_\_\_\_

**PLEASE CHECK ONE ONLY :**

**MEDICAL MARIJUANA FACILITIES LICENSE APPLICATION**

Pursuant to Ordinance 1712

**ADULT USE MARIJUANA ESTABLISHMENT LICENSE APPLICATION**

Pursuant to Ordinance

New \_\_\_\_\_

Renewal \_\_\_\_\_

Amendment \_\_\_\_\_

**APPLICANT INFORMATION** (Person submitting application to Clerk's Office)

FULL NAME: \_\_\_\_\_

Relationship to Business (ex. Owner, manager, etc.) \_\_\_\_\_

Resident Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_ Business Telephone \_\_\_\_\_

Date of Birth \_\_\_\_\_ E-mail \_\_\_\_\_

**TYPE OF FACILITY (Medical Marijuana Facility)**Grower:

Class A (500 plants)       Processor       Provisioning Center  
 Class B (1,000 plants)       Safety Compliance       Secure Transporter  
 Class C (1,500 plants) No. of Class C Permits requested \_\_\_\_\_

**TYPE OF ESTABLISHMENT (Adult Use Marihuana Establishment)**Grower:

Class A (500 plants)       Processor       Retailer  
 Class B (1,000 plants)       Safety Compliance       Secure Transporter  
 Class C (1,500 plants) No. of Class C Permits requested \_\_\_\_\_

### **PROPOSED FACILITY INFORMATION (Medical)**

Property Address \_\_\_\_\_

Real Property Parcel Number \_\_\_\_\_

Property Zoning District \_\_\_\_\_

Advertised Facility Name \_\_\_\_\_

Manager – Full Name \_\_\_\_\_

### **PROPOSED ESTABLISHMENT INFORMATION (Adult Use)**

Property Address \_\_\_\_\_

Real Property Parcel Number \_\_\_\_\_

Property Zoning District \_\_\_\_\_

Advertised Facility Name \_\_\_\_\_

Manager – Full Name \_\_\_\_\_

### **PROPERTY OWNER(S) INFORMATION**

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

### **BUSINESS INFORMATION Ownership**

#### **Type**

- Individual/Sole Proprietorship
- Partnership
- Sole Member LLC
- Corporation      Type: \_\_\_\_\_
- Nonprofit

LLC

LLP

Other

**Official Business Name**

Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Business Phone \_\_\_\_\_

Business E-mail \_\_\_\_\_ Business Website \_\_\_\_\_

Federal Tax ID# (If applicable) \_\_\_\_\_

**If you marked Individual or Sole Proprietorship in the “Business Information” section, complete this section.**

Full Name \_\_\_\_\_

Residence Address \_\_\_\_\_ City \_\_\_\_\_  
\_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_  
\_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_

Business Telephone \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_

*Spouse of Individual/Sole Proprietorship or Sole Member, if applicable*

Full Name \_\_\_\_\_

Residence Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_  
\_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_

Business Telephone \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail \_\_\_\_\_

This Section was left blank intentionally.

Please continue to the next section of this application.

**If you marked LLC, LLP, Partnership, Corporation, Nonprofit or Other in the “Business Information” section, complete this section for every “true party of interest” in the applicant or business as defined in MCL 333.27102. Make additional copies of this page as needed.**

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Residence Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Telephone \_\_\_\_\_

E-mail \_\_\_\_\_

\*\*\*\*\*

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Residence Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Telephone \_\_\_\_\_

E-mail \_\_\_\_\_

\*\*\*\*\*

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Residence Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Telephone \_\_\_\_\_

E-mail \_\_\_\_\_

\*\*\*\*\*

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Residence Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Telephone \_\_\_\_\_

E-mail \_\_\_\_\_

\*\*\*\*\*

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Residence Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_ Telephone \_\_\_\_\_

E-mail \_\_\_\_\_

#### **ADDITIONAL DOCUMENTS REQUIRED**

In order for this application to be complete, you must also submit the following documents:

ATTACHMENT A – PROOF OF CORPORATION REGISTRATION (if applicable);

ATTACHMENT B – DEED/LEASE/OPTION AGREEMENT;

ATTACHMENT C – PROPERTY OWNER’S AUTHORIZATION (if applicable);

ATTACHMENT D – DIAGRAM OF PROPOSED LICENSED PREMISE;

ATTACHMENT E – LIGHTING PLAN;

ATTACHMENT F – SECURITY PLAN;

ATTACHMENT G – PROOF OF INSURANCE;

ATTACHMENT H – STAFFING PLAN;

ATTACHMENT I – CONTACT INFORMATION.

ATTACHMENT J – SOCIAL EQUITY STATEMENT

#### **ATTACHMENT A PROOF OF REGISTRATION**

If the business is a LLC, LLP, Partnership, Corporation, Nonprofit or other, please provide proof of registration with, or a certificate of good standing from, the Michigan Department of Licensing and Regulatory Affairs – Corporations, Securities, and Commercial Licensing Bureau.

## **ATTACHMENT B**

Please attach one:

- A copy of any deed reflecting the applicant's ownership of the proposed licensed premises;  
OR
- A copy of a lease reflecting the right of the applicant to possess the proposed licensed premises;  
OR
- A copy of an option agreement reflecting the applicant's right to purchase the proposed licensed premises;  
OR
- A copy of an option agreement reflecting the applicant's right to lease the proposed licensed premises.

### **ATTACHMENT C PROPERTY OWNER'S AUTHORIZATION**

A notarized statement from the owner of the property authorizing the use of the property for a medical marijuana facility.

**NOTE:** this attachment is necessary only if the applicant is not the owner of the proposed licensed premises.

#### **ATTACHMENT D DIAGRAM OF PROPOSED LICENSED PREMISE**

A “to scale” diagram of the proposed licensed premises, no larger than eleven (11) inches by seventeen (17) inches, showing, without limitation, building floor plan and layout, all entryways, doorways, or passage ways, and means of public entry and exits to the proposed licensed premises, loading zones, available onsite parking spaces, fencing at the premises, and all areas in which medical marijuana will be stored, grown, manufactured or dispensed.

#### **ATTACHMENT E LIGHTING PLAN**

A lighting plan showing the lighting outside of the medical marijuana facility for security purposes and compliance with applicable City outdoor lighting requirements.

## **ATTACHMENT F SECURITY PLAN**

All security plans, including video surveillance, will be reviewed by the Southfield Police Department.

## ATTACHMENT G PROOF OF INSURANCE

### For All Medical MARIJUANA Facility Types

General liability insurance with minimum limits of \$1,000,000 per occurrence and a \$2,000,000 aggregate limit issued from a company licensed to do business in Michigan having an AM Best rating of at least B++. The policy shall name the City of Southfield and its officials and employees as additional insured to the limits required.

### For Secure Transporters (In Addition to Above)

A secure transporter shall provide proof of no-fault automobile insurance with a company licensed to do business in Michigan with limits of liability not less than \$1,000,000 per occurrence combined single limit for bodily injury and property damage, vehicle registration, and registration as a commercial motor vehicle for all vehicles used to transport marijuana or marijuana-infused product.

## ATTACHMENT H STAFFING PLAN

### Summary

Please indicate the number of employees who will be working at the proposed facility once the facility is operational:

Full-time employees (32+ hours per week) \_\_\_\_\_ Part-time

employees (<32 hours per week) \_\_\_\_\_

### Position Types and Compensation

Please provide a description of the types of jobs the proposed facility is expected to create, along with the amount of compensation and benefits expected to be paid for such jobs:

**Position Title:** \_\_\_\_\_

Annual Average Compensation \$ \_\_\_\_\_

How many people will be employed in this position at the proposed facility? \_\_\_\_\_

Are health insurance benefits available for employees in this position? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please indicate the employer contribution to health insurance costs: All \_\_\_\_\_ Partial \_\_\_\_\_  
None \_\_\_\_\_

**Position Title:** \_\_\_\_\_ Annual Average Compensation  
\$ \_\_\_\_\_

How many people will be employed in this position at the proposed facility? \_\_\_\_\_

Are health insurance benefits available for employees in this position? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please indicate the employer contribution to health insurance costs: All \_\_\_\_\_ Partial \_\_\_\_\_  
None \_\_\_\_\_

**Position Title:** \_\_\_\_\_ Annual Average Compensation  
\$ \_\_\_\_\_

How many people will be employed in this position at the proposed facility? \_\_\_\_\_

Are health insurance benefits available for employees in this position? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please indicate the employer contribution to health insurance costs: All \_\_\_\_\_ Partial \_\_\_\_\_  
None \_\_\_\_\_

**Position Title:** \_\_\_\_\_ Annual Average Compensation  
\$ \_\_\_\_\_

How many people will be employed in this position at the proposed facility? \_\_\_\_\_

Are health insurance benefits available for employees in this position? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please indicate the employer contribution to health insurance costs: All \_\_\_\_\_ Partial \_\_\_\_\_  
None \_\_\_\_\_

**Position Title:** \_\_\_\_\_ Annual Average Compensation  
\$ \_\_\_\_\_

How many people will be employed in this position at the proposed facility? \_\_\_\_\_

Are health insurance benefits available for employees in this position? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please indicate the employer contribution to health insurance costs: All \_\_\_\_\_ Partial \_\_\_\_\_  
None \_\_\_\_\_

Please provide information on any benefits other than health insurance that are offered to all employees:

---

---

---

---

Attach additional pages if necessary.

## ATTACHMENT I CONTACT INFORMATION

Please provide your preferred contact information below for communications regarding this application and the requested permit(s), including information that may be time sensitive. Email is the primary communication method the City Clerk's Office will use. All email communications regarding this application will come from the following email address: \_\_\_\_\_ . Please "whitelist" this address in your email contacts to ensure timely delivery of messages.

Name \_\_\_\_\_

Relationship to Business (ex. Owner, manager, etc.) \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Business Telephone \_\_\_\_\_

E-mail \_\_\_\_\_

Neither I, the applicant, nor any "true party of interest" is in default to the City of Southfield for any property tax, special assessment, utility charges, fines, fees or other financial obligation owed to the City of Southfield.

- I the applicant have reviewed and agree to conform its hiring and public accommodation practices to, the City of Southfield's anti-discrimination ordinance provisions.
- Neither I, the applicant, nor any "true party of interest" is ineligible from holding a license for any of the reasons set forth at Section 402 of the MMFLA, MCL 333.27402.
- I the applicant consent to inspections, examinations, searches and seizures required or undertaken pursuant to enforcement or this ordinance.

I hereby certify under the penalty of perjury that the statements made in this application, including all attachments thereto, are true. I further certify that I am an officer, director, or managerial employee of the applicant or a person who holds a direct or indirect ownership interest in the applicant.

Applicant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **ATTACHMENT J SOCIAL EQUITY STATEMENT**

Please provide information relative to your adult use marihuana establishment business operations and any of the following items

- ❖ hiring and maintaining a diverse, multi-ethnic, and multicultural workforce that is reflective of the communities in which it operates;
- ❖ a dedicated percentage of the business' annual spending to diverse supplier(s);working with properly licensed local suppliers and contractors for construction, business services, and the acquisition of products. Women-owned, Minority-owned, as well as including suppliers who were previously disproportionately impacted by marijuana enforcement;
- ❖ commitment to sustainable, environmentally friendly development, and encouraging environmental conservation.
- ❖ community reinvestment plans detailing the licensee's volunteer time or donation percentages of their revenue to organizations, non-profits, and/or charities which positively impact a broad range of diverse groups;
- ❖ Participant in the CRA Social Equity All-Star Program recognizing licensees' social equity efforts

## **POLICE RECORD CHECK**

The following information is being requested so that a complete and accurate record check on your driving and criminal record can be obtained.

---

Last Name

First Name

Middle Name

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Race \_\_\_\_\_ Gender: \_\_\_\_\_

Height: \_\_\_\_ ft. \_\_\_\_ in. Weight: \_\_\_\_ lbs. Hair Color: \_\_\_\_\_

Eye Color: \_\_\_\_\_

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ U.S. Citizen? Yes  No

Driver's License Number: \_\_\_\_\_ Expiration Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you ever been convicted of a felony? Yes  No  If yes, please explain \_\_\_\_\_

---

---

---

Have you ever been convicted of a misdemeanor? Yes  No  If yes, please explain \_\_\_\_\_

---

---

---

Have you ever been addicted to alcohol or drugs? Yes  No

Have you ever used any other name than the one you are now using? Yes  No

If yes, which name(s) \_\_\_\_\_

I hereby certify that the above information is true and any false statement of facts will result in denial of application.

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I hereby authorize the City of Southfield, its agents and employees, to seek information and conduct an investigation into the truth of the statements set forth in this application and the qualifications of the applicant for the license, and I will execute waivers or authorization for the release of information upon request.

State of Michigan)

)ss.

County of Oakland)

I, \_\_\_\_\_, hereby declare under penalty of perjury, that the foregoing information in this application is true and correct and understand any falsification or omission is grounds for denial or if issued a license ground for revocation or recommendation for non-renewal.

---

On the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,  
\_\_\_\_\_, did appear personally before me, a Notary Public, in and for the  
said County, and being duly sworn by me, did state (s)he is the applicant of the within application, and  
that the information contained within the application is true, correct and complete.

---

Notary Public

Oakland County, Michigan

My Commission Expires: \_\_\_\_\_

**This Section was left blank intentionally.**