

MEDICAL CANNABIS | ACKNOWLEDGEMENT AND ATTESTATION FORM



All medical cannabis facility applications must be accompanied by a signed and notarized Acknowledgement and Attestation Form. Forms may be submitted by:

- **Mail and Dropbox** | ABRA, Medical Cannabis Program,
2000 14th Street NW, Suite 400 South, Washington DC 20009
- **Email** | mcfacilities@dc.gov

I affirm and certify that all the information provided in this Acknowledgement and Attestation Form (Form) is complete, true and correct to the best of my knowledge and belief. I understand that any misrepresentation, falsification or omission of any facts called for in this Form or in the Application may render the Application void and subject to denial by the Alcoholic Beverage Control (ABC) Board. I also understand that the making of false statements may be punishable by the imposition of a fine or may constitute the basis for a criminal offense under D.C. Official Code § 22-2514. I authorize the Alcoholic Beverage Regulation Administration (ABRA) to conduct any investigation it deems necessary and appropriate to ascertain the veracity of this Form and my Application.

1. I attest that I am the true and actual owner of the business for which the registration is sought; that I intend to conduct the business for the entity identified in the Application and not as the agent of any other individual, partnership, association, or corporation not identified in the Application; and that I will personally manage the business or ensure its management by a registered manager approved and licensed by ABRA.
2. I attest that I have not been convicted of any felony before filing the Application, with the exception of felony possession without intent to distribute cannabis.
3. I attest that I have not had my authority to participate in the Medical Cannabis Program previously revoked by DC Health or ABRA.
4. I attest that I do not owe more than \$100.00 to the District of Columbia Government.
5. I attest that I am familiar with and subject to the medical cannabis laws and regulations of the District of Columbia and the federal government. Furthermore, I acknowledge that the laws and regulations are subject to change at any time.
6. I acknowledge that a medical cannabis facility registration may be revoked pursuant to the laws and regulations.
7. I acknowledge that ABRA is not required to issue all of the available registrations to operate a medical cannabis facility.
8. I acknowledge and assume all risk of liability that may result under District of Columbia and federal laws from the possession, use, administration, or dispensing of medical cannabis and I accept the limitation of liability against ABRA and the District of Columbia, and the requirement to indemnify, hold harmless, and defend ABRA and the District of Columbia.
9. I have read the above statements, I understand them and I have signed this Acknowledgement and Attestation Form willingly and without reservation.

If the applicant is a/an:

- Sole owner the individual must sign this document.
- Partnership, each partner must sign a copy of this document and submit a copy of the Partnership Agreement.
- Corporation, the President or Vice President must sign.
- LLC, each of the managing member(s) must sign a copy of this document.
- Limited Partnership, each of the general partner(s) must sign this document.

APPLICANT

First Name	Middle Initial	Last Name	Suffix
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Signature	Date
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Company Name (Enter "N/A" if not applicable)

Title (Enter "N/A" if not applicable)

Type: ☐ Sole Owner ☐ Partner ☐ Corporate Officer ☐ Member

NOTARY

First Name	Middle Initial	Last Name	Suffix
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Signature	Date
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Commission Expiration Date and Seal