Medical Marijuana Program

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Fax: (860) 706-5361 • **E-mail:** dcp.mmp@ct.gov • **Website:** www.ct.gov/dcp/mmp

Modification, Remodeling, or Other Physical, Non-Cosmetic Alteration of a Production Facility Form

INSTRUCTIONS: You must complete all portions of this application. This application must be accompanied by a check or money order in the amount of $500.00, made payable to: "Treasurer, State of Connecticut." All application fees are non-refundable.

Section A: Business Information

1. Legal Name of Applicant:		
2. Trade Name of Applicant:		
3. Applicant's Business Address		
4. City:	5. State:	6. Zip Code:
7. Name of Primary Contact:	8. Primary Contact Title:	
9. Primary Contact E-mail Address:	10. Primary Contact Telephone Number: ( ) -	

Section B: Production Facility Information

11. Production Facility Address:	12. Producer License No.:	
13. City:	14. State: CT	15. Zip Code:
16. Telephone Number: ( ) -	17. Fax Number: ( ) -	

Section C: Changes to Production Facility

18. Type of Change:
☐ Modifications ☐ Remodeling ☐ Expansion ☐ Reduction ☐ Other:_____

19. Proposed Start Date:	20. Proposed Completion Date:

21. Description of Project:

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22. Please provide the following information as part of your application:

- A blueprint, or floor plan drawn to scale, of the proposed area of the production facility.
- Copies of all licenses and/or permits required by the town necessary to complete work.
- List of all individuals who will be working at the site for the proposed time frame.
- Attach a detailed description of the security plan to be in place during this project to prevent against theft, diversion and/or loss.

I hereby certify that the above information is correct and complete.

I fully understand that if I knowingly make a statement that is untrue and which is intended to mislead the Department of Consumer Protection or any person designated by the Department in the performance of their official function, I will be in violation of Section 53a-157b of the Connecticut General Statutes. As the duly authorized representative of the applicant, I hereby make the above certifications on behalf of the applicant.

23. Signature: ►	24. Printed Name:	25. Date Signed:

I hereby certify that the above information is correct and complete.

26. Date Received:	☐ Approved ☐ Disapproved	Assigned Drug Control Agent Name:	Date of Action: