STATE OF NEW JERSEY

DEPARTMENT OF HEALTH AND SENIOR SERVICES

PERSONAL HISTORY DISCLOSURE FORM

FORM 2

PERSONAL HISTORY DISCLOSURE FORM 2 INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

I. COMPLETING THIS FORM:

a. You must make accurate statements and include all material facts. Any misrepresentation, or the failure to provide requested information, may result in the denial of the ATC entity's request for permit.

b. Read each question carefully prior to answering. Answer every question completely. Do not leave blank spaces. If a question does not apply to you, indicate "Does Not Apply" in response to that question. If there is nothing to disclose in response to a particular question, indicate "None" in response to that question. Failure to provide a response to every question may result in the denial of the ATC entity's request for permit.

c. All entries on this form, except initials and signatures, must be typed or printed in block lettering using dark ink. If your disclosure form is not legible, it will not be accepted.

d. If the space available is insufficient to respond to a question, you are to supply the required information on an attachment page, and clearly identify which question you are answering. The blank page on page 22 may be used to provide this additional information.

e. If you make any modification to the pre-printed questions or information contained in this form, the ATC entity's request for permit may be rejected. Once your disclosure form is accepted, it becomes the property of the Department of Health and Senior Services and will not be returned.

II. BE SURE TO:

a. Attach a recent (within the past six months) color photograph of yourself in the space provided on page 8.

b. Sign the Statement of Truth form on page 3 in the presence of a notary public, justice of the peace, or other person legally authorized to notarize your signature.

c. Sign the Release Authorization on page 4 in the presence of a notary public or other person legally authorized to notarize your signature.

d. Sign the Release of Information to Alternative Treatment Center on page 5 in the presence of a notary public or other person legally authorized to notarize your signature.

e. Sign the Waiver of Liability on page 6 in the presence of a notary public or other person legally authorized to notarize your signature.

III. BEFORE YOU SUBMIT THIS FORM, BE SURE THAT:

a. You have included all required attachments listed in this form.

b. The Statement of Truth form, Release Authorization, Release of Information to Alternative Treatment Center and Waiver of Liability are notarized on the original application.

c. Every question has been answered completely.

d. You retain a completed copy of your application package for your own records.

STATEMENT OF TRUTH

STATE/PROVINCE OF _____:

SS:

COUNTY/DISTRICT OF _____:

I, _____, being duly sworn according to law, on my oath, under penalties of perjury, depose and say:

1. I am the individual who is submitting this personal history disclosure form 2.
2. I personally supplied the information contained in this form.
3. I understand and read the English language or I have had an interpreter read, explain and record the answer to each and every question on this application form.
4. Any document accompanying this Personal History Disclosure Form that is not an original document is a true copy of the original document.
5. I swear (or affirm) that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

DATED: _____ _____ (LEGAL SIGNATURE)
(Signature of Applicant)

Subscribed and sworn to
before me this _____ day
of _____, _____

_____ _____
NOTARY PUBLIC, JUSTICE OF THE PEACE/ COMMISSIONER FOR DECLARATIONS OR OTHER PERSON AUTHORIZED TO TAKE DECLARATIONS

STATE/PROVINCE, COUNTRY

_____
Print Name

RELEASE AUTHORIZATION

To All Courts, Probation Departments, Selective Service Boards, Employers, Educational Institutions, Banks, Financial and Other Such Institutions, and All Governmental Agencies - federal, state and local, without exception, both foreign and domestic.

I, _____ have authorized
(Print Name)

the New Jersey Department of Health and Senior Services ("DHSS") to conduct a full investigation into my background and activities.

Therefore, you are hereby authorized to release any and all information pertaining to me, documentary or otherwise, as requested by any employee or agent of DHSS, provided that he or she certifies to you that I have submitted a disclosure form to DHSS.

This authorization shall supersede and countermand any prior request or authorization to the contrary.

A photocopy of this authorization will be considered as effective and valid as the original.

DATED: _____ _____(LEGAL SIGNATURE)
(Signature of Applicant)

Subscribed and sworn to

before me this _____ day

of _____, 20 _____

_____
NOTARY PUBLIC

_____
Print Name

RELEASE OF INFORMATION TO ALTERNATIVE TREATMENT CENTER

I, _____ have authorized
(Print Name)

the New Jersey Department of Health and Senior Services ("DHSS") to conduct an investigation into my background and activities.

Upon completion of the DHSS investigation, I authorize the release of the investigation results to the President/CEO of the Alternative Treatment Center where I will serve as a Medical Advisory Board member.

This authorization shall supersede and countermand any prior request or authorization to the contrary.

DATED: _____ _____(LEGAL SIGNATURE)
(Signature of Applicant)

Subscribed and sworn to

before me this _____ day

of _____, 20 _____

_____
NOTARY PUBLIC

_____
Print Name

WAIVER OF LIABILITY

I, _____ hereby waive liability, as to the
(Print Name)

State of New Jersey, the Department of Health and Senior Services, and their instrumentalities and agents, for any damages resulting from any disclosure or publication in any manner, other than a willfully unlawful disclosure or publication, of any material or information acquired during the permitting process or during any inquiries, investigations or hearings.

_____ _____
DATE SIGNATURE

Subscribed and sworn to

before me this _____day

of _____, 20 _____.

_____
NOTARY PUBLIC

_____
Print Name

PERSONAL HISTORY DISCLOSURE FORM 2

PLEASE PRINT OR TYPE THE ANSWERS TO THE FOLLOWING QUESTIONS IN THE SPACES PROVIDED

PERSONAL DATA

NAME: LAST (INCLUDE SR., JR., ETC., IF APPLICABLE) FIRST MIDDLE

MAILING ADDRESS/POSTAL ADDRESS:
NUMBER AND STREET APT # CITY/TOWN STATE/PROVINCE ZIP/POSTAL CODE

HOME ADDRESS: (IF DIFFERENT THAN MAILING ADDRESS/POSTAL ADDRESS)
NUMBER AND STREET APT # CITY/TOWN STATE/PROVINCE ZIP/POSTAL CODE

PRESENT BUSINESS ADDRESS:
NUMBER AND STREET APT # CITY/TOWN STATE/PROVINCE ZIP/POSTAL CODE

HOME TELEPHONE NUMBER: (AREA CODE) (NUMBER)
CURRENT BUSINESS TELEPHONE NO. AT PLACE OF EMPLOYMENT: (AREA CODE) (NUMBER) (EXTENSION)
FAX NUMBER: (AREA CODE) (NUMBER)

DATE OF BIRTH: (MO)(DAY)(YEAR)
E-MAIL ADDRESS (OPTIONAL):

HAVE YOU BEEN KNOWN BY ANY OTHER NAME OR NAMES? YES ☐ NO ☐ IF YES, LIST THE ADDITIONAL NAMES BELOW AND SPECIFY DATES OF USE FOR EACH. (INCLUDE MAIDEN NAME, ALIASES, NICKNAMES, OTHER NAME CHANGES, LEGAL OR OTHERWISE.)

_____

_____

_____

_____

SEX	COLOR OF EYES	COLOR OF HAIR	HEIGHT	WEIGHT
			_____FT _____IN	_____LBS

IMPORTANT

FAILURE TO ANSWER ANY QUESTION ON THIS FORM COMPLETELY AND TRUTHFULLY MAY RESULT IN DENIAL OF THE ATC ENTITY'S REQUEST FOR PERMIT.

AFFIX A COLOR PHOTOGRAPH
HERE THAT WAS TAKEN WITHIN
THE PAST SIX MONTHS.

PRINT YOUR NAME UNDERNEATH
THE FRONT BOTTOM BORDER OF
THE PHOTOGRAPH AFTER
ATTACHING IT.

1. Of what country are you a citizen? _____

   Please indicate:

   Date of birth: _____
   DAY MONTH YEAR

   Place of birth: _____
   CITY/TOWN STATE/PROVINCE COUNTY

   Country of birth: _____

2. Have you ever been issued a passport? Yes ☐ No ☐

If yes, provide the following information about your passport(s):

PASSPORT NUMBER	COUNTRY OF ISSUE	PLACE ISSUED	DATE ISSUED	EXPIRATION DATE

RESIDENCE DATA

3. Begin with your current residence(s) and work back in time to provide the following information with respect to each place where you have lived (including residences while attending college or while in military service) during the past ten (10) years.

DATES		ADDRESS (NO., STREET, APT#, CITY/TOWN, STATE/PROVINCE, COUNTRY & ZIP/POSTAL CODE)	OWN OR RENT
FROM: (MO/YR)	TO: (MO/YR)		

FAMILY/SOCIAL DATA

4. Are any members of your family (including spouse or civil union partner, children, parents and/or siblings) associated with or employed by any Alternative Treatment Center in New Jersey? Yes ☐ No ☐

If yes, provide the following information:

NAME	DATE OF BIRTH	RELATIONSHIP	NAME, ADDRESS, AND TELEPHONE NUMBER OF ALTERNATIVE TREATMENT CENTER	DATES OF EMPLOYMENT

5. Are any members of your family (including spouse or civil union partner, children, parents or siblings) associated with or employed by any company, either for-profit or nonprofit, licensed to cultivate or dispense marijuana for any purpose in any jurisdiction? Yes ☐ No ☐

If yes, provide the following information:

NAME	DATE OF BIRTH	RELATIONSHIP	NAME, ADDRESS AND TELEPHONE NUMBER OF MARIJUANA BUSINESS	BUSINESS TELEPHONE

EMPLOYMENT AND LICENSING DATA

6. Have you ever been employed by any company, either for-profit or nonprofit, licensed to dispense marijuana for medical purposes in any jurisdiction?

Yes ☐ No ☐

If yes, provide the following information:

NAME OF ORGANIZATION AND COUNTRY/STATE WHERE YOU WERE EMPLOYED	NAME, MAILING ADDRESS AND TELEPHONE NUMBER OF EMPLOYER(S)	DATES		TITLE/POSITION HELD AND DESCRIPTION OF DUTIES	NAME OF SUPERVISOR	REASON FOR LEAVING
		FROM: (MO/YR)	TO: (MO/YR)			

7. Please provide the following information regarding your employment for the past ten (10) years or from age 18, whichever is less. Begin with your present job and work back in time. Give dates of any unemployment between jobs in proper sequence. Include all part-time and full-time employment and any military service.

DATES		NAME, MAILING ADDRESS, AND TELEPHONE NUMBER OF EMPLOYER(S)	TITLE/POSITION HELD AND DESCRIPTION OF DUTIES	NAME OF SUPERVISOR	REASON FOR LEAVING/ COMPENSATION AT DEPARTURE
FROM: (MO/YR)	TO: (MO/YR)				

If additional space is needed, please provide an attachment.

8. With regard to the previous question concerning employment:

a. Were you ever discharged, suspended or asked to resign from employment? Yes ☐ No ☐

b. Were you ever charged with any infraction in relation to any employment which was the subject of any disciplinary action? Yes ☐ No ☐

If yes to either question, provide the following information as to each such time you were discharged, suspended, asked to resign or disciplined:

DATE OF DISCHARGE, SUSPENSION, RESIGNATION OR DISCIPLINARY ACTION	NAME AND ADDRESS OF EMPLOYER	NAME OF SUPERVISOR	REASON FOR DISCHARGE, SUSPENSION, RESIGNATION OR DISCIPLINARY ACTION

EDUCATIONAL DATA

9. Beginning with secondary school (high school), provide the information requested below with respect to each school, college, graduate or post graduate school you have attended.

DATES		NAME AND ADDRESS OF SCHOOL, TRAINING PROGRAM, ETC.	DESCRIPTION OF EDUCATION PROGRAM	LIST ANY DEGREE OR CERTIFICATION ATTAINED	GRADUATED YES OR NO
FROM: (MO/YR)	TO: (MO/YR)				

OFFICES AND POSITIONS

10. List all offices, trusteeships, directorships, and fiduciary positions pertaining to work in the medical field. Begin with the most recent and work back in time to provide the following information.

DATES		TITLE OF OFFICE OR POSITION HELD	NAME AND ADDRESS OF FIRM, CORPORATION, ASSOCIATION, PARTNERSHIP, NON-PROFIT ENTITY, FAMILY TRUST AND OTHER BUSINESS ENTITY	COMPENSATION RECEIVED
FROM: (MO/YR)	TO: (MO/YR)			

11. Have you ever made application for, or held, any professional or occupational license, permit or certification, in any jurisdiction, pertaining to work in the medical field?

Yes ☐ No ☐

If yes, provide the following information:

NAME ON LICENSE	TYPE OF LICENSE	DATES		NAME AND ADDRESS OF LICENSING AGENCY/ORGANIZATION	DISPOSITION OF THE APPLICATION
		FROM: (MO/YR)	TO: (MO/YR)		

12. Have you received, or do you expect to receive, any compensation (whether in the form of salary, bonuses, fringe benefits or otherwise) from the ATC and/or its owners, principals, partners, board members, directors, trustees, officers, staff members, employees and/or any other person in any way affiliated or connected with the ATC, whether or not that compensation was related to your position on the Medical Advisory Board?

Yes ☐ No ☐

If yes, provide the following information:

FORM OF COMPENSATION	DATE RECEIVED	AMOUNT

13. Have you made any loans, gifts, or payments in the cumulative amount of $10,000 or more to the ATC and/or its owners, principals, partners, board members, directors, trustees, officers, staff members, employees and/or any other person in any way affiliated or connected with the ATC?

Yes ☐ No ☐

If yes, provide the following information:

NAME OF RECIPIENT	TYPE OF PAYMENT	AMOUNT	TERMS OF REPAYMENT, IF ANY	DATE MADE

CIVIL, CRIMINAL AND INVESTIGATORY PROCEEDINGS

Prior to answering this question, carefully review the definitions which follow.

DEFINITIONS: For purposes of this question:

A. "Arrest" includes any detaining, holding, or taking into custody by any police or other law enforcement authorities to answer for the alleged commission of any "offense."

B. "Charge" includes any indictment, complaint, information, summons, or other notice of the alleged commission of any "offense."

C. "Offense" includes all felonies, crimes, high misdemeanors, misdemeanors, disorderly persons offenses, petty disorderly offenses, driving while intoxicated/impaired motor vehicle offenses and violations of probation or any other court order. Juvenile offenses that occurred within the most recent 10 year period are also included within the definition of "offense."

IMPORTANT

The Department of Health and Senior Services will make inquiries to establish whether you have had any involvement with law enforcement agencies.

Failure to disclose any such involvement will be taken into account in assessing your character, honesty and integrity.

14. a. Have you ever been arrested or charged with any offense in any jurisdiction? Yes ☐ No ☐

b. Did the arrest or charge involve any controlled dangerous substance or controlled dangerous substance analog in violation of N.J.S.A. 2C:35-1 et. seq., any similar law of the United States or any other state (including, but not limited to, unlawful possession of a controlled dangerous substance and possession of a controlled dangerous substance with intent to manufacture, distribute, or dispense)?

Yes ☐ No ☐

If yes, provide the following information:

NATURE OF CHARGE OR OFFENSE/ LOCATION OF WHERE INCIDENT OCCURRED	DATE OF CHARGE OR OFFENSE	NAME AND ADDRESS OF LAW ENFORCEMENT AGENCY OR COURT INVOLVED	DISPOSITION (CONVICTED, ACQUITTED, DISMISSED, PENDING, PARDONED, EXPUNGED, ETC.)	SENTENCE

15. As indicated in the instructions on page 2 of this form, this page is to be used by you for any questions which require additional space to answer. The number of the question must be stated immediately prior to your answer. If additional pages are needed, photocopy this page or add paper of similar size, and identify these pages with corresponding numbers and letters.

IDENTIFY ALL ANSWERS BY ORIGINAL QUESTION NUMBERS

USE ADDITIONAL PAGES IF NECESSARY