



**COLORADO**  
Department of Revenue

**Natural Medicine Division**

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# **Natural Medicine Owner Renewal Application**

**Colorado Natural Medicine Division**  
Owner Renewal Application Instructions

**Application Checklist**

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**1. Application Type**

Owner: An individual or an entity that owns, possesses, or is entitled to any Financial Interest in a Natural Medicine Business or a Natural Medicine Business Applicant; an individual or an entity that owns a share of stock in a corporation, a membership in a nonprofit corporation, a membership interest in a limited liability company, the interest of a member in a cooperative or in a limited cooperative association, a partnership interest in a limited partnership, a partnership interest in a partnership, or the interest of a member in a limited partnership association that holds any interest in a Natural Medicine Business. An owner can be a natural person or a legal entity.

Financial Interest: An 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.

**2. 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. Sign and date the application.

**Attach a copy of your state issued or Government ID (i.e. passport) or driver's license (or see website for additional forms of ID accepted).**

**3. All Forms Signed and Attached**

The following accompanying forms must be completed, signed and returned with the application:

Affirmation and Consent

Tax Check Authorization and Request to Release Information

Applicant's Request to Release Information

## Application Checklist (Continued)

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### 4. Renewal Fees

See fee table on website: [DNM.Colorado.gov](http://DNM.Colorado.gov)

Renewal fees are due at the time of application.

Checks (in the name of the applicant or applicants 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.

**Note:** There is no grace period for Owner licenses. If your license expires, you will be required to reapply for a new license and pay all required fees.

### 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](http://DNM.Colorado.gov)

Application Submission Questions, please contact: [DOR\\_NMD\\_Licensing@state.co.us](mailto:DOR_NMD_Licensing@state.co.us)

Submit complete application packet.

Applications can be submitted in person or via FedEx or UPS with all attachments and requisite fees to:

**Physical Address:**

1707 Cole Blvd., Suite 300  
Lakewood, CO 80401

**If mailing via USPS, please use the mailing address:**

Colorado Department of Revenue  
Attn: NMD/Natural Medicine  
P.O. Box 17087  
Denver, CO 80217-0087

**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 once notification of incomplete application is made.**

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 up to 60 days commensurate with the scope of the request.

### Mandatory Disqualifiers

- |   |     |    |
|---|-----|----|
| <b>1.</b> Are you delinquent in the payment of any Colorado child support? If so, you must provide an agreement to pay. (Select "No" if you can provide an agreement to pay.).....  | Yes | No |
| <b>2.</b> Have you failed to remedy an outstanding delinquency for any judgments, taxes, interest or penalties due to the Department of Revenue, relating to a Regulated Natural Medicine Business?.....  | Yes | No |
| <b>3.</b> Have you received a regulatory warning or action from the State Licensing Authority or another regulatory entity or Court, related to the unlawful marketing, manufacturing, or sale of natural medicine?.....                        | Yes | No |
| <b>4.</b> Are you a person who previously held a license from either the Department of Revenue or the Division of Professions and Occupations that has been denied or revoked in the previous three years?.....                                 | Yes | No |
| <b>5.</b> Have you been convicted of a felony in the preceding 3 years, or are subject to a sentence for a felony conviction, or are subject to a deferred judgment or sentence for a felony conviction, for any of the following charges:..... | Yes | No |
1. A criminal sexual act;
  2. Criminal fraud or embezzlement;
  3. Aggravated assault;
  4. Aggravated abuse, neglect, or endangerment of a child or an at-risk person;
  5. Aggravated robbery;
  6. Arson;
  7. Manslaughter, homicide, or murder;
  8. A violation of the Racketeer Influenced and Corrupt Organizations Act (RICO) or Colorado Organized Crime Control Act (COCCA); or
  9. A conviction for the unlawful manufacturing with an inherently dangerous substance or commercial sale of any Natural Medicine related conduct after 2023.

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I have thoroughly read and understand the questions above, and understand that I cannot hold a Colorado Natural Medicine license if I answered "Yes" to any of the questions above.

Signature of Applicant

Date (MM/DD/YY)

# Natural Medicine Owner Renewal Application Form

<b>License Type Renewing:</b>	Owner	Owner/Facilitator
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NMD Owner License Number	Expiration Date
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Applicant's Last Name (Please Print)	First Name (Please Print)	Full Middle Name
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Maiden/Married Names Used (Full Name) (attach separate sheet if necessary)

**Gender:**      Male      Female      X

<b>Race:</b>	Asian	Mixed Race	Black	Hispanic/Latino	Native American
	Caucasian	Native Hawaiian/Pacific Islander		Undisclosed/Unknown	

Date of Birth (MM/DD/YY)      Social Security Number      Government Issued ID Number & Issuing State/Jurisdiction

## Physical Appearance

Height (in feet & inches)	Weight (in pounds)	Hair Color	Eye Color
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### Owner's Physical Address

Address (include unit or apartment number)

City	County	State/Prov	ZIP Code
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Home Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Email Address

## Owner Renewal Application Form (Continued)

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### Owner's Mailing Address (if different from Owner's Physical Address)

Address (include unit or apartment number)

City

State/Prov    ZIP Code

### Natural Medicine Business Address

Business Address

City

State            ZIP Code

Name of Natural Medicine Business Associated with

Business Phone Number

Business Contact Name

Signature of Applicant

Date (MM/DD/YY)

**Notice:** The Owner Application Form is an official document. If you provide false information on your Natural Medicine license application and/or do not disclose all information the application asks, your application is subject to denial. The Natural Medicine Division will conduct a complete background investigation and will check all sources of information.

### Additional Questions

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1. Provide a list of any privileged or professional licenses, with license numbers, you have held within the last three (3) years prior to the submission of the Owner Application. List those that were issued by the Colorado Department of Revenue or the Department of Regulatory Agencies - Division of Professions and Occupations

None

Applicant's Last Name (Please Print)

First Name (Please Print)

Full Middle Name

2. Have you or any business entity owned by you, ever owned or applied for a Natural Medicine license or psilocybin services license or permit in this or any other jurisdiction, foreign or domestic?..... Yes No
- a. If so, have you ever been subject to any of the following actions: (1) denial; (2) surrender; (3) order to show cause; (4) suspension; (5) revocation; (6) stipulation or settlement. **If yes, provide details on a separate sheet, including jurisdiction, type of action, and date of action**..... Yes No

Do you have a Facilitator, Clinical Facilitator, or a Training License by DORA? ..... Yes No

If Yes, indicate which license type and license number here:

Do you currently provide any services related to natural medicine? ..... Yes No

If Yes, please explain what services you provide.

## Affirmation & Consent

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I,

hereby attest the entire Natural Medicine Owner License Renewal Application, 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 or Owner 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 I do not presently hold a Financial Interest, as defined in Rule 1025, 1 CCR 213-1, in five or more Natural Medicine Business licenses.

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### Print Full Legal Name of Applicant clearly below:

Applicant's Last Name (Please Print)

First Name (Please Print)

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.



## Tax Check Authorization and Request To Release Information

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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 44-50-203(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 the Administrative Procedures Act, 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).

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Applicant's Name (Individual/Business)

Social Security Number/Tax Identification Number

## Tax Check Authorization and Request To Release Information (continued)

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Street Address

City

State    ZIP Code

Legal Last Name (Please Print)

Legal First Name

Full Middle Name

Applicant's Signature

Date (MM/DD/YY)

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## Applicant's Request to Release Information

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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.

### Applicant's Request to Release Information (continued)

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8. I do, for myself, my heirs, executors, administrators, successors, and assigns, hereby release, 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 Last Name (Please Print)

First Name

Full Middle Name

Signature

Date (MM/DD/YY)

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## Natural Medicine Owner Licensee Obligations

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I understand I am being made aware of the following regulations and agree to comply with them:

I must pay a fee to obtain a duplicate license. (Rule 2005(c))

I am required to renew my license prior to the expiration date of the license I am being issued. (Rule 2130(C))

The Natural Medicine Division will send a notice of License renewal 90 days prior to the expiration of an existing license to the electronic mail address on file with the Natural Medicine Division. Failure to receive this notice does not relieve the Licensee from the obligation to timely renew the license. (Rule 2130(B))

If I allow my license to expire for even one day, I must submit a new license application along with the new license application fee. (Rule 2130(D))

If the Natural Medicine Division contacts me regarding this license application, I will provide any information the Natural Medicine Division requests within 7 calendar days (unless otherwise instructed). (Rule 2110(F))

I must cooperate with employees and investigators of the Natural Medicine Division who are conducting inspections or investigations relevant to the enforcement of laws and regulations related to Natural Medicine Code. (Rule 2110(B))

I understand I am responsible to notify the Natural Medicine Division, in writing, when I have a change in physical mailing address, email address, within 28 days, since all correspondence is sent to my last physical mailing address and email address provided to the Natural Medicine Division. Failure to notify the Natural Medicine Division could result in my not receiving my physical license, legal notices, and other correspondence. (Rule 2105(A))

I shall not by any means interfere with, obstruct or impede, the State Licensing Authority or employee or investigator of the Natural Medicine Division, from exercising their duties pursuant to the provisions of the Natural Medicine Code and all rules promulgated pursuant to it. (Rule 9005(A))

I understand that a license issued by the Natural Medicine Division to Owners constitutes a revocable privilege. The burden of proving an Applicant's qualifications for licensure rests at all times with the Applicant. (Rule 2155(A))

I have read all of the above information and understand my responsibilities as a Natural Medicine Owner Licensee. I further understand that failure to comply with any law, regulation, or the provisions of this Statement may be grounds for disciplinary action, including but not limited to, the suspension or revocation of my license and a monetary penalty after an administrative hearing.

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### 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)