Ohio Medical Marijuana Control Program
Tax Authorization Form

This form must be completed by each Associated Key Employee with an aggregate ownership interest of ten percent or more in any Ohio dispensary. The State of Ohio Board of Pharmacy may, in its discretion, require an owner or person who exercises substantial control over a dispensary, but who has less than a ten percent ownership interest, to comply with statutory and regulatory ownership requirements. (OAC 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):	
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, including information relating to the undersigned individual as well as information regarding any business disclosed on the application related to this tax authorization form for which the undersigned individual had an ownership interest. 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 the taxpayer identified below.	
Printed Name of Associated Key Employee (AKE):	Social Security Number:
Signature:	Date:

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

(SEAL)

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NOTARY PUBLIC