Universal Care of PA, Inc.
2913 Beacon Way
Pittsburgh, PA 15241
Office – 724-941-1766
724-941-1171 – Fax

Medical Marijuana Dispensary Permit Application #2

Department of Health Use Only	
#	Received

pennsylvania
DEPARTMENT OF HEALTH

Medical Marijuana Dispensary Permit Application

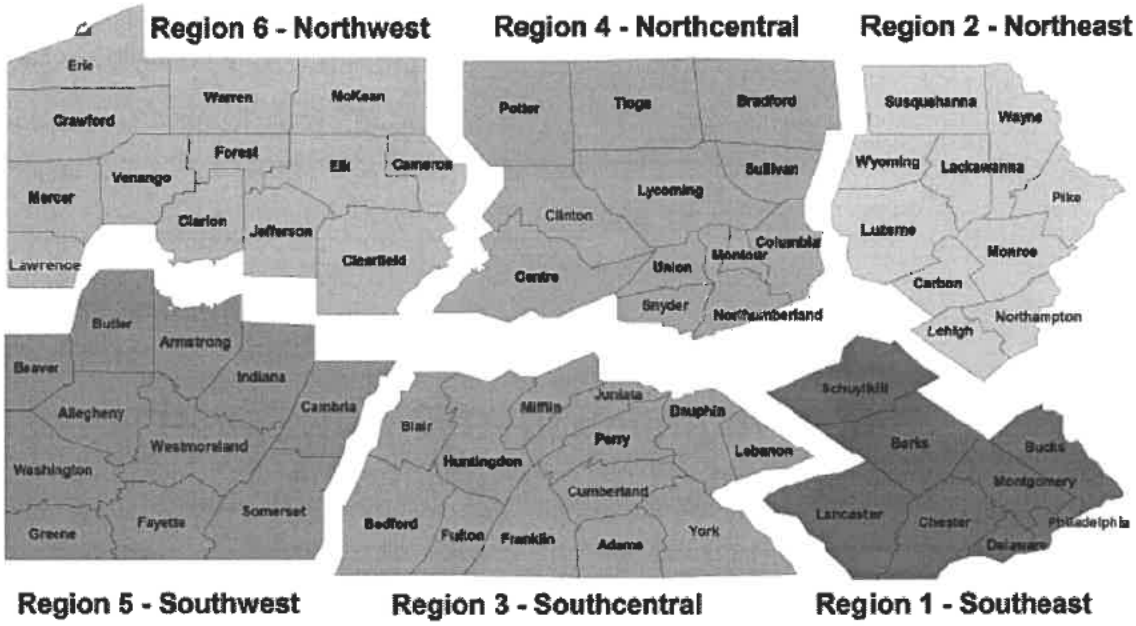
You may apply for one dispensary permit in this application for any of the medical marijuana regions listed below. A separate application must be submitted for each primary dispensary location sought by the applicant. Please see the Medical Marijuana Organization Permit Application Instructions for a table of the counties within each medical marijuana region and the counties in which you are eligible to locate your primary dispensary.

Please check to indicate the medical marijuana region, and specify the county, for which you are applying for a dispensary permit:

☐ Northwest	☐ Northcentral	☐ Northeast
☒ Southwest	☒ Southcentral	☐ Southeast

County 1 (Primary Dispensary Location): Washington
County 2 (if applicable): Allegheny
County 3 (if applicable): Westmoreland

Pennsylvania Department of Health
Medical Marijuana Regions



Medical Marijuana Dispensary Permit Application

Part A - Applicant Identification and Dispensary Information

(Scoring Method: Pass/Fail)

FOR THIS PART, THE APPLICANT IS REQUIRED TO PROVIDE BACKGROUND AND CONTACT INFORMATION FOR THE BUSINESS OR INDIVIDUAL APPLYING FOR A DISPENSARY PERMIT, THE PRIMARY DISPENSARY LOCATION, ALONG WITH ANY SECOND OR THIRD DISPENSARY LOCATIONS THAT ARE BEING SOUGHT UNDER THE APPLICATION.

Section 1 – Applicant Name, Address and Contact Information

Business or Individual Name and Principal Address

Business Name, as it appears on the applicant's certificate of incorporation, charter, bylaws, partnership agreement or other legal business formation documents: Universal Care of PA, Inc.		
Other trade names and DBA (doing business as) names:		
Business Address: 2913 Beacon Way		
City: Pittsburgh	**State:** PA	**Zip Code:** 15241

DOH REDACTED

☒**Primary Contact**, or ☐**Registered Agent for this Application**

Name: William J. Hughes		
Address: 2913 Beacon Way		
City: Pittsburgh	**State:** PA	**Zip Code:** 15241

DOH REDACTED

Section 2 – Dispensary Information

THE APPLICANT IS REQUIRED TO PROVIDE A PRIMARY DISPENSARY LOCATION. THE APPLICANT MAY INCLUDE A SECOND OR THIRD LOCATION UNDER THIS APPLICATION. A SECOND OR THIRD DISPENSARY MAY BE ADDED TO A DISPENSARY PERMIT AT A LATER DATE THROUGH THE FILING OF AN APPLICATION FOR ADDITIONAL DISPENSARY LOCATIONS.

By checking "Yes," you affirm that you possess the ability to obtain in an expeditious manner the right to use sufficient land, buildings and other premises and equipment to properly carry on the activity described in the medical marijuana dispensary permit application, and any proposed location for a dispensary.	☒ Yes	☐ No

Primary Dispensary Location (please indicate dispensary name as you would like it to appear on the dispensary permit)

Facility Name: Sunny Bridge Natural Foods		
Address: 130 Gallery Dr.		
City: McMurray	**State: PA**	**Zip Code:** 15317
County: Washington		**Municipality:** McMurray

PLEASE PROVIDE A DESCRIPTION OF THE PUBLIC ACCESS TO THE DISPENSARY LOCATION, INCLUDING ANY LOCAL PUBLIC TRANSPORTATION THAT MAY BE AVAILABLE:

This location is across from Charleroi Cemetary at 90 Chamber plaza in Charleroi Pa. It is serviced by Freedom Transportation (a division of Washington Rides) which offers complementary Paratransit service to eligible individuals and personal caregivers. Reservations can be made up to 14-days in advance.

Second Dispensary Location

Facility Name: Milton Klein DO		
Address: 1352 5th Ave.		
City: Coraopolis	**State: PA**	**Zip Code:** 115108
County: Allegheny		**Municipality:** Coraopolis

PLEASE PROVIDE A DESCRIPTION OF THE PUBLIC ACCESS TO THE DISPENSARY LOCATION, INCLUDING ANY LOCAL PUBLIC TRANSPORTATION THAT MAY BE AVAILABLE:

This location is located at 1352 5th ave. in Coraopolis Pa. across from State Representive offices with adjacent Port Authority stop. Port authority of Allegheny County offers paratransit service to individuals unable to utilize fixed routes. Access transportation Systems Inc. are operators of paratrainsit door to door service.

Third Dispensary Location

Facility Name: Pain Med P.C.		
Address: 438 Pellis rd.		
City: Greensburg	**State: PA**	**Zip Code:** 15601
County: Westmoreland		**Municipality:** Greensburg

PLEASE PROVIDE A DESCRIPTION OF THE PUBLIC ACCESS TO THE DISPENSARY LOCATION, INCLUDING ANY LOCAL PUBLIC TRANSPORTATION THAT MAY BE AVAILABLE:

This location is at 438 Pellis rd. in Greensburg and is situated in commercial Plaza which is serviced by Go Westmoreland Transportation services. Paratransit program ia available.

Part B – Diversity Plan

(Scoring Method: 100 Points)

IN ACCORDANCE WITH SECTION 615 OF THE ACT (35 P.S. § 10231.615), AN APPLICANT SHALL INCLUDE WITH ITS APPLICATION A DIVERSITY PLAN THAT PROMOTES AND ENSURES THE INVOLVEMENT OF DIVERSE PARTICIPANTS AND DIVERSE GROUPS IN OWNERSHIP, MANAGEMENT, EMPLOYMENT, AND CONTRACTING OPPORTUNITIES. DIVERSE PARTICIPANTS INCLUDE A PERSON, INCLUDING A NATURAL PERSON; INDIVIDUALS FROM DIVERSE RACIAL, ETHNIC AND CULTURAL BACKGROUNDS AND COMMUNITIES; WOMEN; VETERANS; INDIVIDUALS WITH DISABILITIES; CORPORATION; PARTNERSHIP; ASSOCIATION; TRUST OR OTHER ENTITY; OR ANY COMBINATION THEREOF, WHO ARE SEEKING A PERMIT ISSUED BY THE DEPARTMENT OF HEALTH TO GROW AND PROCESS OR DISPENSE MEDICAL MARIJUANA. DIVERSE GROUPS INCLUDE THE FOLLOWING BUSINESSES THAT HAVE BEEN CERTIFIED BY A THIRD-PARTY CERTIFYING ORGANIZATION: A DISADVANTAGED BUSINESS, MINORITY-OWNED BUSINESS, AND WOMEN-OWNED BUSINESS AS THOSE TERMS ARE DEFINED IN 74 PA. C.S. § 303(B); AND A SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS OR VETERAN-OWNED SMALL BUSINESS AS THOSE TERMS ARE DEFINED IN 51 PA. C.S. § 9601.

Section 3 – Diversity Plan

By checking "Yes," the applicant affirms that it has a diversity plan that establishes a goal of opportunity and access in employment and contracting by the medical marijuana organization. The applicant also affirms that it will make a good faith effort to meet the diversity goals outlined in the diversity plan. Changes to the diversity plan must be approved by the Department of Health in writing. The applicant further agrees to report participation level and involvement of Diverse Participants and Diverse Groups in the form and frequency required by the Department, and to provide any other information the Department deems appropriate regarding ownership, management, employment, and contracting opportunities by Diverse Participants and Diverse Groups.	☒ Yes	☐ No

DIVERSITY PLAN

IN NARRATIVE FORM BELOW, DESCRIBE A PLAN THAT ESTABLISHES A GOAL OF DIVERSITY IN OWNERSHIP, MANAGEMENT, EMPLOYMENT AND CONTRACTING TO ENSURE THAT DIVERSE PARTICIPANTS AND DIVERSE GROUPS ARE ACCORDED EQUALITY OF OPPORTUNITY. TO THE EXTENT AVAILABLE, INCLUDE THE FOLLOWING:

1. The diversity status of the Principals, Operators, Financial Backers, and Employees of the Medical Marijuana Organization.
2. An official affirmative action plan for the Medical Marijuana Organization.
3. Internal diversity goals adopted by the Medical Marijuana Organization.
4. A plan for diversity-oriented outreach or events the Medical Marijuana Organization will conduct during the term of the permit.
5. Contracts with diverse groups and the expected percentage and dollar amount of revenues that will be paid to the diverse groups.

6. Any materials from the Medical Marijuana Organization's mentoring, training, or professional development programs for diverse groups.
7. Any other information that demonstrates the Medical Marijuana Organization's commitment to diversity practices.
8. A workforce utilization report including the following information for each job category within the Medical Marijuana Organization:
    a. The total number of persons employed in each job category,
    b. The total number of men employed in each job category,
    c. The total number of women employed in each job category,
    d. The total number of veterans in each job category,
    e. The total number of service-disabled veterans in each job category, and
    f. The total number of members of each racial minority employed in each job category.
9. A narrative description of your ability to record and report on the components of the diversity plan.

DIVERSITY PLAN MISSION STATEMENT

Universal Care of Pa., Inc is committed to respect and promote inclusion of individuals of varying races, religion, age group, classes, ethnicities, sexual orientation, gender and abilities or whom are veterans.

Universal Care of Pa. currently has three employees the Princepal (William Hughes Male), Employees (Christopher McNamara Male) and (Kelli Hughes McNamara Female). We have been actively been recruiting personal within the above menitioned groups. We have also sent out comunation to groups that have various diversity organizations.

We strive to utilize a diverse talent pool to recruit qualifild candidates for employment. We plan to address the variant needs of customersupon reviewing their demographics.

We plan to seek suppliers who are owned and operated by diverse individuals. Our goal is to strive to have a minimum of 25% compliant in year one.

We will seek opportunities to volunteer or direct donations serving diverse segements of the surrounding commuties.

All employees will be required to attend meetings on diversity to review the plan followed by a Q&A session. Empolyees will be encouraged to particapte in all aspects of the plan (employees, customers, community). Quarterly assessments of progress towards the goals will take place and goals will be revised if nessesary to achive our goals.

We plan to attend The Naitonal Diversity Council for Corporate Responsibility Summit in Cincinnati Oh., August 7-11 2017

Part C – Applicant Background Information

(Scoring Method: Pass/Fail)

FOR THIS PART THE APPLICANT IS REQUIRED TO PROVIDE BACKGROUND AND CONTACT INFORMATION FOR THE PRINCIPALS, FINANCIAL BACKERS, OPERATORS AND EMPLOYEES.

Section 4 – Principals, Financial Backers, Operators and Employees

A. Please list all Principals, Financial Backers and Operators

Name and Residential Address			
First Name: William	**Middle Name:** James	**Last Name:** Hughes	**Suffix:**
Occupation: Medical Consultant		**Title in the applicant's business:**	

DOH REDACTED

Name and Residential Address			
First Name: Christopher	**Middle Name:** Paul	**Last Name:** McNamara	**Suffix:**
Occupation: Finance Manager		**Title in the applicant's business:**	

DOH REDACTED

Name and Residential Address			
First Name: Kelli	**Middle Name:** Linn	**Last Name:** Hughes-McNamara	**Suffix:**
Occupation: Registered Nurse		**Title in the applicant's business:**	

DOH REDACTED

Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	

Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	

Name and Residential Address					
First Name:	Middle Name:		Last Name:		Suffix:
Occupation:			Title in the applicant's business:		
Also known as:			Date of birth: MM/DD/YYYY		
Address Line 1:			Address Line 2:		
Address Line 3:		City:		State:	Zip Code:
Phone:	Fax:		Email:		
Name and Residential Address					
First Name:	Middle Name:		Last Name:		Suffix:
Occupation:			Title in the applicant's business:		
Also known as:			Date of birth: MM/DD/YYYY		
Address Line 1:			Address Line 2:		
Address Line 3:		City:		State:	Zip Code:
Phone:	Fax:		Email:		

IF MORE SPACE IS REQUIRED, PLEASE SUBMIT ADDITIONAL INFORMATION ON OTHER INDIVIDUALS IN A SEPARATE DOCUMENT TITLED "PRINCIPALS, FINANCIAL BACKERS AND OPERATORS (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

B. Please list Employees

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR ANY EMPLOYEES THAT HAVE BEEN HIRED TO DATE TO WORK FOR THE APPLICANT LISTED IN THIS APPLICATION. IF NO EMPLOYEES ARE CURRENTLY EMPLOYED, PLEASE LEAVE THIS SECTION BLANK.

Name and Residential Address					
First Name:	Middle Name:		Last Name:		Suffix:
Occupation:			Title in the applicant's business:		
Also known as:			Date of birth: MM/DD/YYYY		
Address Line 1:			Address Line 2:		
Address Line 3:		City:		State:	Zip Code:
Phone:	Fax:		Email:		
Name and Residential Address					
First Name:	Middle Name:		Last Name:		Suffix:
Occupation:			Title in the applicant's business:		
Also known as:			Date of birth: MM/DD/YYYY		
Address Line 1:			Address Line 2:		
Address Line 3:		City:		State:	Zip Code:
Phone:	Fax:		Email:		
Name and Residential Address					
First Name:	Middle Name:		Last Name:		Suffix:
Occupation:			Title in the applicant's business:		
Also known as:			Date of birth: MM/DD/YYYY		
Address Line 1:			Address Line 2:		
Address Line 3:		City:		State:	Zip Code:
Phone:	Fax:		Email:		
Name and Residential Address					

First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	

IF MORE SPACE IS REQUIRED, PLEASE SUBMIT ADDITIONAL INFORMATION ON OTHER INDIVIDUALS IN A SEPARATE DOCUMENT TITLED "EMPLOYEES (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

Section 5 – Moral Affirmation

By checking "Yes," you affirm that each principal, financial backer, operator and employee listed in this permit application is of good moral character.	☒ Yes	☐ No

Section 6 – Compliance with Applicable Laws and Regulations

By checking "Yes," you affirm that you, as well as the principals, financial backers, operators and employees listed in this permit application are able to continuously comply with all applicable Commonwealth laws and regulations relating to the operation of a medical marijuana dispensary.	☒ Yes	☐ No

Section 7 – Civil and Administrative Action

For the statements below:

- By checking "Yes," you affirm the statement
- If you check "No," you must state your reasoning in "Schedule A" below

Civil and Administrative Action	Yes	No
The applicant has never responded to an action resulting in sanctions, disciplinary actions or civil monetary penalties being imposed relating to a registration, license, permit or any other authorization to grow, process or dispense medical marijuana in any state.	☒	☐

The applicant has never responded to a civil or administrative action relating to a registration, license, permit or authorization to grow, process or dispense medical marijuana in any state.	☒	☐
The applicant has never been accused of obtaining a registration, license, permit or other authorization to operate as a grower, processor or dispensary of medical marijuana in any jurisdiction by fraud, misrepresentation, or the submission of false information.	☒	☐
No civil or administrative action has been taken against the applicant under the laws of the Commonwealth or any other state, the United States or a military, territorial or tribal authority relating to a principal, operator, financial backer or employee of the applicant's profession, or occupation or fraudulent practices, including fraudulent billing practices.	☒	☐

Schedule A: Civil or Administrative History Incident					
Defendant	**Name of Case & Docket #**	**Nature of Charge or Complaint**	**Date of Charge or Complaint**	**Disposition**	**Name and Address of the Administrative Agency Involved, and the Tribunal or Court**

Part D – Plan of Operation

(Scoring Method: 550 Points)

A PLAN OF OPERATION IS REQUIRED FOR ALL DISPENSARY PERMIT APPLICATIONS. THE PLAN OF OPERATION MUST INCLUDE A TIMETABLE OUTLINING THE STEPS THE APPLICANT WILL TAKE TO BECOME OPERATIONAL WITHIN SIX MONTHS FROM THE DATE OF ISSUANCE OF A PERMIT. THE PLAN OF OPERATION MUST ALSO DESCRIBE HOW THE APPLICANT'S PROPOSED BUSINESS OPERATIONS WILL COMPLY WITH STATUTORY AND REGULATORY REQUIREMENTS NECESSARY FOR THE CONTINUED OPERATION OF THE FACILITY.

Plan of Operation

What must be covered in a Plan of Operation?

Applicants must identify how they will comply with relevant laws and regulations regarding:

- Security and Surveillance
- Employee qualifications and training
- Transportation of medical marijuana and medical marijuana products
- Storage of medical marijuana products

- Inventory management
- Recordkeeping
- Prevention of unlawful diversion of medical marijuana and medical marijuana products
- A timetable outlining the steps required for the applicant to become operational within six months from the date of issuance of a dispensary permit

By checking "Yes," you affirm that you are able to continuously maintain effective security, surveillance and accounting control measures to prevent diversion, abuse and other illegal conduct regarding medical marijuana and medical marijuana products.	☒ Yes	☐ No

Section 8 – Operational Timetable

IF ISSUED A PERMIT, PLEASE DESCRIBE THE STEPS AND TIMEFRAMES FOR BECOMING FULLY OPERATIONAL AS A DISPENSARY WITHIN SIX MONTHS FROM THE DATE OF ISSUANCE OF A DISPENSARY PERMIT. SPECIFICALLY, PLEASE PROVIDE THE STEPS YOU WILL TAKE TO BEGIN THE PROCESS FOR THE HANDLING, STORING, AND TRANSPORTING OF MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS.

Activity	Estimated Date
Contact INA Consultaints for Security and Surveillanceand transport. Recruit employees from diverse talent pool. Develop templates for record keeping and secure leases on locations. Obtain reputable supplier.	1st month after being awarded the permit
Implement security ans surveillance plan (purchase and install equipment. Complete hiring process of most qualified candidates. Purchase equipment needed to maintain quality and quantity of products. Design training and education program for all employees	Months 2-4
Audit security/surveillance equipment and plan for efficary. Train person el on regulations, laws and policies. Install/Begin calibration of equipment to ensure qualify and quantity of products.	Monthe 5-6

IF MORE SPACE IS REQUIRED FOR THE OPERATIONAL TIMETABLE, PLEASE SUBMIT ADDITIONAL INFORMATION IN A SEPARATE DOCUMENT TITLED "OPERATIONAL TIMETABLE (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

Section 9 – Employee Qualifications, Description of Duties and Training

A. PLEASE PROVIDE A DESCRIPTION OF THE DUTIES, RESPONSIBILITIES, AND ROLES OF EACH PRINCIPAL, FINANCIAL BACKER, OPERATOR AND EMPLOYEE.
1. Principal- Will montor company functionality daily.
2. COO/General Manager- Responsible for day to day operation of dispensary locations, security, PA/Doctors, security record keeping, storage, transportation.quality assurance of products, employmees and dispensary practices.
3. Manger of Training and Process- Responsible for On going training for all empolyees. As well as record keeping and monitoring state regulations
4. Dispensary Technicians – Responsible for despencing Medical Marijuana to quilifed script holders the measurement and, protocal have been followed.
5. Security- Responsible for safey empolyees and customers at each Dispensary
6. Account- Responsible for accounts payable and receivale daily. Aslo for all taxes are payed to the State and Federal goverments.
7. Attorney- responsible for all legal matters that could come up at all locations
8. Pharmacist/Physician- Oversee the dispencing af all Products

B. PLEASE DESCRIBE THE EMPLOYEE QUALIFICATIONS OF EACH PRINCIPAL AND EMPLOYEE.
1. Principal- 25 years as sole owner/proprietor of Unversal care of Pa. which has been in the fore front of therapeutic drug monitoring and pre-employee screenings.
2. COO- Individual who demonstrates administrative capabilities to over see daily operations with integrity and adherence to laws and regulations
3. Manager of Training and Process- Individual to be lisenced by the state of Pa. as a care provider who demonstrates Mentorship, Training and Policy implementation abilites
4. Dispensary Thech- Indiduals to be lisenced by the state of PA, as a Pharmarcy/Medical Tech. who demonstrates compliance with regulations and laws.
5. Security- Individuals to be screened appropriately by sub contracted agency who demonstrate adherence to the policies including recrument and retention of employees

6. Pharmacist/Physician- Individuals who are lisenced by the state of Pa. and who has demonstrated , knowledge and compliance with industry's best practice standards.
7. Attorney/Account- Individuals who are both linsenced by the state of Pa. in good standing

C. PLEASE DESCRIBE THE STEPS THE APPLICANT WILL TAKE TO ASSURE THAT EACH PRINCIPAL AND EMPLOYEE WILL MEET THE TWO-HOUR TRAINING REQUIREMENT UNDER THE ACT AND REGULATIONS.
1. Enroll in the two (2) hour class.
2. Continue with Quarterly Reviews and Training.
3. Verify registration in 2 Hr. training.
4. Advise all personel Mandatory.
5. Provide personel with documention Authorization.
6. Gather endorsed attendance sheets.
7. Adhere to 100% compliance.
8. Retain documents for records and referencing.

IF MORE SPACE IS REQUIRED FOR ANY OF THE ABOVE THREE COMPONENTS OF SECTION 9 (A, B AND C), PLEASE SUBMIT ADDITIONAL INFORMATION IN A SEPARATE DOCUMENT TITLED "EMPLOYEE QUALIFICATIONS, DESCRIPTION OF DUTIES AND TRAINING (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

D. Licensed Medical Professionals at Facility	Yes	No
A physician or a pharmacist will be present at the primary dispensary location listed in this permit application at all times during the hours the primary dispensary facility is open to dispense or to offer to dispense medical marijuana to patients and caregivers.	☒	☐
If the applicant is operating any dispensaries in addition to the primary dispensary location listed under the permit, and a physician or pharmacist is not present onsite at the additional dispensary or dispensaries, a physician assistant or a certified registered nurse practitioner will be present onsite at each of the other dispensaries instead of a physician or pharmacist.	☒	☐

Any physician, pharmacist, physician assistant or certified registered nurse practitioner employed by a dispensary will, prior to assuming any duties at the dispensary facility, successfully complete a four-hour training course developed by the Department.	☒	☐

PLEASE PROVIDE AN EXPLANATION OF ANY RESPONSES ABOVE THAT WERE ANSWERED AS A "NO" AND HOW YOU WILL MEET THESE REQUIREMENTS BY THE TIME THE DEPARTMENT DETERMINES YOU TO BE OPERATIONAL UNDER THE ACT AND REGULATIONS:

Please limit your response to no more than 5,000 words.

Section 10 – Security and Surveillance

A DISPENSARY MUST HAVE SECURITY AND SURVEILLANCE SYSTEMS, UTILIZING COMMERCIAL-GRADE EQUIPMENT, TO PREVENT UNAUTHORIZED ENTRY AND TO PREVENT AND DETECT DIVERSION, THEFT, OR LOSS OF ANY MEDICAL MARIJUANA OR MEDICAL MARIJUANA PRODUCTS.

PLEASE PROVIDE A SUMMARY OF YOUR PROPOSED SECURITY AND SURVEILLANCE EQUIPMENT AND MEASURES THAT WILL BE IN PLACE AT YOUR PROPOSED FACILITY AND SITE. THESE MEASURES SHOULD COVER, BUT ARE NOT LIMITED TO, THE FOLLOWING: GENERAL OVERVIEW OF THE EQUIPMENT, MEASURES AND PROCEDURES TO BE USED, ALARM SYSTEMS, SURVEILLANCE SYSTEM, STORAGE, RECORDING CAPABILITY, RECORDS RETENTION, PREMISES ACCESSIBILITY, AND INSPECTION/SERVICING/ALTERATION PROTOCOLS.

See Atachment

Section 11 – Transportation of Medical Marijuana

A. Transportation	**Yes**	**No**
By checking "Yes," you affirm that any delivery of medical marijuana to any other medical marijuana organization or approved laboratory within the Commonwealth will adhere to the following: If you check "No" to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.		
• Medical marijuana will only be delivered between 7 a.m. and 9 p.m.	☒	☐
• Medical marijuana will not be transported to any location outside of this Commonwealth.	☒	☐

• A global positioning system will be used to ensure safe, efficient delivery of the medical marijuana to a medical marijuana organization.	☒	☐
In addition to having a transport vehicle staffed with a delivery team consisting of at least two individuals, the applicant affirms the following:		
• At least one delivery team member will remain with the vehicle at all times that the vehicle contains medical marijuana.	☒	☐
• Each delivery team member shall have access to a secure form of communication with the dispensary, such as a cellular telephone, at all times that the vehicle contains medical marijuana.	☒	☐
• Upon demand, each delivery team member shall produce an identification badge or card to the Department or its authorized agents, law enforcement or other Federal, State, or local government officials if necessary to perform the government officials' functions and duties.	☒	☐
• Each delivery team member will have a valid driver's license.	☒	☐
• While on duty, a delivery team member will not wear any clothing or symbols that may indicate ownership or possession of medical marijuana.	☒	☐
• Medical marijuana stored inside the transport vehicle may not be visible from the outside of the transport vehicle.	☒	☐
• A delivery team shall proceed in a transport vehicle from the dispensary, where the medical marijuana is loaded, directly to the medical marijuana organization, where the medical marijuana is unloaded, without unnecessary delays. Notwithstanding the foregoing, a transport vehicle may make stops at multiple facilities, as appropriate, to deliver medical marijuana.	☒	☐
• Any vehicle accidents, diversions, losses, or other reportable events that occur during transport of medical marijuana must be immediately reported to the Department either through a designated phone line established by the Department or by electronic communication with the Department in a manner prescribed by the Department.	☒	☐
• The Department shall be notified daily of the dispensary's delivery schedule, including routes and delivery times, either through a designated phone line established by the Department or by electronic communication with the Department in a manner prescribed by the Department.	☒	☐

• A transport vehicle is subject to inspection by the Department or its authorized agents, law enforcement or other Federal, State or local government officials if necessary to perform the government officials' functions and duties.	☒	☐
• A transport vehicle may be stopped and inspected along its delivery route or at any medical marijuana organization.	☒	☐
• If a third-party contractor is used, the contractor must comply with all the transportation requirements listed in the Act and regulations.	☒	☐
B. Transport Manifest	**Yes**	**No**
By checking "Yes" to any statement, you affirm that the transport manifest (printed or electronic) that accompanies every transport vehicle will contain the following information and meet the following requirements: If you check "No" to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.		
• The name, address and permit number of the medical marijuana organization receiving the delivery, and the name of and contact information for a representative of the medical marijuana organization.	☒	☐
• The quantity, by weight or unit, of each medical marijuana harvest batch, harvest lot or process lot contained in the transport, along with the identification number for each harvest batch, harvest lot or process lot.	☒	☐
• The date and approximate time of departure.	☒	☐
• The date and approximate time of arrival.	☒	☐
• The transport vehicle's make, model, and license plate number.	☒	☐
• The identification number of each member of the delivery team accompanying the transport.	☒	☐
• When a delivery team delivers medical marijuana to multiple medical marijuana organizations, the transport manifest must correctly reflect the specific medical marijuana in transit; each recipient will also provide the dispensary with a printed receipt for the medical marijuana received.	☒	☐
• All medical marijuana being transported must be packaged in shipping containers and labeled in accordance with §§ 1151.34 and 1161.28 (relating to packaging and labeling of medical marijuana; and labels and safety inserts).	☒	☐

• Separate copies of the transport manifest will be provided to each recipient receiving the medical marijuana product described in the transport manifest. To maintain confidentiality, a dispensary may prepare separate manifests for each recipient.	☒	☐
• The applicant acknowledges that, upon request, a copy of the printed transport manifest, and any printed receipts for medical marijuana being transported, will be provided to the Department or its authorized agents, law enforcement, or other Federal, State, or local government officials if necessary to perform the government officials' functions and duties.	☒	☐

PLEASE PROVIDE AN EXPLANATION OF ANY RESPONSES ABOVE THAT WERE ANSWERED AS A "NO" AND HOW YOU WILL MEET THESE REQUIREMENTS BY THE TIME THE DEPARTMENT DETERMINES YOU TO BE OPERATIONAL UNDER THE ACT AND REGULATIONS:

Please limit your response to no more than 5,000 words.

C. PLEASE DESCRIBE YOUR PLAN REGARDING THE TRANSPORTATION OF MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS. FOR EXAMPLE, EXPLAIN WHETHER YOU PLAN TO MAINTAIN YOUR OWN TRANSPORTATION OPERATION AS PART OF THE FACILITY OPERATION, OR WHETHER YOU WILL USE A THIRD-PARTY CONTRACTOR. IF YOU CHOOSE TO USE YOUR OWN TRANSPORTATION OPERATION, PLEASE PROVIDE THE NUMBER AND TYPE OF VEHICLES THAT WILL BE USED TO TRANSPORT MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS, THE TRAINING THAT WILL BE PROVIDED TO EMPLOYEES THAT WILL TRANSPORT MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS, AND ANY ADDITIONAL MEASURES YOU WILL TAKE TO PREVENT DIVERSION DURING TRANSPORT. IF YOU WILL BE USING A THIRD-PARTY CONTRACTOR FOR TRANSPORTING MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS, PLEASE EXPLAIN THE STEPS YOU WILL TAKE TO GUARANTEE THE THIRD-PARTY CONTRACTOR WILL BE COMPLIANT WITH THE TRANSPORTATION REQUIREMENTS UNDER THE ACT AND REGULATIONS:

See atachment

Section 12 – Storage of Medical Marijuana

A. Storage Requirements	**Yes**	**No**
By checking "Yes" to any statement, you affirm that the plan of operation will address the below statements:		

If you check "No" to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.		
• There will be separate, locked, limited access areas for the storage of medical marijuana that is expired, damaged, deteriorated, mislabeled, contaminated, recalled, or whose containers or packaging have been opened or breached, until the medical marijuana is returned to a grower/processor, destroyed or otherwise disposed of, as required by § 1151.40 (relating to the management and disposal of medical marijuana waste).	☒	☐
• All storage areas will be maintained in a clean and orderly condition and free from infestation by insects, rodents, birds, and pests.	☒	☐
• A separate and secure area for temporary storage of medical marijuana that is awaiting disposal will be established.	☒	☐

PLEASE PROVIDE AN EXPLANATION OF ANY RESPONSES ABOVE THAT WERE ANSWERED AS A "NO" AND HOW YOU WILL MEET THESE REQUIREMENTS BY THE TIME THE DEPARTMENT DETERMINES YOU TO BE OPERATIONAL UNDER THE ACT AND REGULATIONS:

Please limit your response to no more than 5,000 words.

B. PLEASE DESCRIBE YOUR PLANS REGARDING THE STORAGE OF MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS WITHIN YOUR FACILITY:

See Atachment

Section 13 – Labeling of Medical Marijuana Products

A. Labeling Requirements	**Yes**	**No**
By checking "Yes" to any statement, you affirm that the applicant will implement a quality control process to ensure that the label does not bear any of the following: If you check "No" to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.		
• Any resemblance to the trademarked, characteristic or product-specialized packaging of any commercially available food or beverage product.	☒	☐

• Any statement, artwork or design that could reasonably lead an individual to believe that the package contains anything other than medical marijuana.	☒	☐
• Any seal, flag, crest, coat of arms, or other insignia that could reasonably mislead an individual to believe that the product has been endorsed, manufactured, or approved for use by any State, county or municipality or any agency thereof.	☒	☐
• Any cartoon, color scheme, image, graphic or feature that might make the package attractive to children.	☒	☐

PLEASE PROVIDE AN EXPLANATION OF ANY RESPONSES ABOVE THAT WERE ANSWERED AS A "NO" AND HOW YOU WILL MEET THESE REQUIREMENTS BY THE TIME THE DEPARTMENT DETERMINES YOU TO BE OPERATIONAL UNDER THE ACT AND REGULATIONS:

Please limit your response to no more than 5,000 words.

B. PLEASE DESCRIBE YOUR PROCESS FOR CREATING AND MONITORING THE LABELING USED FOR MEDICAL MARIJUANA PRODUCTS:

See Atachment

Section 14 – Inventory Management

A. Electronic Tracking System	**Yes**	**No**
You acknowledge that you must use the electronic tracking system prescribed by the Department containing the requirements in section 701 of the Act (35 P.S. § 10231.701).	☒	☐
You acknowledge that an electronic tracking system that is approved by the Department will be deployed to log, verify and monitor the receipt of medical marijuana product from a grower/processor, the verification of the validity of an identification card presented by a patient or caregiver, the dispensing of medical marijuana product to a patient or caregiver, the disposal of medical marijuana waste and the recall of defective medical marijuana.	☒	☐

B. Inventory Management	**Yes**	**No**

By checking "Yes" to any statement, you affirm that each dispensary will maintain the following inventory data in its electronic tracking system: If you check "No" to any statement, you must state the reasoning for doing so at the end of this section. If issued a permit, you must be able to affirm each statement by the time the Department determines you to be operational under the Act and regulations.		
• Medical marijuana received from a grower/processor.	☒	☐
• Medical marijuana dispensed to a patient or caregiver.	☒	☐
• Damaged, defective, expired, or contaminated medical marijuana awaiting return to a grower/processor or awaiting disposal.	☒	☐
• Inventory controls and procedures will be established for the conducting of monthly inventory reviews and annual comprehensive inventories of medical marijuana at the facility.	☒	☐
• The written or electronic record will include the date of the inventory, a summary of the inventory findings, and the employee identification numbers and titles or positions of the individuals who conducted the inventory.	☒	☐

PLEASE PROVIDE AN EXPLANATION OF ANY RESPONSES ABOVE THAT WERE ANSWERED AS A "NO" AND HOW YOU WILL MEET THESE REQUIREMENTS BY THE TIME THE DEPARTMENT DETERMINES YOU TO BE OPERATIONAL UNDER THE ACT AND REGULATIONS:

Please limit your response to no more than 5,000 words.

C. PLEASE DESCRIBE YOUR APPROACH REGARDING THE IMPLEMENTATION OF AN INVENTORY MANAGEMENT PROCESS. THIS APPROACH MUST ALSO INCLUDE A PROCESS THAT PROVIDES FOR THE RECALL OF MEDICAL MARIJUANA PRODUCTS AND THE MANAGEMENT OF MEDICAL MARIJUANA PRODUCT RETURNS FROM YOU TO THE ORIGINATING GROWER/PROCESSOR:

Section 15 – Diversion Prevention

A. PLEASE PROVIDE A SUMMARY OF THE PROCEDURES THAT YOU WILL IMPLEMENT AT EACH PROPOSED FACILITY FOR THE PREVENTION OF THE UNLAWFUL DIVERSION OF MEDICAL MARIJUANA AND MEDICAL MARIJUANA PRODUCTS, ALONG WITH THE PROCESS THAT WILL BE FOLLOWED WHEN EVIDENCE OF THEFT/DIVERSION IS IDENTIFIED:

SEE ATTACHMENT

Section 16 – Sanitation and Safety

A. PLEASE PROVIDE A SUMMARY OF THE INTENDED SANITATION AND SAFETY MEASURES TO BE IMPLEMENTED AT EACH PROPOSED FACILITY LISTED IN THE PERMIT APPLICATION. THESE MEASURES SHOULD COVER, BUT ARE NOT BE LIMITED TO, THE FOLLOWING: A WRITTEN PROCESS FOR CONTAMINATION PREVENTION, PEST PROTECTION PROCEDURES, MEDICAL MARIJUANA PRODUCT HANDLER RESTRICTIONS, AND HAND-WASHING FACILITIES.

SEE ATTACHMENT

Section 17 – Recordkeeping

A. PLEASE PROVIDE A SUMMARY OF YOUR RECORDKEEPING PLAN AT EACH PROPOSED FACILITY LISTED IN THE PERMIT APPLICATION. THIS PLAN SHOULD COVER, BUT IS NOT LIMITED TO, RECORDS OF INVENTORY AND ALL DISPENSING TRANSACTIONS:

See Attachment

Part E – Applicant Organization, Ownership, Capital and Tax Status

(Scoring Method: 150 Points)

SECTION 18 – ORGANIZATIONAL STRUCTURE

Applicant's Form of Organization		
Check One		
☐ **C-Corporation**	☒ **S-Corporation**	☐ **Limited Liability Company**
☐ **Sole Proprietorship**	☐ **Partnership**	☐ **Limited Liability Partnership**
☐ **Limited Liability Limited Partnership**	☐ **Non-Profit Organization**	☐ **Other (explain):**

Applicant's Organization Documents	
State of Incorporation or Registration: PA	**Date of Formation:** 12/7/1992
Business Name on Formation Documents: Universal Care of PA, Inc.	

Applicant's Identification Numbers	
Federal Employer ID number: DOH REDACTED	**PA Unemployment Compensation Account Number:** N/A No Employees
PA Department of Revenue Tax number (if applicant is currently doing business in Pennsylvania): DOH REDACTED	**PA Workers' Compensation Policy Number (if applicant is currently doing business in Pennsylvania):** N/A No Employees

The applicant affirms that workers' compensation insurance will be obtained by the time the Department determines you to be operational under the Act and regulations.	☒ Yes	☐ No

Section 19 – Business History and Capacity to Operate

Describe your business history and your ability and plan to maintain a successful and financially sustainable operation:

Universal Care of Pa. was formed in 1992 By myself William Hughes and I'm the sole owner and employee. After graduating from the University of Missouri in 1968 I reloacted to Pittsburgh where I pursured a career in pharmaceutical sales. I worked in this fiels for approx. 12 years, in 1981 I moved in to the sales of equiptment for blood analizing and Had a very successful career.

As this point I developed Universal Care of Pa. a consulting company specializing in blood testing, drug testing and therapeutic drug testing for pre-employment testing. I aslo preformed employment screening and background checks. I have sent my entire career in the medical field with great success.

Section 20 – Current Officers

Provide the position, title in the applicant's business, and address information for all current officers, directors, partners or trustees.

Name and Residential Address			
First Name: William	**Middle Name:** James	**Last Name:** Hughes	**Suffix:**
Occupation: Medical Consultant		**Title in the applicant's business:** CEO	

DOH REDACTED

Name and Residential Address

First Name: Christopher	**Middle Name:** Paul	**Last Name:** McNamara	**Suffix:**
Occupation: Finance Manager		**Title in the applicant's business:** COO	
Also known as:		**Date of birth** DOH REDACTED	
DOH REDACTED			
Name and Residential Address			
First Name: Kelli	**Middle Name:** Linn	**Last Name:** Hughes-McNamara	**Suffix:**
Occupation: Registered Nurse		**Title in the applicant's business:** Mgr or Train ang Process	
DOH REDACTED			
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	

IF MORE SPACE IS REQUIRED, PLEASE SUBMIT ADDITIONAL INFORMATION ON OTHER OFFICERS IN A SEPARATE DOCUMENT

TITLED "CURRENT OFFICERS (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

SECTION 21 – OWNERSHIP

IN THIS SECTION, LIST ALL PERSONS WITH A CONTROLLING INTEREST IN THE BUSINESS, DEFINED AS FOLLOWS:

(1) FOR A PUBLICLY TRADED COMPANY, VOTING RIGHTS THAT ENTITLE A PERSON TO ELECT OR APPOINT ONE OR MORE OF THE MEMBERS OF THE BOARD OF DIRECTORS OR OTHER GOVERNING BOARD, OR THE OWNERSHIP OR BENEFICIAL HOLDING OF 5% OR MORE OF THE SECURITIES OF THE PUBLICLY TRADED COMPANY.

(2) FOR A PRIVATELY HELD ENTITY, THE OWNERSHIP OF ANY SECURITY IN THE ENTITY.

COMPLETE THE APPROPRIATE SECTION(S) BELOW:

A. FOR C-CORPORATIONS, S-CORPORATIONS, LLCS AND LLLCS

Name and Residential Address			
First Name: William	**Middle Name:** James	**Last Name:** Hughes	**Suffix:**
Occupation: Medical Consultant		**Title in the applicant's business:** CEO	

DOH REDACTED

Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	

Stock type or class:	Number of shares held:	Date Acquired: MM/DD/YYYY	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:

Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	

Stock type or class:	Number of shares held:	Date Acquired:	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:

		MM/DD/YYYY		
Name and Residential Address				
First Name:	**Middle Name:**		**Last Name:**	**Suffix:**
Occupation:			**Title in the applicant's business:**	
Also known as:			**Date of birth:** MM/DD/YYYY	
Address Line 1:			**Address Line 2:**	
Address Line 3:		**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**		**Email:**	
Stock type or class:	**Number of shares held:**	**Date Acquired:** MM/DD/YYYY	**Percentage of outstanding voting stock:**	**Terms, conditions, rights and privileges:**
Name and Residential Address				
First Name:	**Middle Name:**		**Last Name:**	**Suffix:**
Occupation:			**Title in the applicant's business:**	
Also known as:			**Date of birth:** MM/DD/YYYY	
Address Line 1:			**Address Line 2:**	
Address Line 3:		**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**		**Email:**	
Stock type or class:	**Number of shares held:**	**Date Acquired:** MM/DD/YYYY	**Percentage of outstanding voting stock:**	**Terms, conditions, rights and privileges:**
Name and Residential Address				
First Name:	**Middle Name:**		**Last Name:**	**Suffix:**
Occupation:			**Title in the applicant's business:**	
Also known as:			**Date of birth:** MM/DD/YYYY	
Address Line 1:			**Address Line 2:**	
Address Line 3:		**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**		**Email:**	
Stock type or class:	**Number of shares held:**	**Date Acquired:** MM/DD/YYYY	**Percentage of outstanding voting stock:**	**Terms, conditions, rights and privileges:**
Name and Residential Address				
First Name:	**Middle Name:**		**Last Name:**	**Suffix:**
Occupation:			**Title in the applicant's business:**	
Also known as:			**Date of birth:** MM/DD/YYYY	
Address Line 1:			**Address Line 2:**	
Address Line 3:		**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**		**Email:**	
Stock type or class:	**Number of shares held:**	**Date Acquired:**	**Percentage of outstanding voting stock:**	**Terms, conditions, rights and privileges:**

		MM/DD/YYYY		

Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth: MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	

Stock type or class:	Number of shares held:	Date Acquired:	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:
		MM/DD/YYYY		

Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth: MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	

Stock type or class:	Number of shares held:	Date Acquired:	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:
		MM/DD/YYYY		

Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth: MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	

Stock type or class:	Number of shares held:	Date Acquired:	Percentage of outstanding voting stock:	Terms, conditions, rights and privileges:
		MM/DD/YYYY		

IF MORE SPACE IS REQUIRED, PLEASE SUBMIT ADDITIONAL INFORMATION ON OTHER OWNERS OF THE CORPORATION IN A SEPARATE DOCUMENT TITLED "OWNERS OF THE CORPORATION (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

B. FOR PARTNERSHIPS AND LLPS

Name and Residential Address			
First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth: MM/DD/YYYY	

Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Partner Type: ☐ **General/Full Partner** ☐ **Limited Partner** ☐ **Dormant/Silent Partner** ☐ **Other:**	**Percentage of ownership:**	**Partnership participation from:** MM/DD/YYYY	**Description of participation in operation of the applicant:**
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Partner Type: ☐ **General/Full Partner** ☐ **Limited Partner** ☐ **Dormant/Silent Partner** ☐ **Other:**	**Percentage of ownership:**	**Partnership participation from:** MM/DD/YYYY	**Description of participation in operation of the applicant:**
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Partner Type: ☐ **General/Full Partner** ☐ **Limited Partner** ☐ **Dormant/Silent Partner** ☐ **Other:**	**Percentage of ownership:**	**Partnership participation from:** MM/DD/YYYY	**Description of participation in operation of the applicant:**
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	

Partner Type:	Percentage of ownership:	Partnership participation from:	Description of participation in operation of the applicant:
☐ General/Full Partner ☐ Limited Partner ☐ Dormant/Silent Partner ☐ Other:		MM/DD/YYYY	

Name and Residential Address

First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth: MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	

Partner Type:	Percentage of ownership:	Partnership participation from:	Description of participation in operation of the applicant:
☐ General/Full Partner ☐ Limited Partner ☐ Dormant/Silent Partner ☐ Other:		MM/DD/YYYY	

Name and Residential Address

First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth: MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	

Partner Type:	Percentage of ownership:	Partnership participation from:	Description of participation in operation of the applicant:
☐ General/Full Partner ☐ Limited Partner ☐ Dormant/Silent Partner ☐ Other:		MM/DD/YYYY	

Name and Residential Address

First Name:	Middle Name:	Last Name:	Suffix:
Occupation:		Title in the applicant's business:	
Also known as:		Date of birth: MM/DD/YYYY	
Address Line 1:		Address Line 2:	
Address Line 3:	City:	State:	Zip Code:
Phone:	Fax:	Email:	

Partner Type:	Percentage of ownership:	Partnership participation from:	Description of participation in operation of the applicant:
☐ General/Full Partner ☐ Limited Partner ☐ Dormant/Silent Partner		MM/DD/YYYY	

☐ Other:			
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Partner Type: ☐ General/Full Partner ☐ Limited Partner ☐ Dormant/Silent Partner ☐ Other:	**Percentage of ownership:**	**Partnership participation from:** MM/DD/YYYY	**Description of participation in operation of the applicant:**
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Partner Type: ☐ General/Full Partner ☐ Limited Partner ☐ Dormant/Silent Partner ☐ Other:	**Percentage of ownership:**	**Partnership participation from:** MM/DD/YYYY	**Description of participation in operation of the applicant:**
Name and Residential Address			
First Name:	**Middle Name:**	**Last Name:**	**Suffix:**
Occupation:		**Title in the applicant's business:**	
Also known as:		**Date of birth:** MM/DD/YYYY	
Address Line 1:		**Address Line 2:**	
Address Line 3:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**	**Email:**	
Partner Type: ☐ General/Full Partner ☐ Limited Partner ☐ Dormant/Silent Partner ☐ Other:	**Percentage of ownership:**	**Partnership participation from:** MM/DD/YYYY	**Description of participation in operation of the applicant:**

IF MORE SPACE IS REQUIRED, PLEASE SUBMIT ADDITIONAL INFORMATION ON OTHER PARTNERS IN A SEPARATE DOCUMENT TITLED "INTEREST OF OTHER PARTNERS (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT

REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

C. OTHER PERSONS HOLDING AN INTEREST IN THE PROPOSED SITE OR FACILITY

LIST ANY OTHER PERSONS HOLDING AN INTEREST IN THE PROPOSED SITE OR FACILITY, THAT ARE OTHERWISE NOT DISCLOSED IN SECTIONS A OR B.

Name and Residential Address				
First Name:	Middle Name:	Last Name:		Suffix:
Occupation:		Title in the applicant's business:		
Also known as:		Date of birth: MM/DD/YYYY		
Address Line 1:		Address Line 2:		
Address Line 3:	City:		State:	Zip Code:
Phone:	Fax:	Email:		
Nature, type, terms and conditions of the interest in the applicant:				

Name and Residential Address				
First Name:	Middle Name:	Last Name:		Suffix:
Occupation:		Title in the applicant's business:		
Also known as:		Date of birth: MM/DD/YYYY		
Address Line 1:		Address Line 2:		
Address Line 3:	City:		State:	Zip Code:
Phone:	Fax:	Email:		
Nature, type, terms and conditions of the interest in the applicant:				

Name and Residential Address				
First Name:	Middle Name:	Last Name:		Suffix:
Occupation:		Title in the applicant's business:		
Also known as:		Date of birth: MM/DD/YYYY		
Address Line 1:		Address Line 2:		
Address Line 3:	City:		State:	Zip Code:
Phone:	Fax:	Email:		
Nature, type, terms and conditions of the interest in the applicant:				

Name and Residential Address				
First Name:	Middle Name:	Last Name:		Suffix:
Occupation:		Title in the applicant's business:		
Also known as:		Date of birth: MM/DD/YYYY		
Address Line 1:		Address Line 2:		
Address Line 3:	City:		State:	Zip Code:
Phone:	Fax:	Email:		
Nature, type, terms and conditions of the interest in the applicant:				

IF MORE SPACE IS REQUIRED, PLEASE SUBMIT ADDITIONAL INFORMATION ON OTHER PERSONS HOLDING AN INTEREST IN THE PROPOSED SITE OR FACILITY IN A SEPARATE DOCUMENT TITLED "OTHER PERSONS HOLDING AN INTEREST IN THE PROPOSED SITE OR FACILITY (CONTD.)" IN ACCORDANCE WITH THE ATTACHMENT FILE NAME FORMAT REQUIREMENTS AND INCLUDE IT WITH THE ATTACHMENTS.

SECTION 22 – CAPITAL REQUIREMENTS

PROVIDE A SUMMARY OF YOUR AVAILABLE CAPITAL AND AN ESTIMATED SPENDING PLAN TO BE USED FOR YOU TO BECOME OPERATIONAL WITHIN SIX MONTHS FROM THE DATE OF ISSUANCE OF THE PERMIT:

DOH REDACTED

Part F – Community Impact

(Scoring Method: 100 Points)

SECTION 23 – COMMUNITY IMPACT

PLEASE BE ADVISED, INDICATION OF SUPPORT FROM PUBLIC OFFICIALS WILL NOT BE CONSIDERED WHEN EVALUATING THIS SECTION.

PROVIDE A SUMMARY OF HOW THE APPLICANT INTENDS TO HAVE A POSITIVE IMPACT ON THE COMMUNITY WHERE ITS OPERATIONS ARE PROPOSED TO BE LOCATED:

MISSION STATEMENT:
UNIVERSAL CARE OF PA. INC IS COMMITTED TO SOCIAL MISSIONS AND OUT REACH BY ENCOURAGING OUR EMPLOYEES, CONSUMERS,SUPPLIERS AND VENDORS OPPORTUNITIES TO PARTICIPATE IN A VARIETY OF PROGRAMS AND ESTABLISH A BENEFITIAL CONNECTION BETWEEN OUR ORGANIZATION AND THE PEOPLE OF THE AREAS WE SERVE

OBJECTIVE:

1. TO PROMOTE A CULTURE OF PURPOSE AND TO HAVE A POSITIVE IMPACT ON THE SURROUNDING COMMUNITIES.
2. TO UTILIZE RECENT DATA FROM AVAILABLE SOURCES AND COMMUNITY LEVEL INDICATORS.
3. TO DEVISE METHODS FOR CREATING GOALS, THAT WILL HAVE MOST EFFECTIVE OUT COMS.
4. TO UTILIZE COMMUNITIES STREANGTHS TO PROMOTE MORE DIRECT RESULTS & POWER TO CHANGE
5. TO SEEK OPPORTUNITIES FOR VOLUNTEERISM, PHILANTHROPY AND OUTREACH TO ASSESS LOCAL NEEDS AND RESOURCES

IMPLEMENTATION:

1. GATHER DATA OBTAINED WITHIN THE PAST YEAR FROM REIALABLE SOURCES LIKE COUNTY HEALTH RANKINGS AND ROADMAPS, LOCAL AND STATE GOVERNMENTS, DEPARTMENT HEALTH AND HUMAN SERVICES, CENTER FOR DISEASE CONTROL, AND THE NATIONAL INSTITUTE OF HEALTH.

2. CONTACT LOCAL UNIVERSITIES, HOSPITALS, HUMAN SERVICE PROVIDERS, CHARITIES AND CHAMBER OF COMMERCE REGARDING EXISTING NEEDS AND PROGRAMS.
3. REVIEW COMMUNITY LEVEL INDICATORS SUCH AS THE AVAILABILITY OF FRESH PRODUCE, TEEN BIRTHS COMPARATIVELY, EMERGENCY ROOM AND CLINIC VISITS AND TRAFFIC STOPS/MOTOR VEHICLE ACCIDENTS RELATED TO ALCOHOL
4. DEVOLP A DIVERSE PLANNING GROUP TO REPRESENT ALL SECTORS ENCOURAGING THEM TO BE A PART OF THE PROCESS AND RESULTING IN A MOST ACCURATE ASSESMENT
5. DEVELOP CRITERION FOR EVALUATING ASSESSMENT TO ENSUE MOST EFFECTIVE OUTCOMES.
6. DEVELOP SURVEY TO DETERMINE THE COMMUNITIES OPINION OF EXISTING DATA AND PERCEPTION OF THEIR NEEDS
7. PROVIDE TRAINING TTO ALL INDIVIDUALS WHO WILL BE GATHERING DATA TO UTILIZE THEIR PREFERENCES , SKILLS AND TALENTS.
8. CREATE TIMELINE FOR DATA COLLECTION MEASUREMENTS AND PRESENTATION TO INDIVIDUALS WHO WILL COLLECTING THE DATA RECIVE THEIR FEEDBACK
9. TO INITIATING FACTORING IN RESOURCE OF DOLLARS, TIME, PEOPLE AND SKILL LEVEL CREATE SOCIAL RESPONSIBILITY THROUGH EMPLOYEE ENGAGEMENTS PROGRAMS THAT TRACK VOLUNTEER HOURS AND MATCH MONETARY DONATIONS
10. ENGAGE IN DISATER RELIEF NEEDS AS NEEDS ARISE WITHIN IN MUNICIPALITY, COUNTY, STATE, COUNTRY OR WORLD.

MEASUREMENT:

1. ANALYZE COMMUNITY PERSPECTIVE AND FEELINGS ON MOST RELEVANT ISSUES COMPARED TO EXHISTING DATA
2. ANALYZE DATA COLLECTED TO IDENTIFY THE ISSUSE AND BARRIERS PRESENT WHEN OBTAINING SERVICES.
3. PRESENT RESULTS IN LAYMANS TERMS PROVIDING CLEAR CHARTS AND GRAPHS POSTING ON SOCIAL MEDIA, WEBSITE, PUBLIC MEETINGS, PUBLIC TV, AND IN PUBLIC LOCATIONS
4. CONNECT VOLUNTEERING AND GIVING TO HUMAN RESOURCE GOALS UTILIZING PERKS LIKE DOLLARS FOR DOERS AND IN KIND GIVING.

Plan of Operation

Table of Contents

Section 9B

Employee Qualifications and Training Plan

Mission Statement:

Universal Care of Pa. is committed to recruiting, retaining and continuing the education of the most qualified individuals for employment.

Objectives:

To employ the most qualified individuals for positions within the organization.

- To retain qualified staff and limit turnover.
- To provide continuing education.

Implementation:

- To verify all licensed staff are active.
- Promote retention programs to limit employee turnover.
- To provide opportunity for continuing education.

Measurements:

- Report undocumented applicants.
- Quantify tenured vs. new employee ratio.
- Specify annual continuing education hours and documents.

Section 9C

Two Hour Training Plan

Mission Statement:

Universal Care of Pa., Inc is committed to company compliance with the two hours training plan by all active employees.

Objectifies:

- To Maintain 100% compliance with the two-hour required training
- To provide continued education amongst personnel quarterly
- To ass knowledge of personnel quarterly.

Implementation:

- Assure 100% 0f personnel enroll in two-hour training and record completion.
- Provide continuing education based on best practices and industry regulations.
- Require personnel to complete continuing education quarterly with exams.

Measurements:

- Audit attendance of training classes
- Audit personnel continuing education with post education exams 80% or better to pass.
- Re-educate employees less than 80%.

Section 10

Security and Surveillance Plan

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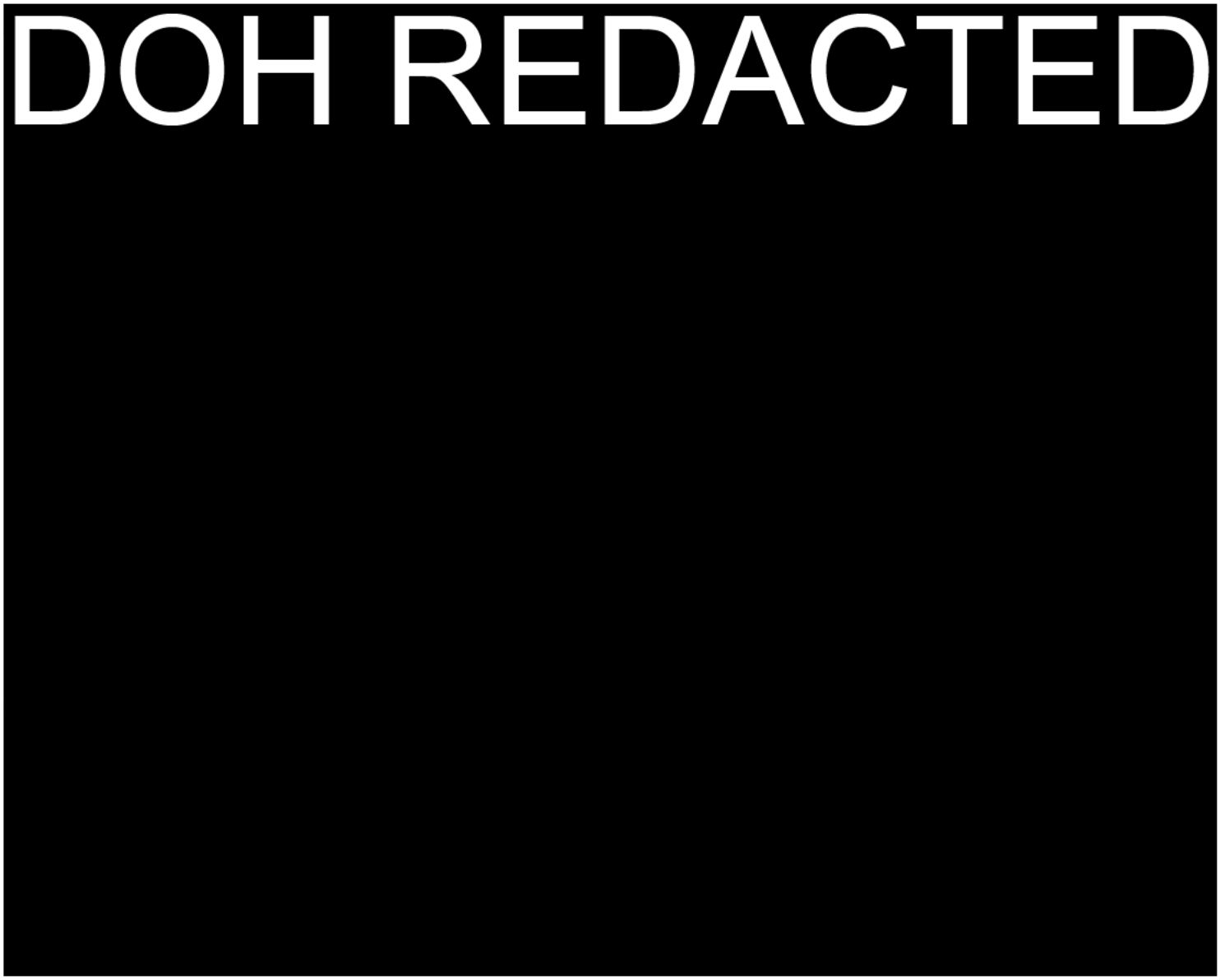
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Section 11

Transportation Plan

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Section 12

Storage of Medical Marijuana

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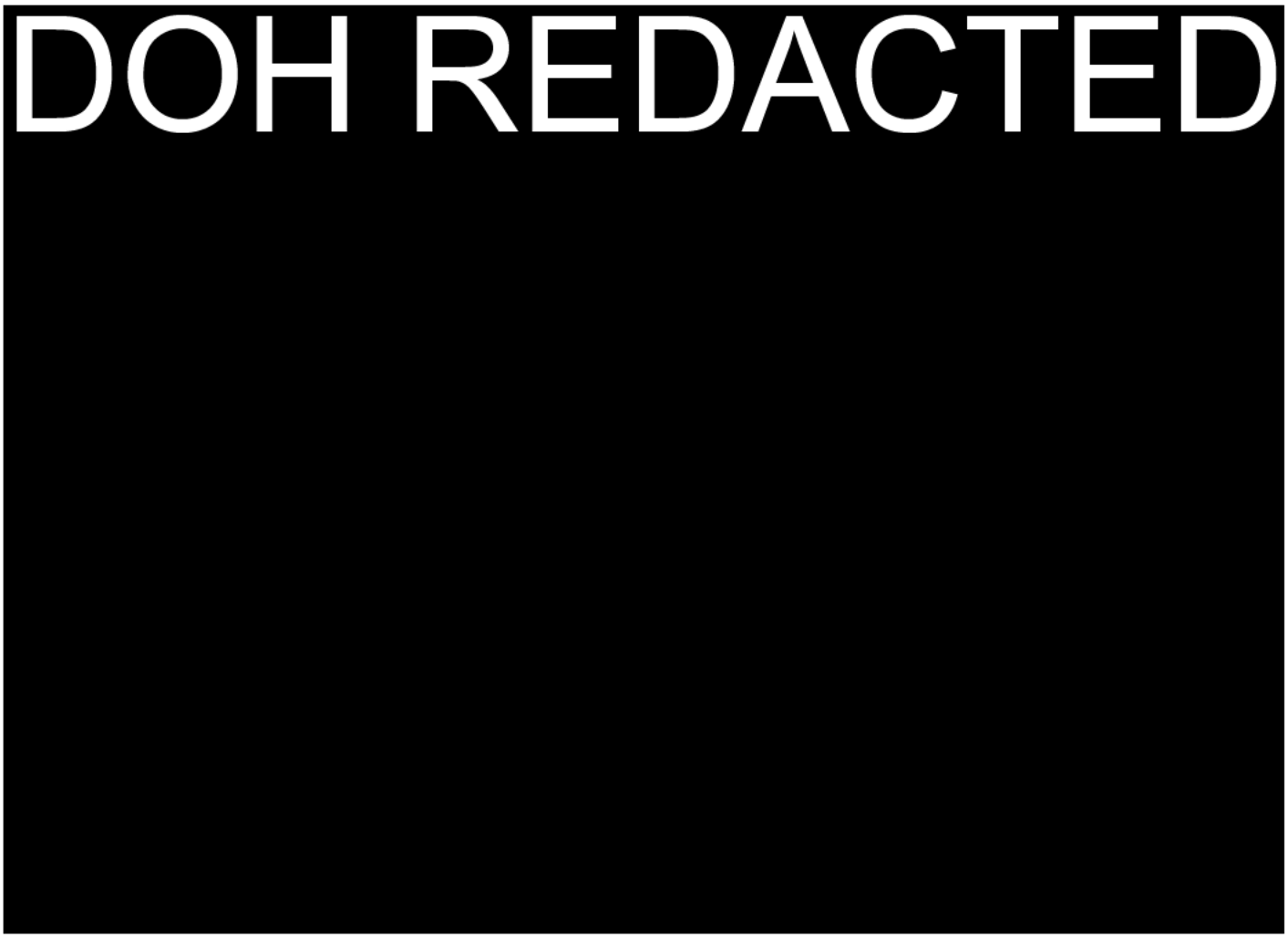
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Section 13

Labeling Plan

DOH REDACTED

Section 14

Inventory Management Plan

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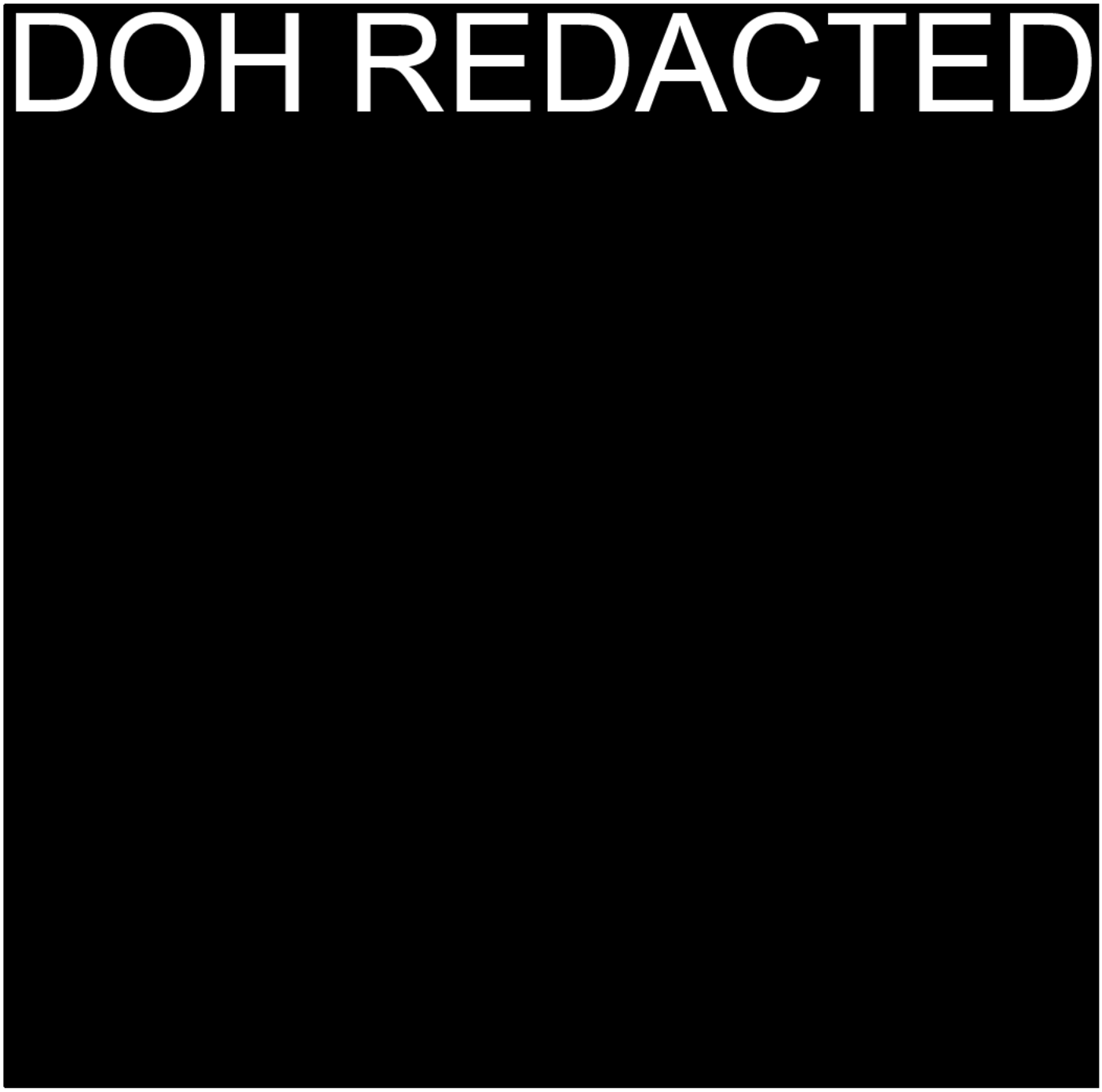
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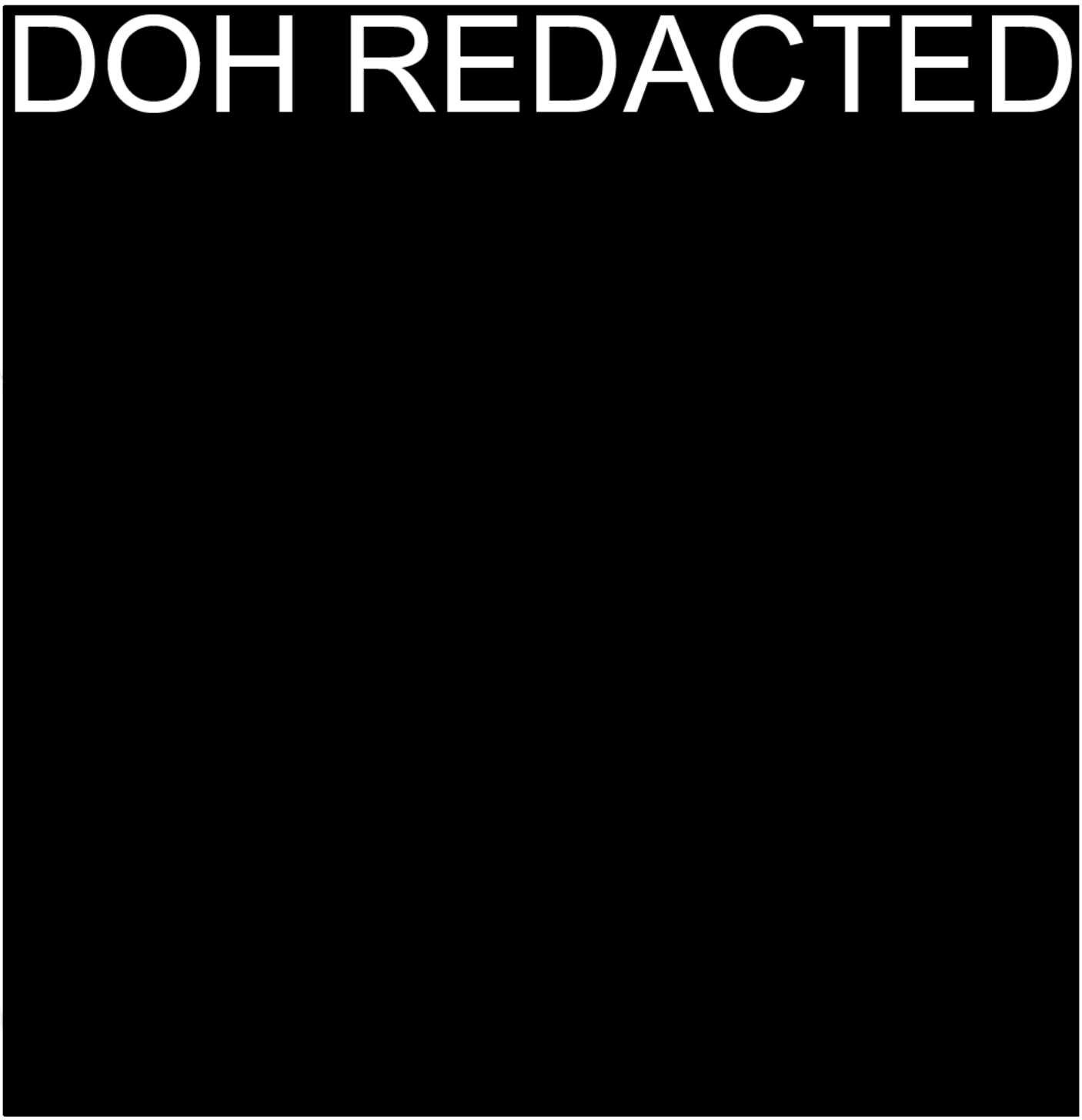
Section 15

Prevention of unlawful diversion on Medical Marijuana and Associated Products

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Section 16 Sanitation/Safety Measures Plan

Mission Statement:

Universal Care of Pa. Inc. is committed to preventing contamination of products and will promote hygiene within facility premises for all personnel, consumers, caregivers, contractors, and vendors. To provide an environment where hazards are highly unlikely and optimum safety prevails.

Objectives:

- To provide facilities free from hazards and to promote the safety of all personnel, consumers, caregivers, contractors and vendors.
- To promote strict adherence to handwashing protocol.
- To maintain mandatory handler restrictions that reduce the risk of contamination.
- To maintain the integrity of the Medical Marijuana and associated products in our possession, we will subcontract our pest protection, building maintenance, and grounds maintenance to companies with the highest standards.

Implementation:

- Develop programs covering the entire scope of sanitation to mitigate contamination, utilizing very reputable contractors who will oversee the entire chain of custody from growers/processors to our dispensaries.
- Develop criteria to assess each contractor's resources, regularly evaluate to assure adherence to the highest standards.

- Utilize qualified personnel, train per established policy and procedures.
- Maintain records that verify policy and procedures have been completed to assure accuracy and quality at all stages of the dispensary process.
- Assure quality control measures are performed and that the results are available to be tested by participating laboratories.
- Utilize contractors with clear labeling practices and a system for addressing complaints, assuring that specimens of all Medical Marijuana and associated products are available for testing.
- Maintain inventory as per Inventory Plan. No Medical Marijuana or associated products to be dispensed without proper authorization.
- Maintain storage as per Storage Plan.
- Maintain transport as per Transport Plan.

Measurement:

- Maintain records documenting contamination incidents along the chain of custody to the dispensaries.
- Document and evaluate complaints and recalls of Medical Marijuana and associated products.
- Continue to educate and credential personnel.
- Audit documentation throughout the chain of custody to assure quality control standards are in effect.
- Assure follow-up, investigations, and documentation for any deviations.

Section 17

Recordkeeping Plan

Mission Statement:

Universal Care of Pa is committed to accurate recordkeeping in all aspects of our organization.

Objective:

- To Maintain appropriate documentation in all aspects of dispensing Medical marijuana and associated products.
- Security and surveillance to be administered by third party provider
- Employee qualification to meet industry standards and expectations.
- To provide secured transport of Medical Marijuana and associated products and document chain of custody transportation.
- To implement strategies to reduce unlawful diversion of Medical Marijuana and associated products

Implementation:

- Demonstrate adherence to laws and regulations of Medical Marijuana and associated products related to recordkeeping for dispensaries.
- To provide accurate documentation in all areas relating to handling, storage, transportation and dispensing of Medical Marijuana and associated products.
- To report as indicated, all data outside standard parameters.
- To limit 14-day supply to less than 2.5 ounces and notify physician of scripts acceding.
- To Maintain documentation relating to security/ surveillance, employee qualifying, transport, storage, inventory management and unlawful diversion of Medical Marijuana and associated products.

Measurements:

- To Maintain Documentation the supports adherence to record keeping standards.
- See Handling under Inventory plan.
- See Storage under Storage plan.
- See Transport under Transportation plan.
- See Security/Surveillance under Security/Surveillance plan.
- See Employee Qualification under Employee Qualification plan.
- See Inventory Management under Inventory Management plan.
- See Unlawful Diversion under Unlawful Diversion plan

pennsylvania
DEPARTMENT OF HEALTH

MEDICAL MARIJUANA ORGANIZATION PERMIT APPLICATION

Attachments

The following attachments are part of the application package. Instructions for each attachment are at the beginning of each attachment.

Attachment A: Signature Page
Attachment B: Organizational Documents
Attachment C: Property Title, Lease, or Option to Acquire Property Location
Attachment D: Site and Facility Plan
Attachment E: Personal Identification
Attachment F: Affidavit of Business History
Attachment G: Affidavit of Criminal Offense
Attachment H: Tax Clearance Certificates
Attachment I: Affidavit of Capital Sufficiency
Attachment J: Sample Medical Marijuana Product Label
Attachment K: Release Authorization
Attachment L: Applicant Priorities for Multiple Applications

Attachment A: Signature Page

By checking "Yes," you acknowledge that you have read the Medical Marijuana Organization Permit Application Instructions before completing an application for a medical marijuana organization permit.	☒ Yes	☐ No

The applicant hereby submits this application for a Medical Marijuana Organization Permit to the Pennsylvania Department of Health, which consists of the completed application parts and attachments listed below:

FEES:

- ☒ Initial Application Fee
- ☒ Initial Permit Fee

APPLICATION:

- ☒ Completed Application

OTHER ATTACHMENTS:

- ☒ Attachment B: Organizational Documents
- ☒ Attachment C: Property Title, Lease, or Option to Acquire Property Location
- ☒ Attachment D: Site and Facility Plan
- ☒ Attachment E: Personal Identification
- ☒ Attachment F: Affidavit of Business History
- ☒ Attachment G: Affidavit of Criminal Offense
- ☒ Attachment H: Tax Clearance Certificates
- ☒ Attachment I: Affidavit of Capital Sufficiency
- ☒ Attachment J: Sample Medical Marijuana Product Label
- ☒ Attachment K: Release Authorization
- ☒ Attachment L: Applicant Priorities for Multiple Applications

1-2 Dispensary Permit

BACKGROUND CHECKS:

- ☒ The applicant has requested background checks, as described in the instructions.

ADDITIONAL ATTACHMENTS:

Please list any other documents you are submitting as part of this application:

File Name	Name of Document	Purpose
Plan of Operations	Table of contents	To supplement application
Medical Marijuana Dispensary Permit application		for Reference

A false statement made in this application is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).

[signature] Co-Owner/Manager 3/19/17

Signature Title in Applicant's Business Date

Christopher McNamara

Printed Name

A false statement made in this application is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).

Signature Title in Applicant's Business Date

Printed Name

A false statement made in this application is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).

Signature Title in Applicant's Business Date

Printed Name

A photocopy, facsimile or other electronic version of this document shall be accepted as an original signature.

Karen S Paul, NOTARY

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Karen S. Paul, Notary Public
Bridgeville Boro, Allegheny County
My Commission Expires April 8, 2018
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

Attachment B: Organizational Documents

Business Name, as it appears on the applicant's certificate of incorporation, charter, bylaws, partnership agreement or other legal business formation documents: Universal Care of PA, INC		
Trade names and DBA (doing business as) names:		
Principal Business Address: 2913 Beacon Way		
City: Pittsburgh	State: PA	Zip Code: 15241

DOH REDACTED

Dispensary Permit see attached Plan of Operations & Application

Attachment C: Property Title, Lease, or Option to Acquire Property Location

Business Name, as it appears on the applicant's certificate of incorporation, charter, bylaws, partnership agreement or other official documents: Universal Care of PA, INC		
Trade names and DBA (doing business as) names:		
Principal Business Address: 2913 Beacon Way		
City: Pittsburgh	State: PA	Zip Code: 15241

DOH REDACTED

Dispensary Permit See page 3. of application for locations.

Lease to be signed after permit obtained as per Timetable page 10.

Attachment D: Site and Facility Plan

Business Name, as it appears on the applicant's certificate of incorporation, charter, bylaws, partnership agreement or other official documents: Universal Care of PA, Inc		
Trade names and DBA (doing business as) names:		
Principal Business Address: 2913 Becon Way		
City: Pittsburgh	State: PA	Zip Code: 15241

DOH REDACTED

Dispensary Permit See Security & Surveillance Section 10 in addition See Section 16 Sanitation & Safety

Attachment E: Personal Identification

Business Name, as it appears on the applicant's certificate of incorporation, charter, bylaws, partnership agreement or other official documents: Universal Care of PA, INC		
Trade names and DBA (doing business as) names:		
Principal Business Address: 2913 Beacon Way		
City: Pittsburgh	State: PA	Zip Code: 15241

DOH REDACTED

Dispensary Permit all documentation in addition to application provided upon request. Medical consultant since 1992

Attachment F: Affidavit of Business History

See Copy: Business Hx
Section 19 on pg 21
of application

Affidavit of Business History

State of Pennsylvania)
) ss:
County of Washington)

The undersigned, Christopher McNAMARA, hereby certifies the following:

During the 10 years preceding the filing date of the initial permit application, the following principal(s), operator(s), financial backer(s) and employee(s), have held a position of management or ownership of a controlling interest in any other business in this Commonwealth or any other jurisdiction involving the manufacturing or distribution of medical marijuana or a controlled substance:

Name of individual	Role (principal, operator, financial backer or employee)	Business name and address	Position of management or ownership of a controlling interest	Dates
	Not applicable	No previous history		

I hereby certify that I am authorized to execute this affidavit on behalf of the applicant and that the information contained herein is true and correct and that there is no misrepresentation, falsification or omissions in this affidavit. I am further aware that any false or misleading statement or omitted information is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).

GM/COO 3/19/17
Signature of Affiant and Title Date

Sworn to and subscribed before me this 19th day of MARCH, 2017.

Karen S. Paul
Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Karen S. Paul, Notary Public
Bridgeville Boro, Allegheny County
My Commission Expires April 8, 2018
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

pennsylvania
DEPARTMENT OF HEALTH

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Karen S. Paul, Notary Public
Bridgeville Boro, Allegheny County
My Commission Expires April 8, 2018
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

MY COMMISSION EXPIRES:

A photocopy, facsimile or other electronic version of this document shall be accepted as an original signature.

Attachment G: Affidavit of Criminal Offense

Affidavit of Criminal Offense

State of Pennsylvania)
) ss:
County of Allegheny)

The undersigned, Christopher McNamara, hereby certifies the following by checking the boxes below:

Principal(s):

☒ No principal(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.

☐ One or more principals listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.

If one or more principal(s) listed in this permit application has been convicted of a criminal offense graded higher than a summary offense, please provide below the name(s) of the principal(s) and the offense(s) of which one or more principal(s) was convicted.

Name(s): _____
Offense(s): _____

Operator(s):

☒ No operator(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.

☐ One or more operator(s) listed in this permit application has been convicted of a criminal offense graded higher than a summary offense.

If one or more operator(s) listed in this permit application has been convicted of a criminal offense graded higher than a summary offense, please provide below the name(s) of the operator(s) and the offense(s) of which one or more operator(s) was convicted.

Name(s): _____
Offense(s): _____

Financial Backer(s):

☒ No financial backer(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.

☐ One or more financial backer(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense.

If one or more financial backer(s) listed in this permit application have been convicted of a criminal offense graded higher than a summary offense, please provide below the name(s) of the financial backer(s) and the offense(s) of which one or more financial backer(s) was convicted.

Name(s): _____

Offense(s): _____

_____ _____

Signature of Affiant and Title Date

Sworn to and subscribed before me this 19th day of MARCH, 2017.

Karen S. Paul

Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Karen S. Paul, Notary Public
Bridgeville Boro, Allegheny County
My Commission Expires April 8, 2018
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

MY COMMISSION EXPIRES:

4-8-18

A photocopy, facsimile or other electronic version of this document shall be accepted as an original signature.

Attachment H: Tax Clearance Certificates

Instructions:

- Completion of this form is a condition of this application and will authorize the Pennsylvania Department of Revenue (DOR) and the Department of Labor and Industry (L&I) to review the tax records of the applicant and its principals and other persons affiliated with the applicant, as part of the permit application review by the Pennsylvania Department of Health (Department)
- Your signature on this form also represents a waiver of confidentiality of this information. Your signature allows DOR and L&I to provide tax information to the Department
- If the applicant's business is not at a stage where a tax clearance certificate is possible, the application may be considered to be complete if the applicant provides a copy of form PA-100, PA Enterprise Registration Form
- Complete this cover sheet. Scan this sheet with the completed Application for a Tax Clearance Review and save it as a PDF file called "Attachment H," using the appropriate file name format

Business Name, as it appears on the applicant's certificate of incorporation, charter, bylaws, partnership agreement or other official documents: Universal Care of PA, INC		
Trade names and DBA (doing business as) names:		
Principal Business Address: 2913 Beacon Way		
City: Pittsburgh	State: PA	Zip Code: 15241

DOH REDACTED

Application for a Tax Clearance Review

Universal Care of PA
Name listed on tax return

25-1698691
Employer Identification Number or Social Security Number

2913 Beacon Way Pittsburgh PA 15241
Address City State Zip Code

I certify that I am the individual whose tax records are to be reviewed. If the tax records are for an entity, I certify that I am the authorized signatory for the applicant.

Signature of officer or authorized signatory

DOH REDACTION
Telephone number

3-19-17
Date

pennsylvania
DEPARTMENT OF HEALTH

A photocopy, facsimile or other electronic version of this document shall be accepted as an original signature.

Attachment I: Affidavit of Capital Sufficiency

ATTACHMENT I-1: AFFIDAVIT OF CAPITAL SUFFICIENCY FOR A GROWER/PROCESSOR PERMIT APPLICANT

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

AFFIDAVIT OF CAPITAL SUFFICIENCY

State of _____)
) ss:
County of _____)

I/WE_____

_____

ADDRESS PHONE

_____

CITY STATE ZIP CODE COUNTY

For the following applicant:

_____

NAME OF BUSINESS

_____

ADDRESS PHONE

_____

CITY STATE ZIP CODE COUNTY

hereby certify that the Applicant named has at least $2,000,000 in capital, $500,000 of which is on deposit with one or more financial institutions, as follows (capital may include cash or securities, real estate, or other assets):

Type of Capital	Source of Capital	Total Value of Capital	Value not encumbered by debt or other obligations	If on deposit, name and address of financial institution	If on deposit, account number

I hereby certify that I am authorized to execute this affidavit on behalf of the applicant and that the information contained herein is true and correct and that there is no misrepresentation, falsification or omissions in this affidavit. I am further aware that any false or misleading statement or omitted information is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).

GM/COO 3/19/17

Signature of Affiant and Title Date

Sworn to and subscribed before me this 19th day of March 2017.

Notary Public

MY COMMISSION EXPIRES:

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Karen S. Paul, Notary Public
Bridgeville Boro, Allegheny County
My Commission Expires April 8, 2018
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

A photocopy, facsimile or other electronic version of this document shall be accepted as an original signature

ATTACHMENT I-2: AFFIDAVIT OF CAPITAL SUFFICIENCY FOR A DISPENSARY PERMIT APPLICANT

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

AFFIDAVIT OF CAPITAL SUFFICIENCY

State of Pennsylvania)
) ss:
County of Allegheny)

I/WE William J Hughes

[redacted]

For the following applicant:

Universal Care of PA, Inc
NAME OF BUSINESS

2913 Beacon Way 724 941-1766
ADDRESS PHONE

Pittsburgh PA 15241 Allegheny
CITY STATE ZIP CODE COUNTY

hereby certify that the Applicant named has at least $150,000 on deposit with one or more financial institutions:

Type of Capital	Source of Capital	Name and address of financial institution	Account number
DOH REDACTED			

I hereby certify that I am authorized to execute this affidavit on behalf of the applicant and that the information contained herein is true and correct and that there is no misrepresentation, falsification or omissions in this affidavit. I am further aware that any false or misleading statement or omitted information is punishable under the applicable provisions of 18 Pa. C.S. Ch. 49 (relating to falsification and intimidation).

GM/COO

Signature of Affiant and Title

Sworn to and subscribed before me this 19th day of MARCH, 2017.

Notary Public

MY COMMISSION EXPIRES:

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Karen S. Paul, Notary Public
Bridgeville Boro, Allegheny County
My Commission Expires April 8, 2018
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

A photocopy, facsimile or other electronic version of this document shall be accepted as an original signature

Attachment J: Sample Medical Marijuana Product Label

Business Name, as it appears on the applicant's certificate of incorporation, charter, bylaws, partnership agreement or other official documents: Universal Care of PA, INC		
Trade names and DBA (doing business as) names:		
Principal Business Address: 2913 Beacon Way		
City: Pittsburgh	State: PA	Zip Code: 15241

DOH REDACTED

Dispensary Permit - See Labeling Plan
Manufacturer to provide labeling as per regulations

Attachment K: Release Authorization

RELEASE AUTHORIZATION

TO: _____

(Do not write above this line – For Department of Health Only)

FROM: William J Hughes

Applicant's Name

I, William J Hughes, by and on behalf of the undersigned applicant, have filed a permit application with the Pennsylvania Department of Health ("Department"). I certify that I am authorized by the applicant to submit this Release Authorization on its behalf and to bind the applicant to all provisions within this Release Authorization. I understand that the applicant is seeking the granting of a privilege and acknowledge that the burden of proving the applicant's qualifications and suitability for a favorable determination is at all times the burden of the applicant.

I understand that a background investigation may be conducted by the Department pursuant to its statutory duty to investigate the character, honesty, integrity and suitability of myself and any entity with which I am associated. I further understand and agree that I am voluntarily executing this Release Authorization to expressly authorize and permit the Department to obtain any and all information it deems necessary, and accept any risk of adverse public notice, embarrassment, criticism, or other action or financial loss which may result from action with respect to this permit application.

The rights and powers herein are granted to facilitate the background investigation being conducted by the Department at my request and on behalf of the applicant and is not otherwise intended to create or establish a legal or fiduciary relationship between the Department, its agents and employees, and me. I hereby acknowledge that no such relationship exists.

1. I hereby authorize and request every person, firm, company, corporation, board, association or institution of any kind, and every Federal, state or local government entity, including but not limited to every court, law enforcement agency, criminal justice agency or probation department, without exception, both foreign and domestic, to whom this Release Authorization is presented having any knowledge, information, documents, forms, photographs, computer files, accounts, ledgers or other items about, relating to or concerning the applicant and to fully discuss with and answer any inquiry made by any duly authorized investigator of the Pennsylvania Department of Health.
2. If this Release Authorization is presented to any brokerage firm, bank, savings and loan, or other financial institution or officer of same, I hereby authorize and request any and all documents, records or correspondence pertaining to the applicant, including but not limited to past loan information, notes, checking account records, savings deposit records, safe deposit box records, passbook records and general ledger folio sheets.
3. I hereby authorize an agent of the Department to obtain and review copies of any and all documents, records or correspondence pertaining to myself and the applicant, and I hereby authorize any Federal, state or municipal agency or body, law enforcement agency or criminal justice agency or department, tax agency or authority, regulatory agency, authority or body, to make full and complete disclosure of any and all information and documents including, but not limited to, documents and information otherwise privileged or not subject to public disclosure, as well as other information on file or available concerning the applicant.
4. This Release Authorization extends to the review and copy of any information protected by law or contact from disclosure, privilege or obligation.

5. I do for the applicant, as well as for myself, my heirs, executors, administrators, successors and assigns, hereby release, remise, exonerate and forever discharge the Department, its members, agents and employees, the Commonwealth of Pennsylvania and its instrumentalities, and any agents and employees thereof, from any and all liabilities including but not limited to all manner of actions, causes of action, suits, debts, judgments, executions, claims, and demands whatsoever, known and unknown, in law or equity, which exist now or in the future against those entities and persons other than relating to a willfully unlawful disclosure or publication of material or information acquired during my investigation.
6. I do for the applicant, as well as for myself, my heirs, administrators, successors and assigns, hereby release, remise, exonerate and forever discharge every person, firm, company, corporation, board, association or institution of any kind, and every Federal, state or local government entity, including but not limited to every court, law enforcement agency, criminal justice agency or probation department, without exception, both foreign and domestic, to whom this request is presented, and any agents or employees thereof, from any and all liabilities, including but not limited to all manner of actions, causes of action, suits, debts, judgments, executions, claims and demands whatsoever, known or unknown, in law or equity, which exist now or in the future against those entities and persons to whom this request is presented, and any agents or employees thereof, arising out of or by reason of the furnishing or inspection of documents, records or other information released in compliance with a request made pursuant to, or as a result of, having been presented with, this Release Authorization.
7. The applicant agrees to indemnify and hold harmless the Department, its officials and employees and every person, firm, company, corporation, board, association or institution of any kind, and every Federal, state or local government agency, to whom this request is presented and form and against all claims, damages, losses, and expenses including reasonable attorneys' fees arising out of or by reason of, the acts permitted and provided for in the Release Authorization.
8. I agree that a reproduction of this request by photocopy, facsimile or other similar process shall be for all intents and purposes as valid as the original.

IN WITNESS WHEREOF, I have executed this Release on this 19 day of March, 2017.

Authorized Signatory

STATE OF PENNSYLVANIA)
) ss:
COUNTY OF ALLEGHENY)

On this 19th day of MARCH 2017, before me, a Notary Public, personally appeared CHRISTOPHER MCNAMARA (known to me or satisfactorily proven) to be the person whose name is subscribed in this Release, and acknowledged that he/she executed the same for the purposes herein contained.

IN WITNESS THEREOF, I hereunto set my hand and official seal.

Notary Public

MY COMMISSION EXPIRES:

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Karen S. Paul, Notary Public
Bridgeville Boro, Allegheny County
My Commission Expires April 8, 2018
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

pennsylvania
DEPARTMENT OF HEALTH

Attachment L: Applicant Priorities for Multiple Applications

Business Name, as it appears on the applicant's certificate of incorporation, charter, bylaws, partnership agreement or other official documents: Universal Care of PA, INC
Trade names and DBA (doing business as) names:
Principal Business Address: 2913 Beacon Way
City: Pittsburgh State: PA Zip Code: 15241

DOH REDACTED

A. Priorities for Multiple Grower/Processor Permit Applications

Please check one of the following:

- ☐ The applicant would like to make the Department aware of the applicant's priorities as listed below
- ☐ The applicant has no preference regarding medical marijuana regions

MEDICAL MARIJUANA REGION	PRIORITY (If you intend to submit a permit application for more than one medical marijuana region, please rank your preferred region from 1-6, with 1 being the highest ranking)
1- Southeast	Priority __
1- Northeast	Priority __
1- Southcentral	Priority __
1- Northcentral	Priority __
1- Southwest	Priority 1 only region
1- Northwest	Priority __

B. Priorities for Multiple Dispensary Permit Applications

Please check one of the following:

☒ The applicant would like to make the Department aware of the applicant's priorities as listed below

☐ The applicant has no preference regarding county

MEDICAL MARIJUANA REGION	For each region for which you plan to submit multiple applications, please indicate the counties in order of priority, with 1 being the highest
1- Southeast	_ Berks _ Bucks _ Chester _ Delaware _ Lancaster _ Montgomery _ Philadelphia
1- Northeast	_ Lackawanna _ Lehigh _ Luzerne _ Northampton
1- Southcentral	_ Blair _ Cumberland _ Dauphin _ York
1- Northcentral	_ Centre _ Lycoming
1- Southwest	2 Allegheny _ Butler 1 Washington 3 Westmoreland
1- Northwest	_ Erie _ McKean