Montana Medical Marijuana Program
Property Owner Permission Form for Patients

(Property Owner signature must be notarized.)

Patient Applicant Information

Current Card Number (if applicable): _____ Expiration date: _____

Legal Name (Last)_____ (First): _____ (Middle): _____

Date of Birth: _____ Social Security Number: _____

_____ _____ _____

Street address City Zip

_____ _____

Signature of Patient Date

Property Owner Information

Legal Name (Last): _____ (First): _____MI: _____

Mailing address: _____ Phone number:_____

I give _____ permission to cultivate and/or use marijuana at the premises identified above to the extent that such cultivation and/or use is done in compliance with Montana Law. In signing this form. I further attest I am the property owner of the above-named property and I authorize the use of the premises to cultivate and/or use marijuana.

_____ _____

Signature of Property Owner Date

State of Montana

County of _____

This instrument was signed or acknowledged before me on _____ by _____

Name of Signer

_____

Notary Signature

Affix seal/stamp above