City of Aurora
16 West 2nd Avenue North
218-229-2614
infor@ci.aurora.mn.us

Cannabinoid License Application

Name of individual, partnership, LLC, corporation: _____

Owner Information:

Name: _____ Email Address:_____

Cell Phone: _____ Office Phone: _____

Business Address: _____

Home Address: _____

Birth Date: _____ Driver's License No: _____

Is the applicant 18 years of age or older? ❑ Yes ❑ No

City of Aurora Tobacco License Number: _____

Has the applicant, person managing the business, or any person associated in the business ever been convicted of any crime, misdemeanor, or violation of any city, state, or federal law involving activities licensed under this article? ❑ Yes ❑ No
If yes, state the nature of the offense(s) and the punishment or penalty assessed therefore. *Attach additional sheets if necessary*. _____

I certify the above information is true and correct. Written notice must be provided to the City within five (5) business days following any changes to the information stated above. I acknowledge the provisions of the tobacco and tobacco products ordinance have been reviewed and attest the property at the above address will be operated and maintained according to the requirements of the ordinance, subject to applicable sanctions and penalties. I affirm I will provide all necessary reports and make all sales tax payments as required by State Statute. I affirm I am aware of and will comply with all Federal, State, and Local requirements with respect to tobacco and tobacco products. I authorize the City of Aurora to investigate any or all statements or facts contained herein; acknowledging that the misrepresentation or the omission of facts called for will be just course for the disqualification or repeal of the license.
I understand that as part of the Cannabinoid License application process, the City shall conduct a criminal background check.

Signature of applicant: _____ Date: _____

Release of Information for Background Check:
The following named individual has made application with this agency for a Tobacco License.

Last Name of Applicant (please print): _____

First Name (please print): _____

Middle (full)(please print): _____

Maiden, Alias or Former (please print): _____

Date of Birth: _____ **Sex** (M or F): _____
Month/Day/Year

Social Security Number (optional): _____

I authorize the Minnesota Bureau of Criminal Apprehension or East Range Police Department to disclose all criminal history record information to the City of Aurora for the purpose of Cannabinoid License Application with this agency.
The expiration of this authorization shall be one year from the date of my signature.

MUST BE SIGNED IN FRONT OF A NOTARY

Signature of Applicant_____ **Date**_____

State of Minnesota
County of St. Louis
This record was acknowledged before me on _____(date)
by _____(name(s) of individual(s)).

My commission expires:_____Stamp:

_____
Notary Signature

Application Rec'd: _____ Paid: _____ Payment Type: _____

Police Chief Approval:_____Date: _____

Council Approval: _____ License no.: _____ Mailed on: _____

Denial: _____