



Step 1: Identify your business or organization

Business name: _____

FEIN: _____ - _____

If your business is a corporation, are you publicly traded? ___ Yes ___ No

SSN: _____ - _____ - _____
(Proprietorship only)

If "Yes", provide the ticker symbol: _____

Phone: (_____) _____ - _____

Contact for this schedule: _____

Email address: _____

Step 2: Identify your medical cannabis business activities

Note: You must have received a cultivation center permit from the Illinois Department of Agriculture or a dispensing organization registration from the Illinois Department of Financial and Professional Regulation, prior to completing Schedule REG-1-MC.

Cultivation center - Check this box and provide the information below only if you have received a cultivation center permit from the Illinois Department of Agriculture. (See instructions.)

Cultivation center permit number: _____

Cultivation center permit number: _____

DBA name: _____

DBA name: _____

Address: _____
Street address - No PO Box numbers Apt. or suite no.

Address: _____
Street address - No PO Box numbers Apt. or suite no.

City State ZIP

City State ZIP

Date cultivation center permit issued: ___ / ___ / ___

Date cultivation center permit issued: ___ / ___ / ___

Starting date of this location: ___ / ___ / ___

Starting date of this location: ___ / ___ / ___

Cultivation center permit number: _____

DBA name: _____

Address: _____
Street address - No PO Box numbers Apt. or suite no.

City State ZIP

Date cultivation center permit issued: ___ / ___ / ___

Starting date of this location: ___ / ___ / ___

Dispensing organization - Check this box and provide the information below only if you have received a dispensing organization registration from the Illinois Department of Financial and Professional Regulation. (See instructions.)

Dispensing organization registry ID number: _____

Dispensing organization registry ID number: _____

DBA name: _____

DBA name: _____

Address: _____
Street address - No PO Box numbers Apt. or suite no.

Address: _____
Street address - No PO Box numbers Apt. or suite no.

City State ZIP

City State ZIP

Date dispensing organization registration issued: ___ / ___ / ___

Date dispensing organization registration issued: ___ / ___ / ___

Starting date of this location: ___ / ___ / ___

Starting date of this location: ___ / ___ / ___

Dispensing organization registry ID number: _____

Dispensing organization registry ID number: _____

DBA name: _____

DBA name: _____

Address: _____
Street address - No PO Box numbers Apt. or suite no.

Address: _____
Street address - No PO Box numbers Apt. or suite no.

City State ZIP

City State ZIP

Date dispensing organization registration issued: ___ / ___ / ___

Date dispensing organization registration issued: ___ / ___ / ___

Starting date of this location: ___ / ___ / ___

Starting date of this location: ___ / ___ / ___

Dispensing organization registry ID number: _____

DBA name: _____

Address: _____
Street address - No PO Box numbers Apt. or suite no.

City State ZIP

Date dispensing organization registration issued: ___ / ___ / ___

Starting date of this location: ___ / ___ / ___

Mail your completed schedule, with any required attachments to:



CENTRAL REGISTRATION DIVISION 3-222
ILLINOIS DEPARTMENT OF REVENUE
PO BOX 19030
SPRINGFIELD IL 62794-9030