
Membership Application

Welcome to the Alliance! Please submit this form by post to 1110 Nu‘uanu Ave, #6, Honolulu, HI 96817, or email to info@hawaiidispensaryalliance.org.

Business Name: _____

Mailing Address: _____

Email Address: _____

Business Phone: _____ Fax Number: _____

Website Address: _____

Company Executive Name & Title: _____

Person Responsible for Billing: _____

Email of Person Responsible for Billing: _____

Number of Full-Time employees: _____ Part-Time: _____

Annual Revenue: _____ NAICS Classification: _____

Business Description: _____

Why are you a part of Hawaii’s medical marijuana industry? _____

Who else should we contact concerning Alliance membership? _____

Membership Level: _____ Annual Dues: _____

Authorized Signature: _____ Date: _____

Creating the Future of Hawai‘i’s
Medical Marijuana *Economy* -
One Partner at a Time

