SFDPH Environmental HEALTH
improving environments protecting health

City and County of San Francisco
DEPARTMENT OF PUBLIC HEALTH
ENVIRONMENTAL HEALTH

Application for Permit to Operate a Medical Cannabis Dispensary

Date of Application: _____

Dispensary Address: _____ Zip Code: _____

Dispensary Name: _____ Dispensary Phone #: _____

Dispensary Operation Structure: ☐ Nonprofit Collective ☐ Nonprofit Cooperative - must be registered w/ state

Dispensary Owner(s): _____

Legal Ownership Structure: ☐ Nonprofit Corporation* ☐Corporation* ☐ Sole Proprietor ☐ Partnership ☐ Cooperative* ☐ Other _____
(*submit a copy of Article of Incorporation)

Applicant/Operator(s) Name*	**Age**	**ID# and ID Type**	**Home Address**
1. _____	_____	_____	_____
_____		_____	_____
(title, if corporate)		(ID type)	
2. _____	_____	_____	_____
_____		_____	_____
(title, if corporate)		(ID type)	

Manager(s):* _____

(Attach additional forms if necessary) **Must submit valid proof of medical cannabis patient or caregiver status*

Has any owner/operator or manager been convicted of a felony? ☐ Yes ☐ No If yes, list felony(s) below and explain. Please note that all owners/operators and managers listed on this form must submit to a criminal background check. Use the back of this form if you need additional room.

List felony(s): _____

Note: California fire code requires a Place of Assembly permit if facility can accommodate 50 or more persons.

Cannabis will be (check all that apply): ☐ Grown on site ☐ Smoked on site ☐ Vaporized on site

Signature(s) of Applicant(s):

X _____ X _____

X _____ X _____

For Department of Public Health Office Use Only

Planning Referral:		Fire Dept. Referral:		Background Check:	
Seller's permit #:		DBI Referral:		Bus. Reg. Certification #:	
MOD Referral:		Facility ID#		Permit Revocation Check:	
DPH Hearing Date:		Additional Notes:			

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Medical Cannabis Dispensary Planning Referral

For Health Department Use Only	
Date of Application: _____	Date to Zoning: _____
Inspector:	Telephone:

To be Completed by Applicant

Business Name: _____

Business Street Address: _____ Zip: _____

Existing Business Use: _____

Change of Ownership: ☐ Yes ☐ No

New Establishment: ☐ Yes ☐ No

Is location now vacant? ☐ Yes ☐ No

What floor(s) will the business occupy? *(check all that apply)* ☐ Street Level ☐ Other than street level

Business Square Footage: _____

Special Note: If any other room or building is to be used in connection with this application; OR, if any part of the proposed operation is not located within or connected to address above, attach explanation sheet.

Applicant's Name: _____

Mailing Address: _____

City, State: _____ Zip Code: _____

Applicant's Daytime Phone #: _____

For Department of City Planning Use Only		
Zoning:	Block:	Lot:
Limitations or Conditions (if any):		
Building Permit Application #:		
Planning Case #:		
Approved: _____ (Planner's Signature) Date: _____		
Disapproved: _____ (Planner's Signature) Date: _____		

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Written Statement of Compliance with Article 33 of the San Francisco Health Code

This form must be filed annually, commencing January 2012

Date: _____

Medical Cannabis Dispensary (MCD): _____

MCD Address: _____

As the undersigned permittee(s) of the above-referenced Medical Cannabis Dispensary, we hereby attest compliance with Article 33 of the San Francisco Health Code during the calendar year _____ for the following issues:

1. We operate in a not-for-profit manner.*
2. All medical cannabis distributed at our facility is from California.**
3. All activities related to the cultivation of medical cannabis conducted by our MCD in San Francisco comply with applicable State and local laws including, but not limited to, building codes and planning codes.***
4. All medical cannabis distributed at our MCD, including medical cannabis in edible form, has been cultivated by our MCD or our members individually.
5. All edible medical cannabis products are produced by our MCD, or our members.

By signing this declaration, we confirm that we have held a membership meeting and notified all members of the above items. We declare under the penalty of perjury that the aforementioned are true and correct.

Owner/Manager Name and Title	Owner/Manager Name and Title
Signature	Signature

*3308 (c) The medical cannabis dispensary shall operate on a **not for profit** basis. It shall receive only compensation for the reasonable costs of operating the dispensary including reasonable compensation incurred for services provided to qualified patients or primary caregivers to enable that person to use or transport cannabis pursuant to California Health and Safety Code Section 11362.7 et seq., or for payment for reasonable out-of-pocket expenses incurred in providing those services, or both. Reasonable out-of-pocket expenses may include reasonable expenses for patient services, rent or mortgage, utilities, employee costs, furniture, maintenance and reserves. Sale of medical cannabis to cover anything other than reasonable compensation and reasonable out-of-pocket expenses is explicitly prohibited.

**3308(d) Medical cannabis dispensaries shall sell or distribute only cannabis manufactured and processed in the State of California that has not left the State before arriving at the medical cannabis dispensary.

***SF Health Code article 33 requires compliance with Cal Health and Safety Code 11362.7 et seq., and the CA Attorney General Guidelines, issued in 2008. A permit to operate may be suspended or revoked if permittee is engaging in conduct regarding operating an MCD that violates state or local law.

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Fire Marshall Referral Form

Fire Marshall
Division of Fire Prevention & Investigation
698 2nd Street, Room 109
San Francisco, CA 94107

This section to be completed by Owner/Operator

Opening Date: _____

Location: _____ DBA: _____

Owner/Operator: _____ Business Type: _____ Cooking: ☐Yes ☐No

Owner Address: _____

Change of ownership: ☐Yes ☐No Phone: _____ Cell: _____

New Construction: ☐Yes ☐No Remodeling: ☐Yes ☐No

This section to be completed by Department of Public Health Staff

Date: _____ Inspector: _____ DPH Receipt #: _____

HD: _____ Phone: _____ Fax: _____

Fire Marshall, the business named above warrants your timely inspection for fire clearance:

☐ The Fire Marshall requires a fire clearance for the approval and issuance of a new Health Permit for this type of facility.

☐ This facility was observed to have questionable or hazardous conditions: _____

☐ For information only to update SFFD Records. (No Fire Fee Collected)

This section to be completed by SFFD Staff

☐ **Approved** Fire Safety

☐ **Disapproved** Fire Safety: _____

☐ Pending Clearance: _____

(Attach a copy of pending SFFD document or NOV)

Date: _____ Inspector: _____ Phone: _____

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Workers' Compensation Declaration for Regulated Businesses

Owner/Operator: _____

DBA/Name of Business: _____

Address of Business: _____ SFDPH Permit Type: _____

I understand that this business must comply with the Workers' Compensation laws of the State of California to obtain and maintain a valid permit to operate from the San Francisco Department of Public Health. I hereby affirm one of the following declarations:

☐ I have and will maintain a "**Certificate of Consent to Self-Insure**" for workers' compensation, as provided for by Section 3700 of the Labor Code, for the performance of the work for which this permit is issued.

☐ I have and will maintain a "**Certificate of Insurance**" for workers' compensation insurance, as required by Section 3700 of the Labor Code, for the performance of the work for which this permit is issued. My workers' compensation insurance carrier and policy number are:

_____
Carrier

_____
Policy Number

☐ I certify that this business is **not subject to requirements of Section 3700 of the Labor Code** at this time.

I agree that if this business employs any person in any manner so as to become subject to the workers' compensation laws of the State of California and the provisions of Section 3700 of the Labor Code, I will comply with those provisions and I will provide proof of coverage as required by the San Francisco Department of Public Health.

_____ _____
Date Applicant Signature

Required Attachment: **Certificate of Insurance** from Carrier *or*
Certificate of Self-Insurance from the State.

Failure to secure workers' compensation coverage is unlawful, and shall subject an employer to criminal penalties and civil fines up to **one hundred thousand dollars ($100,000)**, in addition to the cost of compensation, damages as provided in Section 3706 of the Labor Code, interest and attorney's fees.

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Mayor's Office on Disability (MOD) Referral Form

Date: _____

Mayor's Office on Disability (MOD)
1155 Market Street, 1st Floor
San Francisco, CA
Attn: Jim Whipple

Subject: **Medical Cannabis Dispensary**

Location: _____
Block: _____ Lot: _____
Building Owner: _____
DBA: _____ Applicant: _____

For the Mayor's Office on Disability Use Only

Our office has received an application to operate a Medical Cannabis Dispensary at the above-referenced location. The permitting process requires compliance with San Francisco Health Code Article 33, Section 3308(y) to be determined by the Mayor's Office on Disability. Please mark the appropriate box and return to;

SF Health Dept., Medical Cannabis Dispensary Program @ 1390 Market St #210.
Attn: Ryan Clausnitzer

☐ The building permit(s) pertaining to access pursuant to SF Health Code Article 33, section 3308(y) has been approved for this location. *Comments:* _____

_____

☐ The building permit(s) pertaining to access pursuant to SF Health Code Article 33, section 3308(y) has **not** been approved for this location or has not been filed for this location. *Comments:* _____

_____

_____

Reviewed by: **MOD Name and Phone Number** **Date**

Respectfully,

_____
Richard Lee, Director of
Regulatory Programs
ENVIRONMENTAL HEALTH