

## Medical Marijuana Facility Program Person Responsible for Facility (PRF) Background Check Request

Name (last, first, middle): \_\_\_\_\_

DOB: \_\_\_\_\_

Sex:  Male  Female

Social Security # (SSN): \_\_\_\_\_

(Provision of your SSN is voluntary; it will only be used to confirm that the PRF has been correctly identified by the background check.)

All other names used (Include maiden name): \_\_\_\_\_

Oregon Driver's License or ID card #: \_\_\_\_\_

Mailing address (Street/Apt #): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Street address (If different than mailing address): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home or message phone: \_\_\_\_\_

Email address: \_\_\_\_\_

Dispensary name: \_\_\_\_\_

Dispensary city: \_\_\_\_\_

Have you ever been charged, arrested and/or convicted of a crime?  Yes  No

If yes, list all charges, arrests and/or convictions and the outcome regardless of how long ago. (Attach additional pages if needed.)

Date (or estimate):	List each charge, arrest or conviction:	County:	State:	Outcome:
1.				
2.				
3.				
4.				
5.				

I hereby certify that I am the above named individual and that the information provided is true and correct. I understand that a criminal records check will be completed on me. My signature authorizes the MMD program to request and receive any juvenile, police, court or investigation reports needed to complete this background check. In the event disqualifying information is discovered I will be provided with information about how to challenge the background check information. I certify the information I have provided is correct and complete. I understand that if I provide false or incomplete information, my application may be returned as incomplete or denied. I understand the check may be repeated during the time the facility is registered.

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

DRAFT

|  
Must also submit:

- Electronic fingerprint scan
- Background check fee payment

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