Ohio Medical Marijuana Control Program
Tax Authorization Form

This form must be completed by a licensed associated key employee of the Applicant in accordance with Ohio Adm.Code 3796:6-2-03.

Print and sign this form with an original, wet ink signature. *Electronic or digital signatures are not acceptable*. Please note, authorization given on this form expires 1 year from the date of the signature below.

Dispensary Name (Applicant):	
Certificate of Operation Number (MMD.XXXXXXX):	
Applicant EIN Number:	
I hereby authorize the Ohio Department of Taxation and any of its agents and/or employees to release information to the State of Ohio Board of Pharmacy in accordance with R.C. 3796.11, including whether the business disclosed on the application is in compliance with the applicable tax laws of this state, whether the applicant has any past or pending violations of those tax laws, and any penalty imposed on the applicant for such a violation. These records and information shall be limited to information obtained and maintained by the Ohio Department of Taxation and shall not contain any federal tax information as defined in I.R.C. 6103 and received from the Internal Revenue Service. I expressly waive the confidentiality provisions of the Ohio Revised Code, which would otherwise prohibit disclosure, and agree to hold the Ohio Department of Taxation and the State of Ohio Board of Pharmacy harmless with respect to the disclosure herein. I certify under the penalties of perjury that I am authorized to sign this Tax Authorization Form on behalf of the Applicant identified above.	
Printed Name of Authorized Representative (AKE):	License No. (MME.XXXXXXX):
Signature:	Date:

Subscribed and sworn to before me this _____ day of _____ , 20 _____ .

(SEAL)

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NOTARY PUBLIC