ANTELOPE VALLEY AIR QUALITY MANAGEMENT DISTRICT
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Lancaster, CA 93535
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CALIFORNIA BUSINESS & PROFESSIONS CODE DIVISION 10
CANNABIS ODOR COMPLIANCE PLAN

Section 1: Owner/Operator Information (PLEASE TYPE OR PRINT)

Please refer to Rule 302 for Plan Fee

Owner/Operator		Federal Tax ID#
Company Name/DBA		
Mailing/Billing Address (for above company name) *include city, state, and zip code*:		
Business License Name (for equipment location):		
Facility Address - Location of Equipment (if same as for company, enter "Same"):		
Contact Name/Title:	Email Address:	Phone:
Nature of Business (check all that apply): ☐ Cultivation ☐ Extraction ☐ Packing/repackaging ☐ Edible Goods Manufacturing ☐ Other_____		

Section 2: Nature of Application

Plan is for: ☐ New Operation ☐ Modification ☐ Change of Owner
Do you claim Confidentiality of Data? ☐ No ☐ Yes (Attach explanation: Specify which information provided is confidential)

Section 3: Cultivation Information

The following information is REQUIRED : For each area below, provide square footage of area (for all that apply)	
Canopy Area	
Area outside of canopy-(Immature Plants)	
Flowering Plants	
Pesticide and other chemical storage	
Designated Processing area	
Designated Packaging area	
Designated Composting area	
Designated secured area for waste	
Designated area for harvested Cannabis storage	
Designated area for physically segregating cannabis or non-manufactured cannabis products subject to hold	
Designated area(s) shared between licenses held by one licensee	
Common use area (s) including but not limited to: office space, hallways, bathrooms, or break rooms	

Section 4: Operation Information

Number of crops per year:	
Facility Annual Throughput by Quarters (in percent): ☐ Uniform OR _____ % Jan-Mar _____ % Apr-Jun _____ % Jul-Sep _____ % Oct-Dec	Expected Extraction and Post-Extraction Processing Operating Hours: _____ Hours/Day _____ Days/Week _____ Weeks/Year _____ Total Annual Hours

Section 5: Odor Control Devices

Please provide the following information for EACH different type, make, model, style, etc. of odor control devices you will be operating (Use additional sheets if necessary – Each building will require a separate permit):

ODOR CONTROL SYSTEM 1		
Type of device: ☐ Fixed Regenerative Bed ☐ Fixed Carbon Bed ☐ Concentrator ☐ Fluidized Adsorber ☐ Rechargeable Carbon Canister ☐ Replaceable Carbon Canister ☐ Misting System ☐ Other: _____		
Quantity:	Manufacturer:	Model:
ODOR CONTROL SYSTEM 2		
Type of device: ☐ Fixed Regenerative Bed ☐ Fixed Carbon Bed ☐ Concentrator ☐ Fluidized Adsorber ☐ Rechargeable Carbon Canister ☐ Replaceable Carbon Canister ☐ Misting System ☐ Other: _____		
Quantity:	Manufacturer:	Model:

ODOR CONTROL SYSTEM 3		
Type of device: ☐ Fixed Regenerative Bed ☐ Fixed Carbon Bed ☐ Concentrator ☐ Fluidized Adsorber ☐ Rechargeable Carbon Canister ☐ Replaceable Carbon Canister ☐ Misting System ☐ Other: _____		
Quantity:	Manufacturer:	Model:

Section 6: Certification

I hereby certify that all information contained herein is true and correct.

Print Name of Responsible Official	Title	Signature of Responsible Official	Date Signed

Phone:	Email: