



COLORADO
Department of Revenue

Natural Medicine Division

Regulated Natural Medicine Business License Application

Colorado Natural Medicine Division
Regulated Natural Medicine Business License Application Instructions

Application Checklist

1. Application Fully Completed

Type or clearly print, in English, an answer to every question. If a question does not apply, indicate with an N/A. If the available space is insufficient, continue on a separate sheet and precede each answer with the appropriate title. An applicant is prohibited from having an interest in more than five natural business licenses.

A separate application is required for EACH license type. (ie. a separate application for a Healing Center and a Cultivation is required)

2. All Forms Signed & Attached

The following accompanying forms must be completed, signed and returned by each individual owner and with the application:

Affirmation & Consent

Tax Check Authorization

Applicant's Request to Release Information

3. Required Disclosures

See Application Required Disclosures (page 9-10 of application)

4. Application and Compliance Fees

See fee table on website: <https://DNM.Colorado.gov/>

Application fees paid to the State Licensing Authority and/or the Department of Revenue are non-refundable.

Compliance fees must be paid at the time of conditional approval.

Checks (in the name of the applicant or applicant's attorney's trust account), money orders and major credit cards (subject to service charge), are acceptable forms of payment.

Mail-in applications can only be paid by check or money order.

NO Transfers/Changes of Ownership applications will be accepted until after the state license is issued.

Colorado Natural Medicine Division
Regulated Natural Medicine Business License Application Instructions

Application Checklist (Continued)

5. Application Submittal

All applications and documentation submitted must be single-sided and on 8.5x11 inch paper.

General Questions about the program, please visit: DNM.Colorado.gov

Application Submission Questions, please contact: dor_nmd_licensing@state.co.us

Submit complete original or scanned application packet.

Applications can be submitted in person or by mail with all attachments and requisite fees:

Attn: NMD / Natural Medicine
COLORADO DEPARTMENT OF REVENUE
P.O. BOX 17087
DENVER CO 80217-0087

Physical Address:

1707 Cole Blvd., Suite 300
Lakewood, CO 80401

Note: Incomplete applications will not be processed. Applicants must collect the incomplete application and fees (including those mailed in or delivered via courier), from the Lakewood Office prior to the end of the next business day after they are notified of an incomplete application.

Upon request by the Division, an Applicant must provide additional information or documents required to process and investigate the application, within seven (7) days of the request.

Please note: This deadline may be extended for a period of time commensurate with the scope of the request.

Natural Medicine Division

Regulated Natural Medicine Business License Application

License Types

Healing Center

Natural Medicine Cultivation Facility

Micro Healing Center

Natural Medicine Micro Cultivation

Natural Medicine Product Manufacturer

Natural Medicine Testing Facility

Extraction Endorsement (Must have a Product Manufacturing License. May apply for both concurrently.)

Applicant's Legal Business Name (Please Print)

Registered Trade Name (DBA)

Federal Taxpayer ID

Name of Registered Agent (with CO Secretary of State)

Physical Address

Street Address of Natural Medicine Business

Business Phone Number

City

County

State ZIP Code

Email Address

Mailing Address (if different from Physical Address)

Street Address

City

State ZIP Code

Main Business Contact Person Information

Primary Contact Person for Business

Primary Contact Phone Number

Primary Contact Email

Natural Medicine Division

Regulated Natural Medicine Business License Application (Continued)

Jurisdiction of Incorporation or Creation of Business Entity

Date (MM/DD/YY)

If a Corporation, Partnership, or LLC, list all jurisdictions where authorized to conduct business.

Ownership Structure

The following info must be completed for each proposed owner or any person who may have a financial interest in this license.

Financial Interest means entitlement or agreement to receive a portion of revenue, proceeds or profits from a Natural Medicine Business or a Natural Medicine Business Applicant; or a membership interest, partnership interest or other ownership interest, including but not limited to a share of stock, in a Natural Medicine Business or Natural Medicine Business Applicant.

Last Name

First Name

Street Address

City

State ZIP Code

Business Associated with (Parent business or sub-entity) Total Ownership % in NMB (include Direct ownership and any Entity %)

Last Name

First Name

Street Address

City

State ZIP Code

Business Associated with (Parent business or sub-entity) Total Ownership % in NMB (include Direct ownership and any Entity %)

Ownership Structure (Continued)

Last Name

First Name

Street Address

City

State ZIP Code

Business Associated with (Parent business or sub-entity) Total Ownership % in NMB (include Direct ownership and any Entity %)

Last Name

First Name

Street Address

City

State ZIP Code

Business Associated with (Parent business or sub-entity) Total Ownership % in NMB (include Direct ownership and any Entity %)

Last Name

First Name

Street Address

City

State ZIP Code

Business Associated with (Parent business or sub-entity) Total Ownership % in NMB (include Direct ownership and any Entity %)

Last Name

First Name

Street Address

City

State ZIP Code

Business Associated with (Parent business or sub-entity) Total Ownership % in NMB (include Direct ownership and any Entity %)

Ownership Structure (Continued)

Last Name	First Name
Street Address	
City	State ZIP Code
Business Associated with (Parent business or sub-entity)	Total Ownership % in NMB (include Direct ownership and any Entity %)

Last Name	First Name
Street Address	
City	State ZIP Code
Business Associated with (Parent business or sub-entity)	Total Ownership % in NMB (include Direct ownership and any Entity %)

Last Name	First Name
Street Address	
City	State ZIP Code
Business Associated with (Parent business or sub-entity)	Total Ownership % in NMB (include Direct ownership and any Entity %)

Last Name	First Name
Street Address	
City	State ZIP Code
Business Associated with (Parent business or sub-entity)	Total Ownership % in NMB (include Direct ownership and any Entity %)

Ownership Structure - Other Interests

Printed Legal Business Name

Printed Trade Name (DBA)

Other Interests - List those people with the following interest:

- 1. A real or personal property lease;**
- 2. Secured or unsecured promissory notes;**
- 3. Agreements with a Natural Medicine Business regarding intellectual property;**
- 4. Management agreement(s) with the Natural Medicine Business.**

Name of Interest Holder

Date of Birth

List Types of Interests

Street Address

City

State ZIP Code

Name of Interest Holder

Date of Birth

List Types of Interests

Street Address

City

State ZIP Code

Name of Interest Holder

Date of Birth

List Types of Interests

Street Address

City

State ZIP Code

Additional Questions

- | | | |
|--|-----|----|
| 1. Is the applicant (including any of the partners, if a partnership; members or manager if a limited liability company; or officers, stockholders or directors if a corporation) under the age of twenty-one years?..... | Yes | No |
| 2. Healing Center Only | | |
| Are the premises to be licensed within 1000 feet of a school (as defined in 44-50-302(1)(d)(I)), licensed child care center, preschool, elementary, middle, junior, or high school, or a residential child care facility? If YES, then include a copy of a waiver or ordinance from the local jurisdiction where the business is located. | Yes | No |
| 3. Is the location appropriately zoned for a Natural Medicine Cultivation, Natural Medicine Product Manufacturer, Healing Center, or Natural Medicine Testing Facility?..... | Yes | No |
| 4. Do you have or will you have possession of the licensed premises?..... | Yes | No |
| 5. Is the applicant applying for a license at a location that is currently licensed as a liquor or marijuana establishment? If YES, provide details on a separate sheet, such as a floor plan or location diagram and any other relevant information, to indicate that the business will not be located at the same licensed premises..... | Yes | No |
| 6. Is the applicant, the applicant's parent company or any other intermediary business entity delinquent in the payment of any judgments, taxes, interest or penalties due to the Department of Revenue, relating to a Natural Medicine Business? If YES, provide details on a separate sheet and attach any documents to prove settlement or resolution of the delinquency..... | Yes | No |
| 7. In the past three (3) years, has the applicant (including any parent companies), been indicted, served with a criminal summons, charged with or convicted of ANY crime or offense as listed in Rule 2135(B)? Include ALL felony offenses, regardless of the outcome. If YES, provide details on a separate sheet and attach any applicable documents..... | Yes | No |

New Business Application Required Disclosures

Organizational Chart, **Reflecting All Proposed Owners**, including the identity and ownership percentage of all owners, and including any indigenous person(s) who own 51% or more of the Natural Medicine Business. If you are an indigenous person, please attach 3 references with name, phone number, email address to verify tribal affiliation.

Certificate of Good Standing from the jurisdiction where the Business Entity was formed.

Organizational documents including identity and physical address of the registered agent in Colorado.

Organizational Documents (Indicate which document is being provided)

Articles of Incorporation

By-Laws

Shareholder agreement for Corporations

Operating Agreement for LLC

Partnership Agreement for partnership

New Business Application Required Disclosures (continued)

ESG: Environmental Social Governance Plan

ESG Governance Documents (if applicable)

Proof of Possession of Licensed Property (Indicate which document is being provided)

Deed

Lease

Sublease

Rental Agreement

Contract

Facility Diagrams: If you already have a Premises Diagram (interior and exterior), and a Security Plan, please provide these documents.

Documentation demonstrating that the address for the proposed Licensed Premises is permitted under the Local Jurisdiction's applicable zoning laws for the cultivation, manufacturing, testing, storage, distribution, transfer, and/or dispensation of Regulated Natural Medicine and Regulated Natural Medicine Product.

Licensed Premises (Healing Centers only-Exterior Layout): A diagram or map of the physical location for the proposed Licensed Premises demonstrating the proposed address for a Healing Center license is at least 1000 feet from a licensed child care center, preschool, elementary, middle, junior, or high school, or a residential child care facility, unless the location otherwise complies with section 44-50-302(1)(d)(I), C.R.S.

Licensed Premises (Interior layout): A diagram or map of common areas, such as lobbies, hallways, and bathrooms; Restricted Areas; and Administration Areas.

Security and Surveillance diagram (no later than 30 days after beginning operations.)

A copy of any contracts, agreements, equipment leases, financing agreement, or security.

Provide a list of any sanctions, penalties, assessments or cease and desist orders from the Division of Natural Medicine.

Facilitator Requirement (applicable to Healing Center/Micro Healing Center business applications only)

Healing Center/Micro Healing Center has at least one Owner who is a DORA licensed Facilitator and/or completing the necessary practicum requirements to become a DORA licensed Facilitator; **or**

Healing Center/Micro Healing Center will employ or contract with a DORA licensed Facilitator or person completing the necessary practicum requirements to become a DORA licensed Facilitator

Affirmation of complete application

Signature

Date (MM/DD/YY)

Printed Name

Local Zoning Attestation Form

This form must be completed as part of the Natural Medicine Business application submission. The Natural Medicine Division must confirm that all businesses are in compliance with local zoning code requirements. If there are no natural medicine specific zoning regulations, the Natural Medicine Division will confirm compliance with any applicable local zoning requirements.

Please note that the Division will not license to a private residence.

In order to show compliance with Rule 2125(2)(b),

I,
an authorized representative of:

Business Name

Business License Number

,
attest that the license above is in substantial compliance with the local jurisdiction zoning requirements for my business type:

This includes confirmation that the proposed licensed premises:

Initial Here

Is not located at a private residence; and

Initial Here

Is zoned properly for the Natural Medicine Business; **or**

Initial Here

Does not have a local jurisdiction requirement regarding
Natural Medicine Business locations.

Confirmation of your zoning ordinance can be shown in different ways, please attach a copy of one of the following:

A PDF copy of your jurisdiction's zoning code

A copy of email correspondence from your local jurisdiction confirming their zoning requirements for your Natural Medicine Business type

A copy of email correspondence from your local jurisdiction confirming they have no requirements regarding Natural Medicine Businesses

Printed Name

Owner License Number

Signature

Date (MM/DD/YY)

Affirmation & Consent

I

hereby attest the entire Natural Medicine Business License Application Form, statements, attachments, and supporting schedules are true and correct to the best of my knowledge and belief, and this statement is executed with knowledge that misrepresentation or failure to reveal information requested may be good cause for denial of a Natural Medicine license by the State Licensing Authority. Further, I am aware that later discovery of an omission or misrepresentation may be grounds for disciplinary action against the license. I consent to any background investigation(s) necessary to determine my present and continuing suitability to hold a Colorado Natural Medicine license.

I hereby attest I reviewed the distance restrictions established by the Natural Medicine Code at section 44-50-302(1)(d), C.R.S., and confirm the location for the proposed Natural Medicine Business associated with this Application complies with these distance restrictions. I execute this statement knowing the State Licensing Authority is required to review compliance with distance restrictions and deny this Application if the proposed Natural Medicine Business does not comply with the statutory distance restrictions.

I hereby attest I reviewed and confirmed compliance with all applicable local ordinances and restrictions governing the time, place, and manner of operation of the proposed Natural Medicine Business associated with this Application. I execute this statement knowing it is my obligation, as an applicant for a Natural Medicine Business license, to review and confirm compliance with applicable local ordinances and restrictions, and failure to comply with local ordinances and restrictions is grounds for disciplinary action, including but not limited to application denial.

I hereby attest no proposed Owner of the proposed Natural Medicine Business associated with this Application holds a Financial Interest, as defined in Rule 1025, 1 CCR 213-1, in five or more Natural Medicine Business licenses. I further attest no proposed Owner would hold a Financial Interest in more than five Natural Medicine Business licenses if a Natural Medicine Business license were issued pursuant to this Application.

Print Full Legal Name of Owner clearly below:

Applicant's Legal Business Name

Trade Name (DBA)

Last Name of Owner (Please Print)

First Name of Owner

Middle Name of Owner

Signature

Date (MM/DD/YY)

Confidential Document: This document is the property of the State Licensing Authority and the Natural Medicine Division, and is provided for Official Use Only. Completed documents submitted to the Natural Medicine Division or the State Licensing Authority are confidential and will not be reproduced outside an express disclosure allowance.

Tax Check Authorization and Request To Release Information

I

am signing this waiver on behalf of

(the "Applicant/Licensee") to permit the Colorado Department of Revenue and any other local taxing authority to release information and documents that would otherwise be confidential. If I am signing this waiver for someone other than myself, I certify that I have the authority to execute this waiver on behalf of the Applicant/Licensee.

The information and documentation obtained pursuant to this waiver will be used in connection with the Applicant/Licensee's application for licensure with the Colorado Natural Medicine Division, which requires proof of compliance with certain tax obligations pursuant to section 44-10-203(1)(d) C.R.S., and Natural Medicine Rule 2135(A)(5). This waiver is made pursuant to section 39-21-113(4), C.R.S.; and any other similar law or ordinance concerning the confidentiality of tax returns and return information. This waiver is valid while the application is pending and, if the application is approved, (1) for one year from the date of licensure. If the license is administratively continued pursuant to section 44-10-314, C.R.S., this waiver is valid until the state licensing authority takes final action to approve or deny the renewal of the license. Applicant/Licensee agrees to execute a new waiver for each subsequent licensing period in connection with the renewal of any license.

Applicant/Licensee requests that the Colorado Department of Revenue and any other local taxing authority release the following information and supporting documentation to the Colorado Natural Medicine Division, which is acting as Applicant's/Licensee's duly authorized representative under section 39-21-113(4), C.R.S., solely to obtain the information specified below.

1. Whether the Applicant/Licensee has failed to file any state tax return with the Colorado Department of Revenue or any local taxing authority by the required due date (determined with regard to any extension(s) of time for filing) for any tax year for which filing of a return might have been required.
2. Whether the Applicant/Licensee has failed to pay any tax, penalty, or interest within 30 days of the date on which the Colorado Department of Revenue or any local taxing authority gave notice of the amount due and requested payment.
3. Whether the Applicant/Licensee has entered into a payment plan with the Colorado Department of Revenue or any other local taxing authority and whether applicant/Licensee is current on any payments required by the payment plan.

Applicant/Licensee authorizes the Colorado Department of Revenue and any local taxing authority to release any additional information or documentation necessary to answer the questions above. Applicant/Licensee authorizes the Colorado Natural Medicine Division and its legal representatives to use the information and documentation obtained from the Colorado Department of Revenue and any local taxing authority in any administrative action regarding the application or license. To assist the Colorado Department of Revenue and any local taxing authority locate the tax records, Applicant/Licensee is voluntarily providing the following information (please type or print).

Tax Check Authorization and Request To Release Information (continued)

Applicant's Name (Individual/Business)

Social Security Number/Tax Identification Number

Street Address

City

State ZIP Code

Home Telephone Number

Business/Work Telephone Number

Legal Last Name (Please Print)

Legal First Name

Full Middle Name

Applicant's Signature

Date (MM/DD/YY)

Confidential Document: This document is the property of the State Licensing Authority and the Natural Medicine Division, and is provided for Official Use Only. Completed documents submitted to the Natural Medicine Division or the State Licensing Authority are confidential and will not be reproduced outside an express disclosure allowance.

Applicant's Request to Release Information

TO: (Leave this Blank)

FROM: (Applicant's Printed Name)

1. I hereby authorize and request all persons to whom this request is presented, having information relating to or concerning the above named applicant, to furnish such information to a duly appointed agent of the Natural Medicine Division, whether or not such information would otherwise be protected from disclosure by any constitutional, statutory, or common law privilege.
2. I hereby authorize and request all persons to whom this request is presented having documents relating to or concerning the above named applicant to permit a duly appointed agent of the Natural Medicine Division to review and copy any such documents, whether or not such documents would otherwise be protected from disclosure by any constitutional, statutory, or common law privilege.
3. I hereby authorize and request the Colorado Department of Revenue to permit a duly appointed agent of the Natural Medicine Division to obtain, receive, review, copy, discuss and use any such tax information or documents relating to or concerning the above named applicant, whether or not such information or documents would otherwise be protected from disclosure by any constitutional, statutory, or common law privilege.
4. I do hereby make, constitute, and appoint any duly appointed agent of the Natural Medicine Division, my power of attorney with authority to:
 - (a) To request, review, copy, sign for, or otherwise act for investigative purposes with respect to documents and information in the possession of the person to whom this request is presented as I might;
 - (b) To name the person or entity to whom this request is presented and insert that person's name in the appropriate location in this request;
 - (c) To place the name of the agent presenting this request in the appropriate location on this request.
5. I grant to the power of attorney full power and authority to do, take, and perform any act requisite, proper, or necessary in the exercise of any of the rights and powers herein granted, as fully to all intents and purposes as I might or could do if personally present. I hereby ratify and confirm my consent for all that the power of attorney shall lawfully do or cause to be done by virtue of this power of attorney and the rights and powers herein granted.
6. This power of attorney ends twenty-four (24) months from the date of execution.
7. I understand and accept that by filing an application for a Natural Medicine license, I am seeking the granting of a privilege and acknowledge the burden of proving my qualifications to hold a Natural Medicine license is at all times on me. I further accept any risk of adverse public notice, embarrassment, criticism, or other action of financial loss which may result from action with respect to this application.
8. I do, for myself, my heirs, executors, administrators, successors, and assigns, hereby release,

Applicant's Request to Release Information (Continued)

remise, and forever discharge the person to whom this request is presented, and his/her/their agents and employees from any and all actions, causes of action, suits, debts, judgments, executions, claims, and demands whatsoever, known or unknown, in law or equity, which the applicant ever had, now has, may have, or claims to have against the person to whom this request is being presented or his/her/their agents and employees arising out of or by reason of complying with the request.

9. I agree to indemnify and hold harmless the person to whom this request is presented and his/her/their agents and employees from and against all claims, damages, losses, and expenses, including reasonable attorneys' fees arising out of or by reason of complying with this request.
10. A reproduction of this request by photocopying or similar process shall be for all intents and purposes valid as the original.

Applicant's Legal Business Name

Trade Name (DBA)

Applicant's Last Name (Please Print)

First Name

Full Middle Name

Signature

Date (MM/DD/YY)

Confidential Document: This document is the property of the State Licensing Authority and the Natural Medicine Division, and is provided for Official Use Only. Completed documents submitted to the Natural Medicine Division or the State Licensing Authority are confidential and will not be reproduced outside an express disclosure allowance.