

# MEDICAL MARIJUANA ORGANIZATION PERMIT APPLICATION

## Attachments

The following attachments are part of the application package. Instructions for each attachment are at the beginning of each attachment.

**Attachment A:** Signature Page

**Attachment B:** Organizational Documents

**Attachment C:** Property Title, Lease, or Option to Acquire Property Location

**Attachment D:** Site and Facility Plan

**Attachment E:** Personal Identification

**Attachment F:** Affidavit of Business History

**Attachment G:** Affidavit of Criminal Offense

**Attachment H:** Tax Clearance Certificates

**Attachment I:** Affidavit of Capital Sufficiency

**Attachment J:** Sample Medical Marijuana Product Label

**Attachment K:** Release Authorization

**Attachment L:** Applicant Priorities for Multiple Applications

### Attachment A: Signature Page

Instructions:

**This attachment is the signature page for your application and all other attachments.**

- Please review the application
- By checking the appropriate boxes, indicate the sections that are included in your submission
- Print this attachment
- Sign the document (primary contact or registered agent)
- Scan this sheet and save it as a file called "Attachment A," using the appropriate file name format

Instructions:

**This attachment is the signature page for your application and all other attachments.**

- Please review the application
- By checking the appropriate boxes, indicate the sections that are included in your submission
- Print this attachment
- Sign the document (primary contact or registered agent)
- Scan this sheet and save it as a file called "Attachment A," using the appropriate file name format

By checking "Yes," you acknowledge that you have read the Medical Marijuana Organization Permit Application Instructions before completing an application for a medical marijuana organization permit.

x  
Yes  
  
No

The applicant hereby submits this application for a Medical Marijuana Organization Permit to the Pennsylvania Department of Health, which consists of the completed application parts and attachments listed below.

The applicant hereby submits this application for a Medical Marijuana Organization Permit to the Pennsylvania Department of Health, which consists of the completed application parts and attachments listed below:

**Fees:**

- Initial Application Fee
- Initial Permit Fee

**Application:**

- Completed Application

**Other Attachments:**

- Attachment B: Organizational Documents
- Attachment C: Property Title, Lease, or Option to Acquire Property Location
- Attachment D: Site and Facility Plan
- Attachment E: Personal Identification
- Attachment F: Affidavit of Business History
- Attachment G: Affidavit of Criminal Offense
- Attachment H: Tax Clearance Certificates
- Attachment I: Affidavit of Capital Sufficiency
- Attachment J: Sample Medical Marijuana Product Label
- Attachment K: Release Authorization
- Attachment L: Applicant Priorities for Multiple Applications

**Background Checks:**

- The applicant has requested background checks, as described in the instructions.

**Additional attachments:**

Please list any other documents you are submitting as part of this application:

File Name

Name of Document

Purpose

**A false statement made in this application is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).**

William Walker \_\_\_\_\_ Emmaus Medical Dispensary  
Signature Title in Applicant's Business

Date

4/18/17

William Walker \_\_\_\_\_  
Printed Name

William Walker \_\_\_\_\_  
Printed Name

**A false statement made in this application is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).**

William Walker \_\_\_\_\_ Emmaus Medical Dispensary  
Signature Title in Applicant's Business Date  
4/18/17  
William Walker  
Printed Name  
William Walker

**A false statement made in this application is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).**

William Walker \_\_\_\_\_ Emmaus Medical Dispensary  
Signature Title in Applicant's Business Date  
4/18/17  
William Walker  
Printed Name

A photocopy, facsimile or other electronic version of this document shall be accepted as an original signature.

**Attachment B: Organizational Documents**

**Instructions:**

- Attach certified copies of the applicant's certificate of incorporation, partnership agreement, charter or other such documentation. If the applicant is not organized in Pennsylvania, attach certified copies of documentation that show that the applicant is authorized to do business in Pennsylvania
- Complete this cover sheet. Scan this sheet and the organizational documents and save it as a PDF file called "Attachment B," using the appropriate file name format

**Instructions:**

- Attach certified copies of the applicant's certificate of incorporation, partnership agreement, charter or other such documentation. If the applicant is not organized in Pennsylvania, attach certified copies of documentation that show that the applicant is authorized to do business in Pennsylvania
- Complete this cover sheet. Scan this sheet and the organizational documents and save it as a PDF file called "Attachment B," using the appropriate file name format

Emmaus Medical Dispensary

Trade names and DBA (doing business as) names: Emmaus Medical Dispensary

Principal Business Address: 217 Main Street  
City: Emmaus  
State: PA  
Zip Code: 18049  
Phone: 610-782-1670  
Fax:  
Email:

**Attachment C: Property Title, Lease, or Option to Acquire Property Location**

**Instructions:**

- Attach one of the following:
- Evidence of the applicant's clear legal title to or option to purchase the proposed site and facility

- Attach one of the following:
- Evidence of the applicant's clear legal title to or option to purchase the proposed site and facility
- A fully-executed copy of the applicant's unexpired lease for the proposed site and facility and a written statement from the property owner that the applicant may operate a medical marijuana organization on the proposed site for, at a minimum, the term of the initial permit
- Other evidence that shows that the applicant has a location to operate its medical marijuana organization
- Complete this cover sheet. Scan this sheet and the appropriate document(s) and save it as a PDF file called "Attachment C," using the appropriate file name format

**Instructions:**

- Attach one of the following:
- Evidence of the applicant's clear legal title to or option to purchase the proposed site and facility
- A fully-executed copy of the applicant's unexpired lease for the proposed site and facility and a written statement from the property owner that the applicant may operate a medical marijuana organization on the proposed site for, at a minimum, the term of the initial permit
- Other evidence that shows that the applicant has a location to operate its medical marijuana organization
- Complete this cover sheet. Scan this sheet and the appropriate document(s) and save it as a PDF file called "Attachment C," using the appropriate file name format

Business Name, as it appears on the applicant's certificate of incorporation, charter, bylaws, partnership agreement or other official documents:

Trade names and DBA (doing business as) names:

Principal Business Address:

City:

State:

Zip Code:

Phone:

Fax:

Email:

### Attachment D: Site and Facility Plan

**Instructions:**

- Applicants must show that they can expeditiously use a site and facility to meet the activities described in the permit by attaching one of the following:
  - If the facility is in existence at the time the initial permit application is submitted, submit plans and specifications drawn to scale for the interior of the facility
  - If the facility is in existence at the time the initial permit application is submitted, and the applicant plans to make alterations to the facility, submit renovation plans and specifications for the interior and exterior of the facility
  - If the facility does not exist at the time the initial permit application is submitted, submit a plot plan that shows the proposed location of the facility and an architect's drawing of the facility, including a detailed drawing, to scale, of the interior of the facility
  - The applicant also must submit evidence that the applicant is in compliance or will be in compliance with the municipality's zoning requirements
- Complete this cover sheet. Scan this sheet and the appropriate documents and save it as a PDF file called "Attachment D," using the appropriate file name format

**Instructions:**

- Applicants must show that they can expeditiously use a site and facility to meet the activities described in the permit by attaching one of the following:

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  - If the facility is in existence at the time the initial permit application is submitted, submit plans and specifications drawn to scale for the interior of the facility
  - If the facility is in existence at the time the initial permit application is submitted, and the applicant plans to make alterations to the facility, submit renovation plans and specifications for the interior and exterior of the facility
  - If the facility does not exist at the time the initial permit application is submitted, submit a plot plan that shows the proposed location of the facility and an architect's drawing of the facility, including a detailed drawing, to scale, of the interior of the facility
  - The applicant also must submit evidence that the applicant is in compliance or will be in compliance with the municipality's zoning requirements
  - Complete this cover sheet. Scan this sheet and the appropriate documents and save it as a PDF file called "Attachment D," using the appropriate file name format

## Emmaus Medical Dispensary

Trade names and DBA (doing business as) names: Emmaus Medical Dispensary

Principal Business Address: 217 Main Street

City: Emmaus

State: PA

Zip Code: 18049

Phone: 610-782-1670

Fax:

Email:

## Attachment E: Personal Identification

### Instructions:

- For each principal, financial backer, operator and employee, attach the following:
  - A curriculum vitae or resume, maximum of two pages
  - A verification of identity satisfactory to the Department. The following are acceptable forms of verification of identity:
    - A valid Pennsylvania Photo Driver's License
    - A valid Pennsylvania Photo Identification Card
    - A valid Pennsylvania Photo Exempt Driver's License
    - A valid Pennsylvania Photo Exempt Identification Card
    - A valid U.S. Armed Forces Common Access Card
    - A valid U.S. passport
    - Complete this cover sheet. Scan this sheet and the curricula vitae and identification documents and save as a PDF file called "Attachment E," using the appropriate file name format

### Instructions:

- For each principal, financial backer, operator and employee, attach the following:
  - A curriculum vitae or resume, maximum of two pages
  - A verification of identity satisfactory to the Department. The following are acceptable forms of verification of identity:
    - A valid Pennsylvania Photo Driver's License
    - A valid Pennsylvania Photo Identification Card
    - A valid Pennsylvania Photo Exempt Driver's License
    - A valid Pennsylvania Photo Exempt Identification Card
    - A valid U.S. Armed Forces Common Access Card
    - A valid U.S. passport
    - Complete this cover sheet. Scan this sheet and the curricula vitae and identification documents and save as a PDF file called "Attachment E," using the appropriate file name format

Emmaus Medical Dispensary

Trade names and DBA (doing business as) names: Emmaus Medical Dispensary

Principal Business Address: 217 Main Street

City: Emmaus

State: PA

Zip Code: 18049

Phone: 610-782-1670

Fax:

Email:

### Attachment F: Affidavit of Business History

#### Instructions:

- Each principal or operator of the applicant must complete the Affidavit of Business History
- Execute the affidavit and save as a PDF file called "Attachment F," using the appropriate file name format. A cover sheet is not needed

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State of Pennsylvania )  
 ) ss:  
 County of Lehigh )

The undersigned, \_\_\_\_\_, hereby certifies the following:

During the 10 years preceding the filing date of the initial permit application, the following principal(s), operator(s), financial backer(s) and employee(s), have held a position of management or ownership of a controlling interest in any other business in this Commonwealth or any other jurisdiction involving the manufacturing or distribution of medical marijuana or a controlled substance:

- Name of individual**
- Role (principal, operator, financial backer or employee)**
- Business name and address**
- Position of management or ownership of a controlling interest**

**Dates**

I hereby certify that I am authorized to execute this affidavit on behalf of the applicant and that the information contained herein is true and correct and that there is no misrepresentation, falsification or omissions in this affidavit. I am further aware that any false or misleading statement or omitted information is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).

William Walker

Signature of Affiant and Title

Date

4/18/2017

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

MY COMMISSION EXPIRES:

A photocopy, facsimile or other electronic version of this document shall be accepted as an original signature.

### Attachment G: Affidavit of Criminal Offense

#### Instructions:

- Each principal or operator of the applicant must complete the Affidavit of Criminal Offense
- Execute the affidavit as instructed and save as a PDF file called "Attachment G," using the appropriate file name format. A cover sheet is not needed

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- Each principal or operator of the applicant must complete the Affidavit of Criminal Offense
- Execute the affidavit as instructed and save as a PDF file called "Attachment G," using the appropriate file name format. A cover sheet is not needed

State of \_\_\_\_\_ )

) ss:

County of \_\_\_\_\_ )

County of \_\_\_\_\_ )

) SS:  
)

The undersigned, \_\_\_\_\_, hereby certifies the following by checking the boxes below:

**Principal(s):**

- No principal(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.
- One or more principals listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.

If one or more principal(s) listed in this permit application has been convicted of a criminal offense graded higher than a summary offense, please provide below the name(s) of the principal(s) and the offense(s) of which one or more principal(s) was convicted.

Name(s ): \_\_\_\_\_  
Offense(s): \_\_\_\_\_

**Operator(s):**

- No operator(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.
- One or more operator(s) listed in this permit application has been convicted of a criminal offense graded higher than a summary offense.

If one or more operator(s) listed in this permit application has been convicted of a criminal offense graded higher than a summary offense, please provide below the name(s) of the operator(s) and the offense(s) of which one or more operator(s) was convicted.

Name(s ): \_\_\_\_\_  
Offense(s): \_\_\_\_\_

**Financial Backer(s):**

- No financial backer(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.
- One or more financial backer(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.

If one or more financial backer(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense, please provide below the name(s) of the financial backer(s) and the offense(s) of which one or more financial backer(s) was convicted.

Name(s ): \_\_\_\_\_  
Offense(s): \_\_\_\_\_

\_\_\_\_\_  
Signature of Affiant and Title

\_\_\_\_\_  
Date

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

MY COMMISSION EXPIRES:

A photocopy, facsimile or other electronic version of this document shall be accepted as an original signature.

### Attachment H: Tax Clearance Certificates

#### Instructions:

- **Completion of this form is a condition of this application and will authorize the Pennsylvania** Department of Revenue (DOR) and the Department of Labor and Industry (L&I) to review the tax records of the applicant and its principals and other persons affiliated with the applicant, as part of the permit application review by the Pennsylvania Department of Health (Department)
  - Your signature on this form also represents a waiver of confidentiality of this information. Your signature allows DOR and L&I to provide tax information to the Department
  - If the applicant’s business is not at a stage where a tax clearance certificate is possible, the application may be considered to be complete if the applicant provides a copy of form PA-100, PA Enterprise Registration Form
  - Complete this cover sheet. Scan this sheet with the completed Application for a Tax Clearance Review and save it as a PDF file called "Attachment H," using the appropriate file name format

Business Name, as it appears on the applicant’s certificate of incorporation, charter, bylaws, partnership agreement or other official documents:

Trade names and DBA (doing business as) names:

Principal Business Address:

City:

State:

Zip Code:

Phone:

Fax:

Email:

### Application for a Tax Clearance Review

\_\_\_\_\_  
Name listed on tax return  
or

\_\_\_\_\_  
Employer Identification Number  
Social Security Number

\_\_\_\_\_  
Address  
Code

City

State

Zip

I certify that I am the individual whose tax records are to be reviewed. If the tax records are for an entity, I certify that I am the authorized signatory for the applicant.



hereby certify that the Applicant named has at least \$2,000,000 in capital, \$500,000 of which is on deposit with one or more financial institutions, as follows (capital may include cash or securities, real estate, or other assets):

**Type of Capital**

**Source of Capital**

**Total Value of Capital**

**Value not encumbered by debt or other obligations**

**If on deposit, name and address of financial institution**

**If on deposit, account number**

I hereby certify that I am authorized to execute this affidavit on behalf of the applicant and that the information contained herein is true and correct and that there is no misrepresentation, falsification or omissions in this affidavit. I am further aware that any false or misleading statement or omitted information is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation)

omissions in this affidavit. I am further aware that any false or misleading statement or omitted information is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).

\_\_\_\_\_  
Signature of Affiant and Title

\_\_\_\_\_  
Date

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

MY COMMISSION EXPIRES:

A photocopy, facsimile or other electronic version of this document shall be accepted as an original signature

Attachment I-2: Affidavit of Capital Sufficiency for a Dispensary Permit Applicant

**COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF HEALTH**

**AFFIDAVIT OF CAPITAL SUFFICIENCY**

State of \_\_\_\_\_ )

) ss:

County of \_\_\_\_\_ )

**I/WE** \_\_\_\_\_

\_\_\_\_\_  
ADDRESS PHONE

\_\_\_\_\_  
CITY STATE ZIP CODE COUNTY

For the following applicant:

\_\_\_\_\_  
NAME OF BUSINESS

\_\_\_\_\_  
ADDRESS PHONE

\_\_\_\_\_  
CITY STATE ZIP CODE COUNTY

hereby certify that the Applicant named has at least \$150,000 on deposit with one or more financial institutions:

**Type of Capital**  
**Source of Capital**  
**Name and address of financial institution**  
**Account number**

I hereby certify that I am authorized to execute this affidavit on behalf of the applicant and that the information contained herein is true and correct and that there is no misrepresentation, falsification or omissions in this affidavit. I am further aware that any false or misleading statement or omitted information is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).

\_\_\_\_\_  
Signature of Affiant and Title

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public

MY COMMISSION EXPIRES:

A photocopy, facsimile or other electronic version of this document shall be accepted as an original signature

• Instructions:

A photocopy, facsimile or other electronic version of this document shall be accepted as an original signature

• **Instructions:**

- Provide a sample label for each medical marijuana product you expect to produce
- Complete this cover sheet. Scan this sheet and the sample labels and save it as a PDF file called "Attachment J," using the appropriate file name format

**Instructions:**

- Provide a sample label for each medical marijuana product you expect to produce
- Complete this cover sheet. Scan this sheet and the sample labels and save it as a PDF file called "Attachment J," using the appropriate file name format

Business Name, as it appears on the applicant's certificate of incorporation, charter, bylaws, partnership agreement or other official documents:

Trade names and DBA (doing business as) names:

Principal Business Address:

City:

State:

Zip Code:

Phone:

Fax:

Email:

**Attachment K: Release Authorization**

**Instructions:**

- Execute the following release authorization
- Scan the completed and executed release authorization below save it as a PDF file called "Attachment K," using the appropriate file name format. No cover sheet is needed

**Instructions:**

- Execute the following release authorization
- Scan the completed and executed release authorization below save it as a PDF file called "Attachment K," using the appropriate file name format. No cover sheet is needed

**RELEASE AUTHORIZATION**

TO:

\_\_\_\_\_

(Do not write above this line – For Department of Health Only)

FROM:

\_\_\_\_\_

Applicant's Name

I, \_\_\_\_\_, by and on behalf of the undersigned applicant, have filed a permit application with the Pennsylvania Department of Health ("Department"). I certify that I am authorized by the applicant to submit this Release Authorization on its behalf and to bind the applicant to all provisions within this Release Authorization. I understand that the applicant is seeking the granting of a privilege and acknowledge that the burden of proving the applicant's qualifications and suitability for a favorable determination is at all times the burden of the applicant.

I understand that a background investigation may be conducted by the Department pursuant to its statutory duty to investigate the character, honesty, integrity and suitability of myself and any entity with which I am associated. I further understand and agree that I am voluntarily executing this Release Authorization to expressly authorize and permit the Department to obtain any and all information it deems necessary, and accept any risk of adverse public notice, embarrassment, criticism, or other action or financial loss which may result from action with respect to this permit application.

further understand and agree that I am voluntarily executing this Release Authorization to expressly authorize and permit the Department to obtain any and all information it deems necessary, and accept any risk of adverse public notice, embarrassment, criticism, or other action or financial loss which may result from action with respect to this permit application.

The rights and powers herein are granted to facilitate the background investigation being conducted by the Department at my request and on behalf of the applicant and is not otherwise intended to create or establish a legal or fiduciary relationship between the Department, its agents and employees, and me. I hereby acknowledge that no such relationship exists.

- I hereby authorize and request every person, firm, company, corporation, board, association or institution of any kind, and every Federal, state or local government entity, including but not limited to every court, law enforcement agency, criminal justice agency or probation department, without exception, both foreign and domestic, to whom this Release Authorization is presented having any knowledge, information, documents, forms, photographs, computer files, accounts, ledgers or other items about, relating to or concerning the applicant and to fully discuss with and answer any inquiry made by any duly authorized investigator of the Pennsylvania Department of Health.

- If this Release Authorization is presented to any brokerage firm, bank, savings and loan, or other financial institution or officer of same, I hereby authorize and request any and all documents, records or correspondence pertaining to the applicant, including but not limited to past loan information, notes, checking account records, savings deposit records, safe deposit box records, passbook records and general ledger folio sheets.

- I hereby authorize an agent of the Department to obtain and review copies of any and all documents, records or correspondence pertaining to myself and the applicant, and I hereby authorize any Federal, state or municipal agency or body, law enforcement agency or criminal justice agency or department, tax agency or authority, regulatory agency, authority or body, to make full and complete disclosure of any and all information and documents including, but not limited to, documents and information otherwise privileged or not subject to public disclosure, as well as other information on file or available concerning the applicant.

- This Release Authorization extends to the review and copy of any information protected by law or contact from disclosure, privilege or obligation.

- I do for the applicant, as well as for myself, my heirs, executors, administrators, successors and assigns, hereby release, remise, exonerate and forever discharge the Department, its members, agents and employees, the Commonwealth of Pennsylvania and its instrumentalities, and any agents and employees thereof, from any and all liabilities including but not limited to all manner of actions, causes of action, suits, debts, judgments, executions, claims, and demands whatsoever, known and unknown, in law or equity, which exist now or in the future against those entities and persons other than relating to a willfully unlawful disclosure or publication of material or information acquired during my investigation.

- I do for the applicant, as well as for myself, my heirs, administrators, successors and assigns, hereby release, remise, exonerate and forever discharge every person, firm, company, corporation, board, association or institution of any kind, and every Federal, state or local government entity, including but not limited to every court, law enforcement agency, criminal justice agency or probation department, without exception, both foreign and domestic, to whom this request is presented, and any agents or employees thereof, from any and all liabilities, including but not limited to all manner of actions, causes of action, suits, debts, judgments, executions, claims and demands whatsoever, known or unknown, in law or equity, which exist now or in the future against those entities and persons to whom this request is presented, and any agents or employees thereof, arising out of or by reason of the furnishing or inspection of documents, records or other information released in compliance with a request made pursuant to, or as a result of, having been presented with, this Release Authorization.

- The applicant agrees to indemnify and hold harmless the Department, its officials and employees and every person, firm, company, corporation, board, association or institution of any kind, and every Federal, state or local government agency, to whom this request is presented and from against all claims, damages, losses, and expenses including reasonable attorneys' fees arising out of or by reason of, the acts permitted and provided for in the Release Authorization.

- I agree that a reproduction of this request by photocopy, facsimile or other similar process shall be for all intents and purposes as valid as the original.

IN WITNESS WHEREOF, I have executed this Release on this \_\_\_\_\_ day of \_\_\_\_\_, 2017.

\_\_\_\_\_  
Authorized Signatory

STATE OF \_\_\_\_\_ )  
 ) ss:  
COUNTY OF \_\_\_\_\_ )

On this \_\_\_\_ day of \_\_\_\_\_, 2017, before me, a Notary Public, personally appeared \_\_\_\_\_ (known to me or satisfactorily proven) to be the person whose name is subscribed in this Release, and acknowledged that he/she executed the same for the purposes herein contained.

IN WITNESS THEREOF, I hereunto set my hand and official seal.

\_\_\_\_\_  
Notary Public

MY COMMISSION EXPIRES:

### Attachment L: Applicant Priorities for Multiple Applications

**Instructions:**

- This attachment is for applicants who are submitting multiple medical marijuana organization permit applications. Use this attachment to indicate your priorities for which medical marijuana regions or counties you prefer for issuance of a permit. Not providing Attachment L as part of your medical marijuana organization permit application indicates that you have no preference
- If you submit this form more than once, the last form the Department receives will represent your prioritization. This form cannot be submitted without being part of an application
- If you elect to submit this attachment, please scan the completed form and save it as a PDF file called "Attachment L," using the appropriate file name format

**Instructions:**

- This attachment is for applicants who are submitting multiple medical marijuana organization permit applications. Use this attachment to indicate your priorities for which medical marijuana regions or counties you prefer for issuance of a permit. Not providing Attachment L as part of your medical marijuana organization permit application indicates that you have no preference
- If you submit this form more than once, the last form the Department receives will represent your prioritization. This form cannot be submitted without being part of an application
- If you elect to submit this attachment, please scan the completed form and save it as a PDF file called "Attachment L," using the appropriate file name format

Business Name, as it appears on the applicant’s certificate of incorporation, charter, bylaws, partnership agreement or other official documents:

Trade names and DBA (doing business as) names:

Principal Business Address:

- City:
- State:
- Zip Code:
- Phone:
- Fax:
- Email:

• **Priorities for Multiple Grower/Processor Permit Applications**

Please check one of the following:

- The applicant would like to make the Department aware of the applicant’s priorities as listed below
- The applicant has no preference regarding medical marijuana regions

- The applicant has no preference regarding medical marijuana regions

MEDICAL MARIJUANA REGION

PRIORITY (If you intend to submit a permit application for more than one medical marijuana region, please rank your preferred region from 1-6, with 1 being the highest ranking)

- Priority \_\_\_ • Southeast
- Priority \_\_\_ • Northeast
- Priority \_\_\_ • Southcentral
- Priority \_\_\_ • Northcentral
- Priority \_\_\_ • Southwest
- Priority \_\_\_ • Northwest

- **Priorities for Multiple Dispensary Permit Applications**

Please check one of the following:

- The applicant would like to make the Department aware of the applicant's priorities as listed below
- The applicant has no preference regarding county

MEDICAL MARIJUANA REGION

For each region for which you plan to submit multiple applications, please indicate the counties in order of priority, with 1 being the highest

- Southeast
  - \_\_\_ *Berks*
  - \_\_\_ *Bucks*
  - \_\_\_ *Chester*
  - \_\_\_ *Delaware*
  - \_\_\_ *Lancaster*
  - \_\_\_ *Montgomery*
  - \_\_\_ *Philadelphia*
- Northeast
  - \_\_\_ *Lackawanna*
  - \_\_\_ *Lehigh*
  - \_\_\_ *Luzerne*
  - \_\_\_ *Northampton*
- Southcentral
  - \_\_\_ *Blair*
  - \_\_\_ *Cumberland*
  - \_\_\_ *Dauphin*
  - \_\_\_ *York*
- Northcentral
  - \_\_\_ *Centre*
  - \_\_\_ *Lycoming*
- Southwest
  - \_\_\_ *Allegheny*
  - \_\_\_ *Butler*
  - \_\_\_ *Washington*
  - \_\_\_ *Westmoreland*
- Northwest
  - \_\_\_ *Erie*
  - \_\_\_ *McKean*



Department of Health Use Only

#

Received

## Medical Marijuana Dispensary Permit Application

You may apply for one dispensary permit in this application for any of the medical marijuana regions listed below. A separate application must be submitted for each primary dispensary location sought by the applicant. Please see the Medical Marijuana Organization Permit Application Instructions for a table of the counties within each medical marijuana region and the counties in which you are eligible to locate your primary dispensary.

**Please check to indicate the medical marijuana region, and specify the county, for which you are applying for a dispensary permit:**

Northwest

Northcentral

Northeast

Southwest

Southcentral

Southeast

County 1 (Primary Dispensary Location): [Lehigh](#)

County 2 (if applicable): [Text Here](#)

County 3 (if applicable): [Text Here](#)

## Medical Marijuana Dispensary Permit Application

Part A - Applicant Identification and Dispensary Information

**(Scoring Method: Pass/Fail)**

For this part, the applicant is required to provide background and contact information for the business or individual applying for a dispensary permit, the primary dispensary location, along with any second or third dispensary locations that are being sought under the application.

Section 1 – Applicant Name, Address and Contact Information

**Business or Individual Name and Principal Address**

**Business Name, as it appears on the applicant’s certificate of incorporation, charter, bylaws, partnership agreement or other legal business formation documents:**

[William Walker 800 Hausman Rd. Apt. 228 Allentown PA, 18015](#)

**Other trade names and DBA (doing business as) names:**

[Emmaus Medical Dispensary](#)

**Business Address:** [217 Main Street](#)

**City:** [Emmaus](#)

**State:** [PA](#)

**Zip Code:** [18049](#)

**Phone:** [610-782-1670](#)

**Fax:** [TEXT HERE](#)

**Email:**

**Primary Contact**, or  **Registered Agent for this Application**

**Name:** [William Walker](#)

**Address:** [800 Hausman Rd. Apt. 228 Allentown PA, 18015](#)

**City:** [Emmaus](#)

**State:** [PA](#)

**City:** Emmaus  
**State:** PA  
**Zip Code:** 18049  
**Phone:** 610-782-1670  
**Fax:** TEXT HERE  
**Email:** TEXT HERE

### Section 2 – Dispensary Information

The applicant is required to provide a primary dispensary location. The applicant may include a second or third location under this application. A second or third dispensary may be added to a dispensary permit at a later date through the filing of an application for additional dispensary locations.

By checking “Yes,” you affirm that you possess the ability to obtain in an expeditious manner the right to use sufficient land, buildings and other premises and equipment to properly carry on the activity described in the medical marijuana dispensary permit application, and any proposed location for a dispensary.

x  
Yes  
  
No

Primary Dispensary Location (please indicate dispensary name as you would like it to appear on the dispensary permit)

**Facility Name:** Emmaus Medical Dispensary  
**Address:** 217 Main Street  
**City:** Emmaus  
**State:** PA  
**Zip Code:** 18049  
**County:** Lehigh  
**Municipality:** Lehigh

Please provide a description of the public access to the dispensary location, including any local public transportation that may be available:

Fanta Bus Terminals are located in route on the main street. Public transportation access is located roughly a block in each direction.

### Second Dispensary Location

**Facility Name:** TEXT HERE  
**Address:** TEXT HERE  
**City:** TEXT HERE  
**State:** PA  
**Zip Code:** 55555  
**County:** TEXT HERE  
**Municipality:** TEXT HERE

Please provide a description of the public access to the dispensary location, including any local public transportation that may be available:

### Third Dispensary Location

**Facility Name:** TEXT HERE  
**Address:** TEXT HERE  
**City:** TEXT HERE  
**State:** PA  
**Zip Code:** 55555

City: TEXT HERE

State: PA

Zip Code: 55555

County: TEXT HERE

Municipality: TEXT HERE

Please provide a description of the public access to the dispensary location, including any local public transportation that may be available:

Part B – Diversity Plan

(Scoring Method: 100 Points)

In accordance with section 615 of the Act (35 P.S. § 10231.615), an applicant shall include with its application a diversity plan that promotes and ensures the involvement of diverse participants and diverse groups in ownership, management, employment, and contracting opportunities.

Diverse Participants include a person, including a natural person; individuals from diverse racial, ethnic and cultural backgrounds and communities; women; veterans; individuals with disabilities; corporation; partnership; association; trust or other entity; or any combination thereof, who are seeking a permit issued by the Department of Health to grow and process or dispense medical marijuana. Diverse Groups include the following businesses that have been certified by a third-party certifying organization: a disadvantaged business, minority-owned business, and women-owned business as those terms are defined in 74 Pa. C.S. § 303(b); and a service-disabled veteran-owned small business or veteran-owned small business as those terms are defined in 51 Pa. C.S. § 9601.

Section 3 – Diversity Plan

By checking “Yes,” the applicant affirms that it has a diversity plan that establishes a goal of opportunity and access in employment and contracting by the medical marijuana organization. The applicant also affirms that it will make a good faith effort to meet the diversity goals outlined in the diversity plan. Changes to the diversity plan must be approved by the Department of Health in writing.

The applicant further agrees to report participation level and involvement of Diverse Participants and Diverse Groups in the form and frequency required by the Department, and to provide any other information the Department deems appropriate regarding ownership, management, employment, and contracting opportunities by Diverse Participants and Diverse Groups.

- Yes
- No

Diversity Plan

In narrative form below, describe a plan that establishes a goal of diversity in ownership, management, employment and contracting to ensure that diverse participants and diverse groups are accorded equality of opportunity. to the extent available, include the following:

- The diversity status of the Principals, Operators, Financial Backers, and Employees of the Medical Marijuana Organization.
- An official affirmative action plan for the Medical Marijuana Organization.
- Internal diversity goals adopted by the Medical Marijuana Organization.
- A plan for diversity-oriented outreach or events the Medical Marijuana Organization will conduct during the term of the permit.
- Contracts with diverse groups and the expected percentage and dollar amount of revenues that will be paid to the diverse groups.
- Any materials from the Medical Marijuana Organization’s mentoring

amount of revenues that will be paid to the diverse groups.

- Any materials from the Medical Marijuana Organization’s mentoring, training, or professional development programs for diverse groups.
- Any other information that demonstrates the Medical Marijuana Organization’s commitment to diversity practices.
- A workforce utilization report including the following information for each job category within the Medical Marijuana Organization:
  - The total number of persons employed in each job category,
  - The total number of men employed in each job category,
  - The total number of women employed in each job category,
  - The total number of veterans in each job category,
  - The total number of service-disabled veterans in each job category, and
  - The total number of members of each racial minority employed in each job category.
- A narrative description of your ability to record and report on the components of the diversity plan.

Records and Reports will be assigned and kept with a principal of the Marketing and Operations team.

### Part C – Applicant Background Information

**(Scoring Method: Pass/Fail)**

For this part the applicant is required to provide background and contact information for the principals, financial backers, operators and employees.

#### Section 4 – Principals, Financial Backers, Operators and Employees

##### **A. Please list all Principals, Financial Backers and Operators Name and Residential Address**

**First Name: William**

**Middle Name:**

**Last Name: Walker**

**Suffix:**

**Occupation:**

**Title in the applicant’s business: Emmaus Medical Dispensary**

**Also known as:**

**Date of birth: DOHDOH**

**Address Line 1: DOHDOHDOHDOHDOH**

**Address Line 2:**

**Address Line 3:**

**City: DOHDOH**

**State: DOH**

**Zip Code: DOH**

**Phone: DOHDOH**

**Fax:**

**Email:**

##### **Name and Residential Address**

**First Name: Brian**

**Middle Name:**

**Last Name: Lee**

**Suffix:**

**Occupation: Financial Advisor/Stock Broker**

**Last Name:** Lee

**Suffix:**

**Occupation:** Financial Advisor/Stock Broker

**Title in the applicant's business:** Manager at Janney Montgomery Scott Financial

**Institutions**

**Also known as:**

**Date of birth:** DOHDOH

**Address Line 1:** DOHDOHDOHDOHDOHDOH

**Address Line 2:**

**Address Line 3:**

**City:** DOHDOH

**State:** DOH

**Zip Code:** DOH

**Phone:** DOHDOH

**Fax:**

**Email:**

**Name and Residential Address**

**First Name:**

**Middle Name:**

**Last Name:**

**Suffix:**

**Occupation:**

**Title in the applicant's business:**

**Also known as:**

**Date of birth:** MM/DD/YYYY

**Address Line 1:**

**Address Line 2:**

**Address Line 3:**

**City:**

**State:**

**Zip Code:**

**Phone:**

**Fax:**

**Email:**

**Name and Residential Address**

**First Name:**

**Middle Name:**

**Last Name:**

**Suffix:**

**Occupation:**

**Title in the applicant's business:**

**Also known as:**

**Date of birth:**

**Address Line 1:**

**Address Line 2:**

**Address Line 3:**

**City:**

**State:**

**Zip Code:**

**Phone:**

**Fax:**

**Email:**

**Name and Residential Address**

**First Name:**

**Middle Name:**

**Last Name:**

**Suffix:**

**Occupation:**

**Title in the applicant's business:**

**Occupation:**  
**Title in the applicant's business:**  
**Also known as:**  
**Date of birth:**  
**Address Line 1:**  
**Address Line 2:**  
**Address Line 3:**  
**City:**  
**State:**  
**Zip Code:**  
**Phone:**  
**Fax:**  
**Email:**

**Name and Residential Address**

**First Name:**  
**Middle Name:**  
**Last Name:**  
**Suffix:**  
**Occupation:**  
**Title in the applicant's business:**  
**Also known as:**  
**Date of birth:**  
**Address Line 1:**  
**Address Line 2:**  
**Address Line 3:**  
**City:**  
**State:**  
**Zip Code:**  
**Phone:**  
**Fax:**  
**Email:**

**Name and Residential Address**

**First Name:**  
**Middle Name:**  
**Last Name:**  
**Suffix:**  
**Occupation:**  
**Title in the applicant's business:**  
**Also known as:**  
**Date of birth:**  
**Address Line 1:**  
**Address Line 2:**  
**Address Line 3:**  
**City:**  
**State:**  
**Zip Code:**  
**Phone:**  
**Fax:**  
**Email:**

If more space is required, please submit additional information on other individuals in a separate document titled "Principals, Financial Backers and Operators (Contd.)" in accordance with the attachment file name format requirements and include it with the attachments.

**B. Please list Employees**

Please provide the following information for any employees that have been hired to date to work for the applicant listed in this application. If no employees are currently employed, please leave this section blank.

**Name and Residential Address**

for the applicant listed in this application. If no employees are currently employed, please leave this section blank.

**Name and Residential Address**

**First Name:** Aaron  
**Middle Name:**  
**Last Name:** Baker  
**Suffix:**  
**Occupation:**  
**Title in the applicant's business:**  
**Also known as:**  
**Date of birth:** DOHDOH  
**Address Line 1:** DOHDOHDOHDOH  
**Address Line 2:**  
**Address Line 3:**  
**City:** DOHDOH  
**State:** DOH  
**Zip Code:** DOH  
**Phone:** DOHDOH  
**Fax:**  
**Email:**

**Name and Residential Address**

**First Name:** Joseph  
**Middle Name:**  
**Last Name:** Luther  
**Suffix:**  
**Occupation:**  
**Title in the applicant's business:**  
**Also known as:**  
**Date of birth:** DOHDOH  
**Address Line 1:** DOHDOHDOHDOH  
**Address Line 2:**  
**Address Line 3:**  
**City:** DOH  
**State:** DOH  
**Zip Code:** DOH  
**Phone:** DOHDOH  
**Fax:**  
**Email:**

**Name and Residential Address**

**First Name:** Gary  
**Middle Name:**  
**Last Name:** Schrantz  
**Suffix:**  
**Occupation:**  
**Title in the applicant's business:**  
**Also known as:**  
**Date of birth:** DOHDOH  
**Address Line 1:** DOHDOH  
**Address Line 2:**  
**Address Line 3:**  
**City:** DOHDOH  
**State:** DOH  
**Zip Code:** DOH  
**Phone:** DOHDOH  
**Fax:**  
**Email:**

**Name and Residential Address**

**First Name:** Robert  
**Middle Name:**

**First Name:**Robert  
**Middle Name:**  
**Last Name:**Clauss  
**Suffix:**  
**Occupation:**  
**Title in the applicant's business:**REC Home Maintenance  
**Also known as:**  
**Date of birth:** DOHDOHDOH  
**Address Line 1:** DOHDOHDOHDOH  
**Address Line 2:**  
**Address Line 3:**  
**City:**DOHDOH  
**State:**DOH  
**Zip Code:**DOH  
**Phone:**DOHDOH  
**Fax:**  
**Email:**

**Name and Residential Address**

**First Name:**  
**Middle Name:**  
**Last Name:**  
**Suffix:**  
**Occupation:**  
**Title in the applicant's business:**  
**Also known as:**  
**Date of birth:** MM/DD/YYYY  
**Address Line 1:**  
**Address Line 2:**  
**Address Line 3:**  
**City:**  
**State:**  
**Zip Code:**  
**Phone:**  
**Fax:**  
**Email:**

If more space is required, please submit additional information on other individuals in a separate document titled "Employees (Contd.)" in accordance with the attachment file name format requirements and include it with the attachments.

**Section 5 – Moral Affirmation**

By checking "Yes," you affirm that each principal, financial backer, operator and employee listed in this permit application is of good moral character.

- Yes
- 
- No

**Section 6 – Compliance with Applicable Laws and Regulations**

By checking "Yes," you affirm that you, as well as the principals, financial backers, operators and employees listed in this permit application are able to continuously comply with all applicable Commonwealth laws and regulations relating to the operation of a medical marijuana dispensary.

- Yes
- No

**Section 7 – Civil and Administrative Action**

For the statements below:



TEXT HERE  
TEXT HERE  
TEXT HERE  
TEXT HERE  
TEXT HERE  
TEXT HERE  
TEXT HERE  
TEXT HERE  
TEXT HERE  
TEXT HERE  
TEXT HERE

**Part D – Plan of Operation**  
**(Scoring Method: 550 Points)**

A Plan of Operation is required for all dispensary permit applications. The Plan of Operation must include a timetable outlining the steps the applicant will take to become operational within six months from the date of issuance of a permit. The plan of operation must also describe how the applicant’s proposed business operations will comply with statutory and regulatory requirements necessary for the continued operation of the facility.

**Plan of Operation**

**What must be covered in a Plan of Operation?**

Applicants must identify how they will comply with relevant laws and regulations regarding:

- Security and Surveillance
- Employee qualifications and training
- Transportation of medical marijuana and medical marijuana products
- Storage of medical marijuana products
- Inventory management
- Recordkeeping
- Prevention of unlawful diversion of medical marijuana and medical marijuana products
- A timetable outlining the steps required for the applicant to become operational within six months from the date of issuance of a dispensary permit

By checking “Yes,” you affirm that you are able to continuously maintain effective security, surveillance and accounting control measures to prevent diversion, abuse and other illegal conduct regarding medical marijuana and medical marijuana products.

- Yes
- No

**Section 8 – Operational Timetable**

If issued a permit, please describe the steps and timeframes for becoming fully operational as a dispensary within six months from the date of issuance of a dispensary permit. Specifically, please provide the steps you will take to begin the process for the handling, storing, and transporting of medical marijuana and medical marijuana products.

**Activity**  
**Estimated Date**

Acquire all zoning licenses, fees and contact bureau for public works, construction, public access and parking.

Acquire an interior design team, marketing team, and construction crew.

Acquire the materials needed to establish Foundation, Interior Remodeling, as well as marketing

Acquire an interior design team, marketing team, and construction crew.

Acquire the materials needed to establish Foundation, interior Remodeling, as well as marketing tools and surveillance system at the needed retail suppliers

Contact the proper excavation team for plumbing, electrical and foundation work as well as a secure security system

Acquire necessary mechanical devices and marketing merchandise needed to retain a functioning, safe and effective dispensary

Effectively Utilize and examine property for remodeling and put marketing strategy into place.

Continue to Utilize and access marketing to retain current clientele and obtain new patients

If more space is required for the Operational Timetable, please submit additional information in a separate document titled “Operational Timetable (Contd.)” in accordance with the attachment file name format requirements and include it with the attachments.

- Section 9 – Employee Qualifications, Description of Duties and Training
- Please provide a description of the duties, responsibilities, and roles of each principal, financial backer, operator and employee.

- Principals will be required to monitor and keep careful calculations of gross product being shipped or transported to and from dispensary and licensed grower, they will be responsible with providing the department with data charts and daily calculations of the product and also providing the department with information on all aspects of the dispensary including security, maintenance, costs and spending, marketing and distribution as well as descriptive detail on employee interaction and behavior

- Financial backer will be in close contact with principals, monitor and regulate spending, as well as financing and financial planning and cost to be submitted to the department

- Operators will be in charge of maintaining the facility, fixing proper machinery, and providing proper materials and units necessary for the medical marijuana. A licensed pharmacist will be readily available and employed to maintain, inspect and evaluate the medical product before and after being processed through the dispensary.

- Employees will be responsible for sales and interactions between the customers/patients, they will be the blunt of the operations, checking IDs and verifying proper documentation as well as performing necessary and qualified designated actions throughout the dispensary to keep a safe and clean environment. A designated employee properly trained and suited will be in contact with the licensed pharmacists for any verification or any needs requiring him/her.

- Please describe the employee qualifications of each principal and employee.

- Must complete a background check and be free of any drug related charges and be evaluated on a local, state and federal level.

- Must have references that will be willing to participate in background checks and further evaluations.

- Must be willing to comply with all stipulations of hiring process including a probational period.

- Please describe the steps the applicant will take to assure that each principal and employee will meet the two-hour training requirement under the Act and regulations.

- Employee will be mandated to fill out an online application process explaining their reasons for applying to Emmaus Medical Dispensary.

Regulations:

- Employee will be mandated to fill out an online application process explaining their reasons for applying to Emmaus Medical Dispensary
- Employees will be required to give consent to a full background check, giving their name, SSN, DOB, License, another valid form of Id, and complete a FULL descriptive survey on their experience/knowledge/understanding of any sources related to the medical marijuana industry. Employees must require to participate online and in person before offered a position
- Selected employees will be required to contact the department of health to obtain any further information and packets/guidelines included within the department and report to if necessary to the department for further training/information.
- Upon completion of training, employees are placed on a 2 week probation period to monitor and protect the wellbeing of the community and state policies.

If more space is required for any of the above three components of Section 9 (A, B and C), please submit additional information in a separate document titled “Employee Qualifications, Description of Duties and Training (Contd.)” in accordance with the attachment file name format requirements and include it with the attachments.

- **Licensed Medical Professionals at Facility**

**Yes**

**No**

A physician or a pharmacist will be present at the primary dispensary location listed in this permit application at all times during the hours the primary dispensary facility is open to dispense or to offer to dispense medical marijuana to patients and caregivers.

If the applicant is operating any dispensaries in addition to the primary dispensary location listed under the permit, and a physician or pharmacist is not present onsite at the additional dispensary or dispensaries, a physician assistant or a certified registered nurse practitioner will be present onsite at each of the other dispensaries instead of a physician or pharmacist.

Any physician, pharmacist, physician assistant or certified registered nurse practitioner employed by a dispensary will, prior to assuming any duties at the dispensary facility, successfully complete a four-hour training course developed by the Department.

Please provide an explanation of any responses above that were answered as a “No” and how you will meet these requirements by the time the department determines you to be operational under the Act and regulations:

### Section 10 – Security and Surveillance

A dispensary must have security and surveillance systems, utilizing commercial-grade equipment, to prevent unauthorized entry and to prevent and detect diversion, theft, or loss of any medical marijuana or medical marijuana products.

equipment, to prevent unauthorized entry and to prevent and detect diversion, theft, or loss of any medical marijuana or medical marijuana products.

Please provide a summary of your proposed security and surveillance equipment and measures that will be in place at your proposed facility and site. These measures should cover, but are not limited to, the following: general overview of the equipment, measures and procedures to be used, alarm systems, surveillance system, storage, recording capability, records retention, premises accessibility, and inspection/servicing/alteration protocols.

Security proposition of a surveillance system posted within the posterior emergency exit and the front entrance. Multiple cameras will be posted along side the premises as well as covering a broad spectrum of the parking vicinity. Routine surveillance checks will be performed before the upcoming weekend

- Section 11 – Transportation of Medical Marijuana
- **Transportation**

**Yes**

**No**

By checking “Yes,” you affirm that any delivery of medical marijuana to any other medical marijuana organization or approved laboratory within the Commonwealth will adhere to the following:

If you check “No” to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.

- Medical marijuana will only be delivered between 7 a.m. and 9 p.m.

- Medical marijuana will not be transported to any location outside of this Commonwealth.

- A global positioning system will be used to ensure safe, efficient delivery of the medical marijuana to a medical marijuana organization.

In addition to having a transport vehicle staffed with a delivery team consisting of at least two individuals, the applicant affirms the following:

- At least one delivery team member will remain with the vehicle at all times that the vehicle contains medical marijuana.

- Each delivery team member shall have access to a secure form of communication with the dispensary, such as a cellular telephone, at all times that the vehicle contains medical marijuana.

communication with the dispensary, such as a cellular telephone, at all times that the vehicle contains medical marijuana.

x

- Upon demand, each delivery team member shall produce an identification badge or card to the Department or its authorized agents, law enforcement or other Federal, State, or local government officials if necessary to perform the government officials' functions and duties.

x

- Each delivery team member will have a valid driver's license.

x

- While on duty, a delivery team member will not wear any clothing or symbols that may indicate ownership or possession of medical marijuana.

x

- Medical marijuana stored inside the transport vehicle may not be visible from the outside of the transport vehicle.

x

- A delivery team shall proceed in a transport vehicle from the dispensary, where the medical marijuana is loaded, directly to the medical marijuana organization, where the medical marijuana is unloaded, without unnecessary delays. Notwithstanding the foregoing, a transport vehicle may make stops at multiple facilities, as appropriate, to deliver medical marijuana.

x

- Any vehicle accidents, diversions, losses, or other reportable events that occur during transport of medical marijuana must be immediately reported to the Department either through a designated phone line established by the Department or by electronic communication with the Department in a manner prescribed by the Department.

x

- The Department shall be notified daily of the dispensary's delivery schedule, including routes and delivery times, either through a designated phone line established by the Department or by electronic communication with the Department in a manner prescribed by the Department.

x

- A transport vehicle is subject to inspection by the Department or its authorized agents, law enforcement or other Federal, State or local government officials if necessary to perform the government officials' functions and duties.

x

- A transport vehicle may be stopped and inspected along its delivery route or at any medical marijuana organization

- A transport vehicle may be stopped and inspected along its delivery route or at any medical marijuana organization.

x

- If a third-party contractor is used, the contractor must comply with all the transportation requirements listed in the Act and regulations.

x

- **Transport Manifest**

**Yes**

**No**

By checking “Yes” to any statement, you affirm that the transport manifest (printed or electronic) that accompanies every transport vehicle will contain the following information and meet the following requirements:

If you check “No” to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.

- The name, address and permit number of the medical marijuana organization receiving the delivery, and the name of and contact information for a representative of the medical marijuana organization.

x

- The quantity, by weight or unit, of each medical marijuana harvest batch, harvest lot or process lot contained in the transport, along with the identification number for each harvest batch, harvest lot or process lot.

x

- The date and approximate time of departure.

x

- The date and approximate time of arrival.

x

- The transport vehicle’s make, model, and license plate number.

x

- The identification number of each member of the delivery team accompanying the transport.

x

- When a delivery team delivers medical marijuana to multiple medical marijuana organizations, the transport manifest must correctly reflect the specific medical marijuana in transit; each recipient will also provide the dispensary with a printed receipt for the medical marijuana received.

marijuana in transit; each recipient will also provide the dispensary with a printed receipt for the medical marijuana received.

x

- All medical marijuana being transported must be packaged in shipping containers and labeled in accordance with §§ 1151.34 and 1161.28 (relating to packaging and labeling of medical marijuana; and labels and safety inserts).

x

- Separate copies of the transport manifest will be provided to each recipient receiving the medical marijuana product described in the transport manifest. To maintain confidentiality, a dispensary may prepare separate manifests for each recipient.

x

- The applicant acknowledges that, upon request, a copy of the printed transport manifest, and any printed receipts for medical marijuana being transported, will be provided to the Department or its authorized agents, law enforcement, or other Federal, State, or local government officials if necessary to perform the government officials' functions and duties.

x

Please provide an explanation of any responses above that were answered as a “No” and how you will meet these requirements by the time the department determines you to be operational under the Act and regulations:

- Please describe your plan regarding the transportation of medical marijuana and medical marijuana products. For example, explain whether you plan to maintain your own transportation operation as part of the facility operation, or whether you will use a third-party contractor. If you choose to use your own transportation operation, please provide the number and type of vehicles that will be used to transport medical marijuana and medical marijuana products, the training that will be provided to employees that will transport medical marijuana and medical marijuana products, and any additional measures you will take to prevent diversion during transport. If you will be using a third-party contractor for transporting medical marijuana and medical marijuana products, please explain the steps you will take to guarantee the third-party contractor will be compliant with the transportation requirements under the Act and regulations:

The plan is to use our own company vehicles to transport all medicinal marijuana to proper and designated dispensaries. The drivers of the vehicles will be required to obtain special post training programs and will be monitored closely by one of the appointed principles. mile markers and proper company tracking devices will be installed in the vehicles and will be reported to the department of health during routine and mandatory times. Drivers will be obligated to present their Id's at all times entering and exiting any facility and will be required to sign their own designated clock sheet.

- Section 12 – Storage of Medical Marijuana
- **Storage Requirements**

**Yes**

• **Storage Requirements**

**Yes**

**No**

By checking “Yes” to any statement, you affirm that the plan of operation will address the below statements:

If you check “No” to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.

- There will be separate, locked, limited access areas for the storage of medical marijuana that is expired, damaged, deteriorated, mislabeled, contaminated, recalled, or whose containers or packaging have been opened or breached, until the medical marijuana is returned to a grower/processor, destroyed or otherwise disposed of, as required by § 1151.40 (relating to the management and disposal of medical marijuana waste).

x

- All storage areas will be maintained in a clean and orderly condition and free from infestation by insects, rodents, birds, and pests.

x

- A separate and secure area for temporary storage of medical marijuana that is awaiting disposal will be established.

x

Please provide an explanation of any responses above that were answered as a “No” and how you will meet these requirements by the time the Department determines you to be operational under the Act and regulations:

- Please describe your plans regarding the storage of medical marijuana and medical marijuana products within your facility:

Medical Marijuana will be stored in a separate chamber specifically remodeled to do so, it will be air suppressed, vacuumed and oxidized to obtain an environment suitable for storage of timely delivered cannabis

- Section 13 – Labeling of Medical Marijuana Products
- **Labeling Requirements**

**Yes**

**No**

By checking “Yes” to any statement, you affirm that the applicant will implement a quality control process to ensure that the label does not bear any of the following:

If you check “No” to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.

determines you to be operational under the Act and regulations.

- Any resemblance to the trademarked, characteristic or product-specialized packaging of any commercially available food or beverage product.

x

- Any statement, artwork or design that could reasonably lead an individual to believe that the package contains anything other than medical marijuana.

x

- Any seal, flag, crest, coat of arms, or other insignia that could reasonably mislead an individual to believe that the product has been endorsed, manufactured, or approved for use by any State, county or municipality or any agency thereof.

x

- Any cartoon, color scheme, image, graphic or feature that might make the package attractive to children.

x

Please provide an explanation of any responses above that were answered as a “No” and how you will meet these requirements by the time the department determines you to be operational under the Act and regulations:

- Please describe your process for creating and monitoring the labeling used for medical marijuana products:

Allowing the marketing team to publish sole towards the market of patients who are of legal and properly prescribed by a physician. using matte and darker colors, designing advertisement using mostly text

- Section 14 – Inventory Management
- **Electronic Tracking System**

**Yes**

**No**

You acknowledge that you must use the electronic tracking system prescribed by the Department containing the requirements in section 701 of the Act (35 P.S. § 10231.701).

x

You acknowledge that an electronic tracking system that is approved by the Department will be deployed to log, verify and monitor the receipt of medical marijuana product from a grower/processor, the verification of the validity of an identification card presented by a patient or caregiver, the dispensing of medical marijuana product to a patient or caregiver, the disposal of medical marijuana waste and the recall of defective medical marijuana.

or caregiver, the dispensing of medical marijuana product to a patient or caregiver, the disposal of medical marijuana waste and the recall of defective medical marijuana.

x

- **Inventory Management**

**Yes**

**No**

By checking “Yes” to any statement, you affirm that each dispensary will maintain the following inventory data in its electronic tracking system:

If you check “No” to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.

- Medical marijuana received from a grower/processor.

x

- Medical marijuana dispensed to a patient or caregiver.

x

- Damaged, defective, expired, or contaminated medical marijuana awaiting return to a grower/processor or awaiting disposal.

x

- Inventory controls and procedures will be established for the conducting of monthly inventory reviews and annual comprehensive inventories of medical marijuana at the facility.

x

- The written or electronic record will include the date of the inventory, a summary of the inventory findings, and the employee identification numbers and titles or positions of the individuals who conducted the inventory.

x

Please provide an explanation of any responses above that were answered as a “No” and how you will meet these requirements by the time the department determines you to be operational under the Act and regulations:

- Please describe your approach regarding the implementation of an inventory management process. This approach must also include a process that provides for the recall of medical marijuana products and the management of medical marijuana product returns from you to the originating grower/processor:

All recalls will be submitted to the bureau and documentation will be obtained by both the

All recalls will be submitted to the bureau and documentation will be obtained by both the dispensary and its original grower, any and all medicinal marijuana disposed of will be done so by proper waste and disposal procedures and will be submitted directly to the bureau upon discharge.

- Section 15 – Diversion Prevention
- Please provide a summary of the procedures that you will implement at each proposed facility for the prevention of the unlawful diversion of medical marijuana and medical marijuana products, along with the process that will be followed when evidence of theft/diversion is identified:

Surveillance systems will be checked regularly each week along with a routine visual investigation of the areas covered by appointed principal. Any unlawful acts or diversions will be reported to authorities and file and submitted to the bureau

- Section 16 – Sanitation and Safety
- Please provide a summary of the intended sanitation and safety measures to be implemented at each proposed facility listed in the permit application. These measures should cover, but are not be limited to, the following: a written process for contamination prevention, pest protection procedures, medical marijuana product handler restrictions, and hand-washing facilities.

A proper sanitation crew will be designated to clean and disinfect the facility on proper basis, all hired crew will be obligated to sign and submit valid license and or registration that will be submitted to the bureau.

- Section 17 – Record keeping
- Please provide a summary of your recordkeeping plan at each proposed facility listed in the permit application. This plan should cover, but is not limited to, records of inventory and all dispensing transactions:

Record keeping will be appointed to proper principle and will be in contact with the financial planner with all data collecting including dispensing transactions and any other action taken. All recorded data will be submitted to the bureau

**Part E – Applicant Organization, Ownership, Capital and Tax Status  
(Scoring Method: 150 Points)**

**Section 18 – Organizational Structure**

**Applicant’s Form of Organization**

**Check One**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> <b>C-Corporation</b>                         | <input type="checkbox"/> <b>S-Corporation</b>           | <input type="checkbox"/> <b>Limited Liability</b> |
| <input type="checkbox"/> <b>Company</b>                               |   |   |
| <input type="checkbox"/> <b>Sole Proprietorship</b>                   | <input checked="" type="checkbox"/> <b>Partnership</b>  | <input type="checkbox"/> <b>Limited Liability</b> |
| <input type="checkbox"/> <b>Partnership</b>                           |   |   |
| <input type="checkbox"/> <b>Limited Liability Limited Partnership</b> | <input type="checkbox"/> <b>Non-Profit Organization</b> | <input type="checkbox"/> <b>Other (explain):</b>  |

TEXT HERE

**Applicant's Organization Documents**

**State of Incorporation or Registration: Pennsylvania**

**Date of Formation:** February 2017

**Business Name on Formation Documents: Emmaus Medical Dispensary**

**Applicant's Identification Numbers**

**Federal Employer ID number:**

**47-1668732**

**PA Unemployment Compensation Account Number:**

**N/A**

**PA Department of Revenue Tax number (if applicant is currently doing business in Pennsylvania):**

**N/A**

**PA Workers' Compensation Policy Number (if applicant is currently doing business in Pennsylvania):**

**N/A**

The applicant affirms that workers' compensation insurance will be obtained by the time the Department determines you to be operational under the Act and regulations.

x  
Yes  
 □  
No

**Section 19 – Business History and Capacity to Operate**

Describe your business history and your ability and plan to maintain a successful and financially sustainable operation:

Buisness Ownership of Night Club in Los Angeles California, The plan to maintain the business is proper documentation by filing fictitious name statement and address proper entities in order to sustain a success business

**Section 20 – Current Officers**

Provide the position, title in the applicant's business, and address information for all current officers, directors, partners or trustees.

**Name and Residential Address**

**First Name: William**

**Middle Name:**

**Last Name: Walker**

**Suffix:**

**Occupation:**

**Title in the applicant's business:**

**Also known as:**

**Date of birth:**

**Address Line 1: DOHDOHDOHDOHDOH**

**Address Line 2:**

**Address Line 3:**

**City: DOHDOH**

**State: DOH**

**Zip Code: DOH**

**Phone: DOHDOH**

**Fax:**

**E-mail:**

Phone: DOHDOH

Fax:

Email:

**Name and Residential Address**

**First Name:** Brian

**Middle Name:**

**Last Name:** Lee

**Suffix:**

**Occupation:** Financial Advisor/Stock Broker

**Title in the applicant's business:** Manager Janney Montgomery Scott

**Also known as:**

**Date of birth:** DOHDOH

**Address Line 1:** DOHDOHDOHDOHDOHDOH

**Address Line 2:**

**Address Line 3:**

**City:** DOHDOH

**State:** DOH

**Zip Code:** DOH

**Phone:** DOHDOH

**Fax:**

**Email:**

**Name and Residential Address**

**First Name:** TEXT HERE

**Middle Name:** TEXT HERE

**Last Name:** TEXT HERE

**Suffix:** 55555

**Occupation:** TEXT HERE

**Title in the applicant's business:** TEXT HERE

**Also known as:** TEXT HERE

**Date of birth:** MM/DD/YYYY

**Address Line 1:** TEXT HERE

**Address Line 2:** Text Here.

**Address Line 3:** TEXT HERE

**City:** TEXT HERE

**State:** WW

**Zip Code:** 55555

**Phone:** TEXT HERE

**Fax:** TEXT HERE

**Email:** TEXT HERE

**Name and Residential Address**

**First Name:** TEXT HERE

**Middle Name:** TEXT HERE

**Last Name:** TEXT HERE

**Suffix:** 55555

**Occupation:** TEXT HERE

**Title in the applicant's business:** TEXT HERE

**Also known as:** TEXT HERE

**Date of birth:** MM/DD/YYYY

**Address Line 1:** TEXT HERE

**Address Line 2:** Text Here.

**Address Line 3:** TEXT HERE

**City:** TEXT HERE

**State:** WW

**Zip Code:** 55555

**Phone:** TEXT HERE

**Fax:** TEXT HERE

**Email:** TEXT HERE

**Name and Residential Address**

**First Name:** TEXT HERE

**Name and Residential Address**

First Name: TEXT HERE  
Middle Name: TEXT HERE  
Last Name: TEXT HERE  
Suffix: 55555  
Occupation: TEXT HERE  
Title in the applicant's business: TEXT HERE  
Also known as: TEXT HERE  
Date of birth: MM/DD/YYYY  
Address Line 1: TEXT HERE  
Address Line 2: Text Here.  
Address Line 3: TEXT HERE  
City: TEXT HERE  
State: WW  
Zip Code: 55555  
Phone: TEXT HERE  
Fax: TEXT HERE  
Email: TEXT HERE

**Name and Residential Address**

First Name: TEXT HERE  
Middle Name: TEXT HERE  
Last Name: TEXT HERE  
Suffix: 55555  
Occupation: TEXT HERE  
Title in the applicant's business: TEXT HERE  
Also known as: TEXT HERE  
Date of birth: MM/DD/YYYY  
Address Line 1: TEXT HERE  
Address Line 2: Text Here.  
Address Line 3: TEXT HERE  
City: TEXT HERE  
State: WW  
Zip Code: 55555  
Phone: TEXT HERE  
Fax: TEXT HERE  
Email: TEXT HERE

**Name and Residential Address**

First Name: TEXT HERE  
Middle Name: TEXT HERE  
Last Name: TEXT HERE  
Suffix: 55555  
Occupation: TEXT HERE  
Title in the applicant's business: TEXT HERE  
Also known as: TEXT HERE  
Date of birth: MM/DD/YYYY  
Address Line 1: TEXT HERE  
Address Line 2: Text Here.  
Address Line 3: TEXT HERE  
City: TEXT HERE  
State: WW  
Zip Code: 55555  
Phone: TEXT HERE  
Fax: TEXT HERE  
Email: TEXT HERE

If more space is required, please submit additional information on other officers in a separate document titled "Current Officers (Contd.)" in accordance with the attachment file name format requirements and include it with the attachments.

document titled "Current Officers (Contd.)" in accordance with the attachment file name format requirements and include it with the attachments.

### Section 21 – Ownership

In this section, list all persons with a controlling interest in the business, defined as follows:

- (1) For a publicly traded company, voting rights that entitle a person to elect or appoint one or more of the members of the board of directors or other governing board, or the ownership or beneficial holding of 5% or more of the securities of the publicly traded company.
- (2) For a privately held entity, the ownership of any security in the entity.

Complete the appropriate section(s) below:

- For C-corporations, S-corporations, LLCs and LLCs  
**Name and Residential Address**

**First Name:**

**Middle Name:**

**Last Name:**

**Suffix:**

**Occupation:**

**Title in the applicant's business:**

**Also known as:**

**Date of birth:**

**Address Line 1:**

**Address Line 2:**

**Address Line 3:**

**City:**

**State:**

**Zip Code:**

**Phone:**

**Fax:**

**Email:**

**Stock type or class:**

TEXT HERE

**Number of shares held:**

TEXT HERE

**Date Acquired:**

MM/DD/YYYY

**Percentage of outstanding voting stock:**

TEXT HERE

**Terms, conditions, rights and privileges:**

TEXT HERE

**Name and Residential Address**

**First Name:**

**Middle Name:**

**Last Name:**

**Suffix:**

**Occupation:**

**Title in the applicant's business:**

**Also known as:**

**Date of birth:**

**Address Line 1:**

**Address Line 2:** Text Here.

**Address Line 3:** TEXT HERE

**City:**

**State:**

Address Line 3: TEXT HERE

City:

State:

Zip Code:

Phone:

Fax: TEXT HERE

Email: TEXT HERE

Stock type or class:

TEXT HERE

Number of shares held:

TEXT HERE

Date Acquired:

MM/DD/YYYY

Percentage of outstanding voting stock:

TEXT HERE

Terms, conditions, rights and privileges:

TEXT HERE

**Name and Residential Address**

First Name: TEXT HERE

Middle Name: TEXT HERE

Last Name: TEXT HERE

Suffix: 55555

Occupation: TEXT HERE

Title in the applicant's business: TEXT HERE

Also known as: TEXT HERE

Date of birth: MM/DD/YYYY

Address Line 1: TEXT HERE

Address Line 2: Text Here.

Address Line 3: TEXT HERE

City: TEXT HERE

State: WW

Zip Code: 55555

Phone: TEXT HERE

Fax: TEXT HERE

Email: TEXT HERE

Stock type or class:

TEXT HERE

Number of shares held:

TEXT HERE

Date Acquired:

MM/DD/YYYY

Percentage of outstanding voting stock:

TEXT HERE

Terms, conditions, rights and privileges:

TEXT HERE

**Name and Residential Address**

First Name: TEXT HERE

Middle Name: TEXT HERE

Last Name: TEXT HERE

First Name: TEXT HERE  
Middle Name: TEXT HERE  
Last Name: TEXT HERE  
Suffix: 55555  
Occupation: TEXT HERE  
Title in the applicant's business: TEXT HERE  
Also known as: TEXT HERE  
Date of birth: MM/DD/YYYY  
Address Line 1: TEXT HERE  
Address Line 2: Text Here.  
Address Line 3: TEXT HERE  
City: TEXT HERE  
State: WW  
Zip Code: 55555  
Phone: TEXT HERE  
Fax: TEXT HERE  
Email: TEXT HERE  
Stock type or class:

TEXT HERE

Number of shares held:

TEXT HERE

Date Acquired:

MM/DD/YYYY

Percentage of outstanding voting stock:

TEXT HERE

Terms, conditions, rights and privileges:

TEXT HERE

#### Name and Residential Address

First Name: TEXT HERE  
Middle Name: TEXT HERE  
Last Name: TEXT HERE  
Suffix: 55555  
Occupation: TEXT HERE  
Title in the applicant's business: TEXT HERE  
Also known as: TEXT HERE  
Date of birth: MM/DD/YYYY  
Address Line 1: TEXT HERE  
Address Line 2: Text Here.  
Address Line 3: TEXT HERE  
City: TEXT HERE  
State: WW  
Zip Code: 55555  
Phone: TEXT HERE  
Fax: TEXT HERE  
Email: TEXT HERE  
Stock type or class:

TEXT HERE

Number of shares held:

TEXT HERE

Date Acquired:

MM/DD/YYYY

Percentage of outstanding voting stock:

MM/DD/YYYY

**Percentage of outstanding voting stock:**

TEXT HERE

**Terms, conditions, rights and privileges:**

TEXT HERE

**Name and Residential Address**

**First Name:** TEXT HERE

**Middle Name:** TEXT HERE

**Last Name:** TEXT HERE

**Suffix:** 55555

**Occupation:** TEXT HERE

**Title in the applicant's business:** TEXT HERE

**Also known as:** TEXT HERE

**Date of birth:** MM/DD/YYYY

**Address Line 1:** TEXT HERE

**Address Line 2:** Text Here.

**Address Line 3:** TEXT HERE

**City:** TEXT HERE

**State:** WW

**Zip Code:** 55555

**Phone:** TEXT HERE

**Fax:** TEXT HERE

**Email:** TEXT HERE

**Stock type or class:**

TEXT HERE

**Number of shares held:**

TEXT HERE

**Date Acquired:**

MM/DD/YYYY

**Percentage of outstanding voting stock:**

TEXT HERE

**Terms, conditions, rights and privileges:**

TEXT HERE

**Name and Residential Address**

**First Name:** TEXT HERE

**Middle Name:** TEXT HERE

**Last Name:** TEXT HERE

**Suffix:** 55555

**Occupation:** TEXT HERE

**Title in the applicant's business:** TEXT HERE

**Also known as:** TEXT HERE

**Date of birth:** MM/DD/YYYY

**Address Line 1:** TEXT HERE

**Address Line 2:** Text Here.

**Address Line 3:** TEXT HERE

**City:** TEXT HERE

**State:** WW

**Zip Code:** 55555

**Phone:** TEXT HERE

**Fax:** TEXT HERE

**Email:** TEXT HERE

**Fax:** TEXT HERE  
**Email:** TEXT HERE  
**Stock type or class:**

TEXT HERE

**Number of shares held:**

TEXT HERE

**Date Acquired:**

MM/DD/YYYY

**Percentage of outstanding voting stock:**

TEXT HERE

**Terms, conditions, rights and privileges:**

TEXT HERE

**Name and Residential Address**

**First Name:** TEXT HERE  
**Middle Name:** TEXT HERE  
**Last Name:** TEXT HERE  
**Suffix:** 55555  
**Occupation:** TEXT HERE  
**Title in the applicant's business:** TEXT HERE  
**Also known as:** TEXT HERE  
**Date of birth:** MM/DD/YYYY  
**Address Line 1:** TEXT HERE  
**Address Line 2:** Text Here.  
**Address Line 3:** TEXT HERE  
**City:** TEXT HERE  
**State:** WW  
**Zip Code:** 55555  
**Phone:** TEXT HERE  
**Fax:** TEXT HERE  
**Email:** TEXT HERE  
**Stock type or class:**

TEXT HERE

**Number of shares held:**

TEXT HERE

**Date Acquired:**

MM/DD/YYYY

**Percentage of outstanding voting stock:**

TEXT HERE

**Terms, conditions, rights and privileges:**

TEXT HERE

**Name and Residential Address**

**First Name:** TEXT HERE  
**Middle Name:** TEXT HERE  
**Last Name:** TEXT HERE  
**Suffix:** 55555  
**Occupation:** TEXT HERE  
**Title in the applicant's business:** TEXT HERE  
**Also known as:** TEXT HERE  
**Date of birth:** MM/DD/YYYY

Title in the applicant's business: TEXT HERE  
Also known as: TEXT HERE  
Date of birth: MM/DD/YYYY  
Address Line 1: TEXT HERE  
Address Line 2: Text Here.  
Address Line 3: TEXT HERE  
City: TEXT HERE  
State: WW  
Zip Code: 55555  
Phone: TEXT HERE  
Fax: TEXT HERE  
Email: TEXT HERE  
Stock type or class:

TEXT HERE

Number of shares held:

TEXT HERE

Date Acquired:

MM/DD/YYYY

Percentage of outstanding voting stock:

TEXT HERE

Terms, conditions, rights and privileges:

TEXT HERE

#### Name and Residential Address

First Name: TEXT HERE  
Middle Name: TEXT HERE  
Last Name: TEXT HERE  
Suffix: 55555  
Occupation: TEXT HERE  
Title in the applicant's business: TEXT HERE  
Also known as: TEXT HERE  
Date of birth: MM/DD/YYYY  
Address Line 1: TEXT HERE  
Address Line 2: Text Here.  
Address Line 3: TEXT HERE  
City: TEXT HERE  
State: WW  
Zip Code: 55555  
Phone: TEXT HERE  
Fax: TEXT HERE  
Email: TEXT HERE  
Stock type or class:

TEXT HERE

Number of shares held:

TEXT HERE

Date Acquired:

MM/DD/YYYY

Percentage of outstanding voting stock:

TEXT HERE

Terms, conditions, rights and privileges:

TEXT HERE

**Terms, conditions, rights and privileges:**

TEXT HERE

If more space is required, please submit additional information on other owners of the corporation in a separate document titled "Owners of the Corporation (Contd.)" in accordance with the attachment file name format requirements and include it with the attachments.

- For partnerships and LLPs  
**Name and Residential Address**

**First Name: William**

**Middle Name:**

**Last Name: Walker**

**Suffix:**

**Occupation:**

**Title in the applicant's business:**

**Also known as:**

**Date of birth: DOHDOHDOH**

**Address Line 1: DOHDOHDOHDOHDOH**

**Address Line 2:**

**Address Line 3:**

**City: DOHDOH**

**State: DOH**

**Zip Code: DOH**

**Phone: DOHDOH**

**Fax: TEXT HERE**

**Email: TEXT HERE**

**Partner Type:**

**General/Full Partner**

**Limited Partner**

**Dormant/Silent Partner**

**Other: TEXT HERE**

**Percentage of ownership:**

**50%**

**Partnership participation from:**

**DOHDOHDOH**

**Description of participation in operation of the applicant:**

**Ownership/Director**

**Name and Residential Address**

**First Name: Brian**

**Middle Name:**

**Last Name: Lee**

**Suffix:**

**Occupation: Financial Advisor/Stock Broker**

**Title in the applicant's business: Manager at Janney Montgomery Scott**

**Also known as:**

**Date of birth: DOHDOH**

**Address Line 1: DOHDOHDOHDOHDOHDOH**

**Address Line 2: Text Here.**

**Address Line 3: TEXT HERE**

**City: DOHDOH**

**State: DOH**

**Zip Code: DOH**

**Phone: DOHDOH**

**Fax:**

**Email:**

Phone: DOHDOH

Fax:

Email:

Partner Type:

General/Full Partner

Limited Partner

Dormant/Silent Partner

Other: TEXT HERE

Percentage of ownership:

50%

Partnership participation from:

DOHDOHDOH

Description of participation in operation of the applicant:

Ownership/Director

Name and Residential Address

First Name: TEXT HERE

Middle Name: TEXT HERE

Last Name: TEXT HERE

Suffix: 5555

Occupation: TEXT HERE

Title in the applicant's business: TEXT HERE

Also known as: TEXT HERE

Date of birth: MM/DD/YYYY

Address Line 1: TEXT HERE

Address Line 2: Text Here.

Address Line 3: TEXT HERE

City: TEXT HERE

State: WW

Zip Code: 55555

Phone: TEXT HERE

Fax: TEXT HERE

Email: TEXT HERE

Partner Type:

General/Full Partner

Limited Partner

Dormant/Silent Partner

Other: TEXT HERE

Percentage of ownership:

TEXT HERE

Partnership participation from:

MM/DD/YYYY

Description of participation in operation of the applicant:

TEXT HERE

Name and Residential Address

First Name: TEXT HERE

Middle Name: TEXT HERE

Last Name: TEXT HERE

Suffix: 5555

Occupation: TEXT HERE

Title in the applicant's business: TEXT HERE

Also known as: TEXT HERE

Date of birth: MM/DD/YYYY

Title in the applicant's business: TEXT HERE

Also known as: TEXT HERE

Date of birth: MM/DD/YYYY

Address Line 1: TEXT HERE

Address Line 2: Text Here.

Address Line 3: TEXT HERE

City: TEXT HERE

State: WW

Zip Code: 55555

Phone: TEXT HERE

Fax: TEXT HERE

Email: TEXT HERE

Partner Type:

General/Full Partner

Limited Partner

Dormant/Silent Partner

Other: TEXT HERE

Percentage of ownership:

TEXT HERE

Partnership participation from:

MM/DD/YYYY

Description of participation in operation of the applicant:

TEXT HERE

Name and Residential Address

First Name: TEXT HERE

Middle Name: TEXT HERE

Last Name: TEXT HERE

Suffix: 55555

Occupation: TEXT HERE

Title in the applicant's business: TEXT HERE

Also known as: TEXT HERE

Date of birth: MM/DD/YYYY

Address Line 1: TEXT HERE

Address Line 2: Text Here.

Address Line 3: TEXT HERE

City: TEXT HERE

State: WW

Zip Code: 55555

Phone: TEXT HERE

Fax: TEXT HERE

Email: TEXT HERE

Partner Type:

General/Full Partner

Limited Partner

Dormant/Silent Partner

Other: TEXT HERE

Percentage of ownership:

TEXT HERE

Partnership participation from:

MM/DD/YYYY

Description of participation in operation of the applicant:

TEXT HERE

TEXT HERE

**Name and Residential Address**

**First Name:** TEXT HERE  
**Middle Name:** TEXT HERE  
**Last Name:** TEXT HERE  
**Suffix:** 55555  
**Occupation:** TEXT HERE  
**Title in the applicant's business:** TEXT HERE  
**Also known as:** TEXT HERE  
**Date of birth:** MM/DD/YYYY  
**Address Line 1:** TEXT HERE  
**Address Line 2:** Text Here.  
**Address Line 3:** TEXT HERE  
**City:** TEXT HERE  
**State:** WW  
**Zip Code:** 55555  
**Phone:** TEXT HERE  
**Fax:** TEXT HERE  
**Email:** TEXT HERE  
**Partner Type:**  
 **General/Full Partner**  
 **Limited Partner**  
 **Dormant/Silent Partner**  
 **Other:** TEXT HERE  
**Percentage of ownership:**

TEXT HERE

**Partnership participation from:**

MM/DD/YYYY

**Description of participation in operation of the applicant:**

TEXT HERE

**Name and Residential Address**

**First Name:** TEXT HERE  
**Middle Name:** TEXT HERE  
**Last Name:** TEXT HERE  
**Suffix:** 55555  
**Occupation:** TEXT HERE  
**Title in the applicant's business:** TEXT HERE  
**Also known as:** TEXT HERE  
**Date of birth:** MM/DD/YYYY  
**Address Line 1:** TEXT HERE  
**Address Line 2:** Text Here.  
**Address Line 3:** TEXT HERE  
**City:** TEXT HERE  
**State:** WW  
**Zip Code:** 55555  
**Phone:** TEXT HERE  
**Fax:** TEXT HERE  
**Email:** TEXT HERE  
**Partner Type:**  
 **General/Full Partner**  
 **Limited Partner**  
 **Dormant/Silent Partner**  
 **Other:** TEXT HERE  
**Percentage of ownership:**

- Dormant/Silent Partner
- Other: TEXT HERE

Percentage of ownership:

TEXT HERE

Partnership participation from:

MM/DD/YYYY

Description of participation in operation of the applicant:

TEXT HERE

**Name and Residential Address**

First Name: TEXT HERE

Middle Name: TEXT HERE

Last Name: TEXT HERE

Suffix: 55555

Occupation: TEXT HERE

Title in the applicant's business: TEXT HERE

Also known as: TEXT HERE

Date of birth: MM/DD/YYYY

Address Line 1: TEXT HERE

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Address Line 3: TEXT HERE

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State: WW

Zip Code: 55555

Phone: TEXT HERE

Fax: TEXT HERE

Email: TEXT HERE

Partner Type:

- General/Full Partner
- Limited Partner
- Dormant/Silent Partner
- Other: TEXT HERE

Percentage of ownership:

TEXT HERE

Partnership participation from:

MM/DD/YYYY

Description of participation in operation of the applicant:

TEXT HERE

**Name and Residential Address**

First Name: TEXT HERE

Middle Name: TEXT HERE

Last Name: TEXT HERE

Suffix: 55555

Occupation: TEXT HERE

Title in the applicant's business: TEXT HERE

Also known as: TEXT HERE

Date of birth: MM/DD/YYYY

Address Line 1: TEXT HERE

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Address Line 3: TEXT HERE

City: TEXT HERE

State: WW

Zip Code: 55555

Phone: TEXT HERE

State: WW  
Zip Code: 55555  
Phone: TEXT HERE  
Fax: TEXT HERE  
Email: TEXT HERE

**Partner Type:**

- General/Full Partner
- Limited Partner
- Dormant/Silent Partner
- Other: TEXT HERE

**Percentage of ownership:**

TEXT HERE

**Partnership participation from:**

MM/DD/YYYY

**Description of participation in operation of the applicant:**

TEXT HERE

**Name and Residential Address**

**First Name:** TEXT HERE  
**Middle Name:** TEXT HERE  
**Last Name:** TEXT HERE  
**Suffix:** 55555  
**Occupation:** TEXT HERE  
**Title in the applicant's business:** TEXT HERE  
**Also known as:** TEXT HERE  
**Date of birth:** MM/DD/YYYY  
**Address Line 1:** TEXT HERE  
**Address Line 2:** Text Here.  
**Address Line 3:** TEXT HERE  
**City:** TEXT HERE  
**State:** WW  
**Zip Code:** 55555  
**Phone:** TEXT HERE  
**Fax:** TEXT HERE  
**Email:** TEXT HERE  
**Partner Type:**  
 General/Full Partner  
 Limited Partner  
 Dormant/Silent Partner  
 Other: TEXT HERE  
**Percentage of ownership:**

TEXT HERE

**Partnership participation from:**

MM/DD/YYYY

**Description of participation in operation of the applicant:**

TEXT HERE

If more space is required, please submit additional information on other partners in a separate document titled "Interest of Other partners (Contd.)" in accordance with the attachment file name format requirements and include it with the attachments.

- Other persons holding an interest in the proposed site or facility  
List any other persons holding an interest in the proposed site or facility, that are otherwise not

- Other persons holding an interest in the proposed site or facility

List any other persons holding an interest in the proposed site or facility, that are otherwise not disclosed in sections A or B.

**Name and Residential Address**

**First Name:** TEXT HERE

**Middle Name:** TEXT HERE

**Last Name:** TEXT HERE

**Suffix:** 55555

**Occupation:** TEXT HERE

**Title in the applicant's business:** TEXT HERE

**Also known as:** TEXT HERE

**Date of birth:** MM/DD/YYYY

**Address Line 1:** TEXT HERE

**Address Line 2:** Text Here.

**Address Line 3:** TEXT HERE

**City:** TEXT HERE

**State:** WW

**Zip Code:** 55555

**Phone:** TEXT HERE

**Fax:** TEXT HERE

**Email:** TEXT HERE

**Nature, type, terms and conditions of the interest in the applicant:**

TEXT HERE

**Name and Residential Address**

**First Name:** TEXT HERE

**Middle Name:** TEXT HERE

**Last Name:** TEXT HERE

**Suffix:** 55555

**Occupation:** TEXT HERE

**Title in the applicant's business:** TEXT HERE

**Also known as:** TEXT HERE

**Date of birth:** MM/DD/YYYY

**Address Line 1:** TEXT HERE

**Address Line 2:** Text Here.

**Address Line 3:** TEXT HERE

**City:** TEXT HERE

**State:** WW

**Zip Code:** 55555

**Phone:** TEXT HERE

**Fax:** TEXT HERE

**Email:** TEXT HERE

**Nature, type, terms and conditions of the interest in the applicant:**

TEXT HERE

**Name and Residential Address**

**First Name:** TEXT HERE

**Middle Name:** TEXT HERE

**Last Name:** TEXT HERE

**Suffix:** 55555

**Occupation:** TEXT HERE

**Title in the applicant's business:** TEXT HERE

**Also known as:** TEXT HERE

**Date of birth:** MM/DD/YYYY

**Address Line 1:** TEXT HERE

**Address Line 2:** Text Here.

**Address Line 3:** TEXT HERE

**City:** TEXT HERE

**State:** WW

Address Line 3: TEXT HERE

City: TEXT HERE

State: WW

Zip Code: 55555

Phone: TEXT HERE

Fax: TEXT HERE

Email: TEXT HERE

Nature, type, terms and conditions of the interest in the applicant:

TEXT HERE

**Name and Residential Address**

First Name: TEXT HERE

Middle Name: TEXT HERE

Last Name: TEXT HERE

Suffix: 55555

Occupation: TEXT HERE

Title in the applicant's business: TEXT HERE

Also known as: TEXT HERE

Date of birth: MM/DD/YYYY

Address Line 1: TEXT HERE

Address Line 2: Text Here.

Address Line 3: TEXT HERE

City: TEXT HERE

State: WW

Zip Code: 55555

Phone: TEXT HERE

Fax: TEXT HERE

Email: TEXT HERE

Nature, type, terms and conditions of the interest in the applicant:

Text Here.

If more space is required, please submit additional information on other persons holding an interest in the proposed site or facility in a separate document titled "Other Persons Holding an Interest in the proposed site or facility (Contd.)" in accordance with the attachment file name format requirements and include it with the attachments.

**Section 22 – Capital Requirements**

Provide a summary of your available capital and an estimated spending plan to be used for you to become operational within six months from the date of issuance of the permit:

Any questions about capital and Revenue please direct towards Brian Lee, Owner and Director, Manager at Janney Montgomery Scott Financial Institutions

Part F – Community Impact  
(Scoring Method: 100 Points)

**Section 23 – Community Impact**

please be advised, Indication of support from public officials will not be considered when evaluating this section.

Provide a summary of how the applicant intends to have a positive impact on the community where its operations are proposed to be located:

An intention is to donate available proceeds to charitable organizations throughout the greater Lehigh Valley, and some charitable International organizations as well.

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5. Each entity, other than an individual, interested in such business is (are):

Name	Form of Organization	Organizing Jurisdiction
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Principal Office Address

PA Registered Office, if any

6. The applicant is familiar with the provisions of 54 Pa.C.S. § 332 (relating to effect of registration) and understands that filing under the Fictitious Names Act does not create any exclusive or other right in the fictitious name.

7. (Optional): The name(s) of the agent(s), if any, any one of whom is authorized to execute amendments to, withdrawals from or cancellation of this registration in behalf of all then existing parties to the registration, is (are):

William Walker

IN TESTIMONY WHEREOF, the undersigned has caused this Application for Registration of Fictitious Name to be executed this

18th day of April, 2017.

William Walker  
Individual Signature