Americans For Safe Access

AN ORGANIZATION OF MEDICAL PROFESSIONALS, SCIENTISTS, AND PATIENTS HELPING PATIENTS

MEDICAL CANNABIS DISPENSING COLLECTIVES AND LOCAL REGULATION

Advancing Legal Medical Marijuana Therapeutics and Research

MEDICAL CANNABIS DISPENSING COLLECTIVES AND LOCAL REGULATION

February 2011

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EXECUTIVE SUMMARY

California's original medical cannabis law, the Compassionate Use Act of 1996 (Prop. 215), encouraged state and federal governments to develop programs for safe and affordable distribution of medical cannabis (marijuana). Although self-regulated medical cannabis dispensing collectives (dispensaries) have existed for more than 14 years in California, the passage of state legislation (SB 420) in 2003, court rulings in *People v. Urziceanu* (2005) and *County of Butte v. Superior Court* (2009), and guidelines from the state Attorney General, all recognized and affirmed their status as legal entities under state law. With most of the 300,000 cannabis patients in California relying on dispensaries for their medicine, local officials across the state are developing regulatory ordinances that address business licensing, zoning, and other safety and operational requirements that meet the needs of patients and the community.

Americans for Safe Access, the leading national organization representing the interests of medical cannabis patients and their doctors, has undertaken a study of the experience of those communities that have dispensary ordinances to act as a guide to policy makers tackling dispensary regulations in their communities. The report that follows details those experiences, as related by local officials; it also covers some of the political background and current legal status of dispensaries, outlines important issues to consider in drafting dispensary regulations, and summarizes a recent study by a University of California, Berkeley researcher on the community benefits of dispensaries. In short, this report describes:

Benefits of regulated dispensaries to communities include:

- providing access for the most seriously ill and injured,
- offering a safer environment for patients than having to buy on the illicit market,
- improving the health of patients through social support,
- helping patients with other social services, such as food and housing,
- having a greater than average customer satisfaction rating for health care.

Creating dispensary regulations combats crime because:

- dispensary security reduces crime in the vicinity,
- street sales tend to decrease,
- patients and operators are vigilant; any criminal activity is reported to police.

Regulated dispensaries are:

- legal under California state law,
- helping revitalize neighborhoods,
- bringing new customers to neighboring businesses,
- not a source of community complaints.

This report concludes with a section outlining the important elements for local officials to consider as they move forward with regulations for dispensaries. ASA has worked successfully with officials across the state to craft ordinances that meet the state's legal requirements, as well as the needs of patients and the larger community.

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OVERVIEW OF MEDICAL CANNABIS DISPENSARIES

"As the number of patients in the state of California who rely upon medical cannabis for their treatment continues to grow, it is increasingly imperative that cities and counties address the issue of dispensaries in our respective communities. In the city of Oakland we recognized this need and adopted an ordinance which balances patients' need for safe access to treatment while reassuring the community that these dispensaries are run right. A tangential benefit of the dispensaries has been that they have helped to stimulate economic development in the areas where they are located."

—Desley Brooks, Oakland City Councilmember

ABOUT THIS REPORT

Land-use decisions are now part of the implementation of California's medical marijuana, or cannabis, laws. As a result, medical cannabis dispensing collectives (dispensaries) are the subject of considerable debate by planning and other local officials. Dispensaries have been operating openly in many communities since the passage of Proposition 215 in 1996. As a compassionate, community-based response to the problems patients face in trying to access cannabis, dispensaries are currently used by more than half of all patients in the state and are essential to those most seriously ill or injured. Since 2003, when the legislature further implemented state law by expressly addressing the issue of patient collectives and compensation for cannabis, more dispensaries have opened and more communities have been faced with questions about business permits and land use options.

In an attempt to clarify the issues involved, Americans for Safe Access has conducted a survey of local officials in addition to continuously tracking regulatory activity throughout the state (see AmericansForSafeAccess.org/regulations). The report that follows outlines some of the underlying questions and provides an overview of the experiences of cities and counties around the state. In many parts of California, dispensaries have operated responsibly and provided essential services to the most needy without local intervention, but city and county officials are also considering how to arrive at the most effective regulations for their community, ones that respect the rights of patients for safe and legal access within the context of the larger community.

ABOUT AMERICANS FOR SAFE ACCESS

Americans for Safe Access (ASA) is the largest national member-based organization of patients, medical professionals, scientists, and concerned citizens promoting safe and legal access to cannabis for therapeutic use and research. ASA works in partnership with state, local and national legislators to overcome barriers and create policies that improve access to cannabis for patients and researchers. We have more than 50,000 active members with chapters and affiliates in all 50 states.

THE NATIONAL POLITICAL LANDSCAPE

A substantial majority of Americans support safe and legal access to medical cannabis. Public opinion polls in every part of the country show majority support cutting across political and demographic lines. Among them, a Time/CNN poll in 2002 showed 80% national support; a survey of AARP members in 2004 showed 72% of older Americans support legal access, with those in the western states polling 82% in favor. The two largest physician-based professional organizations in the U.S., the American Medical Association and the

American College of Physicians, have urged the federal government to reconsider its regulatory classification of cannabis.

For decades, the federal government has maintained the position that cannabis has no medical value, despite the overwhelming evidence of marijuana's medical efficacy and the broad public support for its use. Not to be deterred, Americans have turned to state-based solutions. The laws passed by voters and legislators are intended to mitigate the effects of the federal government's prohibition on medical cannabis by allowing qualified patients to use it without state or local interference.

Fifteen states have adopted medical marijuana laws in the U.S. Beginning with California in 1996, voters passed initiatives in nine states plus the District of Columbia—Alaska, Arizona, Colorado, Maine, Michigan, Montana, Nevada, Oregon, and Washington. State legislatures followed suit, with elected officials in Hawaii, Maryland, New Jersey, New Mexico, Rhode Island, and Vermont taking action to protect patients from criminal penalty. Understanding the need to address safe and affordable access to medical cannabis, Arizona, California, Colorado, Maine, New Jersey, New Mexico, and Rhode Island all adopted local or state laws that regulate its production and distribution.

Despite *Gonzales v. Raich*, a U.S. Supreme Court ruling in 2005 that gave government the discretion to enforce federal cannabis laws even in medical cannabis states, more states continue to adopt laws each year.

With the election of President Barack Obama, a new approach to medical cannabis is taking shape. In October 2009, the Justice Department issued guidelines discouraging U.S. Attorneys from investigating and prosecuting medical cannabis cases. While this new policy specifically addresses enforcement, ASA continues to work with Congress and the President to push for expanded research and protection for all medical cannabis in the U.S. The public advocacy of well-known cannabis patients such as the Emmy-winning talk show host Montel Williams and music artist Melissa Etheridge has also increased public awareness and helped to create political pressure for changes in state and federal policies.

HISTORY OF MEDICAL CANNABIS IN CALIFORNIA

Since 1996, when 56% of California voters approved the Compassionate Use Act (CUA), public support for safe and legal access to medical cannabis has steadily increased. A statewide Field poll in 2004 found that "three in four voters (74%) favors implementation of the law." In 2003, the state legislature recognized that the Compassionate Use Act (CUA) gave little direction to local officials, which greatly impeded the safe and legal access to medical cannabis envisioned by voters.

Legislators passed Senate Bill 420, the Medical Marijuana Program (MMP) Act, which provided a greater blueprint for the implementation of California's medical cannabis law. Since the passage of the MMP, ASA has been responsible for multiple landmark court cases, including *City of Garden Grove v. Superior Court*, *County of San Diego v. San Diego NORML*, and *County of Butte v. Superior Court*. Such cases affirm and expand the rights granted by the CUA and MMP, and at the same time help local officials better implement state law.

In August 2008, California's Attorney General issued a directive to law enforcement on state medical marijuana law. In addition to reviewing the rights and responsibilities of patients and their caregivers, the guidelines affirmed the legality of storefront dispensaries and outlined a set of requirements for state law compliance. The attorney general guidelines also represent a roadmap by which local officials can develop regulatory ordinances for dispensaries.

WHAT IS A MEDICAL CANNABIS DISPENSING COLLECTIVE?

The majority of medical marijuana (cannabis) patients cannot cultivate their medicine for

themselves and cannot find a caregiver to grow it for them. Most of California's estimated 300,000 patients obtain their medicine from a Medical Cannabis Dispensing Collective (MCDC), often referred to as a "dispensary." Dispensaries are typically storefront facilities that provide medical cannabis and other services to patients in need. As of early 2011, ASA estimates there are approximately 2,000 medical cannabis dispensaries in California.

Dispensaries operate with a closed membership that allows only qualified patients and primary caregivers to obtain cannabis, and only after membership is approved (upon verification of patient documentation). Many dispensaries offer on-site consumption, providing a safe and comfortable place where patients can medicate. An increasing number of dispensaries offer additional services for their patient membership, including such services as: massage, acupuncture, legal trainings, free meals, or counseling. Research on the social benefits for patients is discussed in the last section of this report.

RATIONALE FOR MEDICAL CANNABIS DISPENSING COLLECTIVES

While the Compassionate Use Act does not explicitly discuss medical cannabis dispensaries, it calls for the federal and state governments to "implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana" (Health & Safety Code § 11362.5). This portion of the law has been the basis for the development of compassionate, community-based systems of access for patients in various parts of California. In some cases, that has meant the creation of patient-run growing collectives that allow those with cultivation expertise to help other patients obtain medicine. In most cases, particularly in urban settings, that has meant the establishment of medical cannabis dispensing collectives, or dispensaries. These dispensaries are typically organized and run by groups of patients and their caregivers in a collective model of patient-directed health care that is becoming a prototype for the delivery of other health services.

MEDICAL CANNABIS DISPENSARIES ARE LEGAL UNDER STATE LAW

In an effort to clarify the voter initiative of 1996 and aid in its implementation across the state, the California legislature passed the Medical Marijuana Program Act (MMP), or Senate Bill 420, in 2003, establishing that qualified patients and primary caregivers may collectively or cooperatively cultivate and distribute cannabis for medical purposes (Cal. Health & Safety Code section 11362.775). The Act also exempts collectives and cooperatives from criminal sanctions associated with "sales" and maintaining a place where sales occur.

In 2005, California's Third District Court of Appeal affirmed the legality of collectives and cooperatives in the landmark case of *People v. Urziceanu*, which held that the MMP provides collectives and cooperatives a defense to marijuana distribution charges. Another landmark decision from the Third District Court of Appeal in the case of *County of Butte v. Superior Court* (2009) not only affirmed the legality of collectives but also found that collective members could contribute financially without having to directly participate in the cultivation.

In August 2008, the State Attorney General issued guidelines declaring that "a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law." The Attorney General provided law enforcement with a list of operational practices for collectives to help ensure compliance with state law. By adhering to a set of rules—including not-for-profit operation, the collection of sales tax, and the verification of patient status for collective members—dispensaries can operate lawfully and maintain legitimacy. In addition, local officials can use the Attorney General guidelines to help them adopt local regulatory ordinances.

In September 2010, the California Legislature

enacted Assembly Bill 2650, which states that medical marijuana dispensaries must be located further than 600-ft from a school. By recognizing "a medical marijuana cooperative, collective, dispensary, operator, establishment, or provider that is authorized by law to possess, cultivate, or distribute medical marijuana and that has a storefront or mobile retail outlet which ordinarily requires a local business license," the Legislature has expressed its intent that storefront dispensaries and delivery services are legal under California law.

WHY PATIENTS NEED CONVENIENT DISPENSARIES

While some patients with long-term illnesses or injuries have the time, space, and skill to cultivate their own cannabis, the majority of patients, particularly those in urban settings, do not have the ability to produce it themselves. For those patients, dispensaries are the only option for safe and legal access. This is all the more true for those individuals who are suffering from a sudden, acute injury or illness.

Many of the most serious and debilitating injuries and illnesses require immediate relief. A cancer patient, for instance, who has just begun chemotherapy will typically need immediate access for help with nausea, which is why a Harvard study found that 45% of oncologists were already recommending cannabis to their patients, even before it was legal in any state. It is unreasonable to exclude those patients most in need simply because they are incapable of gardening or cannot wait months for relief.

WHAT COMMUNITIES ARE DOING TO HELP PATIENTS

Many communities in California have recognized the essential service that dispensaries provide and have either tacitly allowed their operation or adopted ordinances regulating them. Dispensary regulation is one way in which the cities can exert local control and ensure that the needs of patients and the community at large are being met. As of January 2011, 42 cities and nine counties have enacted regulations, and many more are considering doing so soon.

Officials recognize their duty to implement state laws, even in instances where they may not have previously supported medical cannabis legislation. Duke Martin, former mayor pro tem of Ridgecrest said during a city council hearing on a local dispensary ordinance, "it's something that's the law, and I will uphold the law."

This understanding of civic obligation was echoed at the Ridgecrest hearing by then-Councilmember Ron Carter, now mayor pro tem, who said, "I want to make sure everything is legitimate and above board. It's legal. It's not something we can stop, but we can have an ordinance of regulations."

Similarly, Whittier Planning Commissioner R.D. McDonnell spoke publicly of the benefits of dispensary regulations at a city government hearing. "It provides us with reasonable protections," he said. "But at the same time provides the opportunity for the legitimate operations."

Whittier officials discussed the possibility of an outright ban on dispensary operations, but Councilmember Greg Nordback said, "It was the opinion of our city attorney that you can't ban them; it's against the law. You have to come up with an area they can be in." Whittier passed its dispensary ordinance in December 2005.

Placerville Police Chief George Nielson commented that, "The issue of medical marijuana continues to be somewhat controversial in our community, as I suspect and hear it remains in other California communities. The issue of 'safe access' is important to some and not to others. There was some objection to the dispensary ordinance, but I would say it was a vocal minority on the issue."

IMPACT OF DISPENSARIES AND REGULATORY ORDINANCES ON COMMUNITIES IN CALIFORNIA

DISPENSARIES REDUCE CRIME AND IMPROVE PUBLIC SAFETY

Some reports have suggested that dispensaries are magnets for criminal activity and other undesirable behavior, which poses a problem for the community. But the experience of those cities with dispensary regulations says otherwise. Crime statistics and the accounts of local officials surveyed by ASA indicate that crime is actually reduced by the presence of a dispensary. And complaints from citizens and surrounding businesses are either negligible or are significantly reduced with the implementation of local regulations.

This trend has led multiple cities and counties to consider regulation as a solution. Kern County, which passed a dispensary ordinance in July 2006, is a case in point. The sheriff there noted in his staff report that "regulatory oversight at the local levels helps prevent crime directly and indirectly related to illegal operations occurring under the pretense and protection of state laws authorizing Medical Marijuana Dispensaries." Although dispensary-related crime has not been a problem for the county, the regulations will help law enforcement determine the legitimacy of dispensaries and their patients.

The sheriff specifically pointed out that, "existing dispensaries have not caused noticeable law enforcement problems or secondary effects for at least one year. As a result, the focus of the proposed Ordinance is narrowed to insure Dispensary compliance with the law" (Kern County Staff Report, Proposed Ordinance Regulating Medical Cannabis Dispensaries, July 11, 2006).

The presence of a dispensary in the neighborhood can actually improve public safety and reduce crime. Most dispensaries take security for their members and staff more seriously than many businesses. Security cameras are often used both inside and outside the premises, and security guards are often employed to ensure safety. Both cameras and security guards serve as a general deterrent to criminal activity and other problems on the street. Those likely to engage in such activities tend to move to a less-monitored area, thereby ensuring a safe environment not only for dispensary members and staff, but also for neighbors and businesses in the surrounding area.

Residents in areas surrounding dispensaries have reported improvements to the neighborhood. Kirk C., a long time San Francisco resident, commented at a city hearing, "I have lived in the same apartment along the Divisadero corridor in San Francisco for the past five years. Each store that has opened in my neighborhood has been nicer, with many new restaurants quickly becoming some of the city's hottest spots. My neighborhood's crime and vandalism seems to be going down year after year. It strikes me that the dispensaries have been a vital part of the improvement that is going on in my neighborhood."

Oakland city administrator Barbara Killey, who was responsible for the ordinance regulating dispensaries, noted that "The areas around the dispensaries may be some of the safest areas of Oakland now because of the level of security, surveillance, etc…since the ordinance passed."

Likewise, former Santa Rosa Mayor Jane Bender noted that since her city passed its ordinance, there appears to be "a decrease in criminal activity. There certainly has been a decrease in complaints. The city attorney says there have been no complaints either from citizens or from neighboring businesses."

Neighboring Sebastopol has had a similar experience. Despite public opposition to medical cannabis dispensaries, Sebastopol Police Chief Jeffrey Weaver admitted that for more than two years, "We've had no increased crime associated [with Sebastopol's medical cannabis dispensary], no fights, no loitering, no increase in graffiti, no increase in littering, zip."

"The parade of horrors that everyone predicted has not materialized. The sky has not fallen. To the contrary…California jurisdictions have shown that having medical cannabis in place does not impact…public safety." —San Francisco Supervisor David Campos

Those dispensaries that go through the permitting process or otherwise comply with local ordinances tend, by their very nature, to be those most interested in meeting community standards and being good neighbors. Many local officials surveyed by ASA said dispensaries operating in their communities have presented no problems, or what problems there may have been significantly diminished once an ordinance or other regulation was instituted.

Several officials said that regulatory ordinances had significantly improved relations with other businesses and the community at large. An Oakland city council staff member noted that prior to adopting a local ordinance, the city had received reports of break-ins. However, the council staff member said that with the adoption of Oakland's dispensary ordinance, "That kind of activity has stopped. That danger has been eliminated." Assistant City Administrator Arturo Sanchez, a nuisance enforcement officer, affirmed that since 2004 he has "never received a nuisance complaint concerning lawfully established medical marijuana dispensaries in Oakland…[or] had to initiate an enforcement action."

The absence of any connection between dispensaries and increased local crime can be seen in data from Los Angeles and San Diego. During the two-year period from 2008 to 2010 in which Los Angeles saw the proliferation of more than 500 dispensaries, the overall crime rate in the city dropped considerably. A study commissioned by Los Angeles Police Chief Charlie Beck, comparing the number of crimes in 2009 at the city's banks and medical marijuana dispensaries, found that 71 robberies had occurred at the more than 350 banks in the city, compared to 47 robberies at the more than 500 medical marijuana facilities. Chief Beck observed that, "banks are more likely to get robbed than medical marijuana dispensaries," and that the claim that dispensaries attract crime "doesn't really bear out." In San Diego, where some officials have made similar allegations about increased crime associated with dispensaries, an examination of city police reports by a local paper, the San Diego CityBeat, found that as of late 2009 the number of crimes in areas with dispensaries was frequently lower than it was before the dispensary opened or, at worst, stayed the same.

WHY DIVERSION OF MEDICAL CANNABIS IS TYPICALLY NOT A PROBLEM

One of the concerns of public officials is that dispensaries make possible or even encourage the resale of cannabis on the street. But the experience of those cities that have instituted ordinances is that such problems, which are rare in the first place, quickly disappear. In addition to being monitored by law enforcement, dispensaries universally have strict rules about how members are to behave in and around the facility. Many have "good neighbor" trainings for their members that emphasize sensitivity to the concerns of neighbors, and all dispensaries absolutely prohibit the resale of cannabis. Anyone violating that prohibition is typically banned from any further contact with the dispensary.

As Oakland's city administrator for the regulatory ordinance explains, "dispensaries themselves have been very good at self policing

against resale because they understand they can lose their permit if their patients resell."

In the event of an illegal resale, local law enforcement has at its disposal all of the many legal penalties provided by the state. This all adds up to a safer street environment with fewer drug-related problems than before dispensary operations were permitted in the area. The experience of the City of Oakland is a good example of this phenomenon. The city's legislative analyst, Lupe Schoenberger, stated that, "…[P]eople feel safer when they're walking down the street. The level of marijuana street sales has significantly reduced."

> "The areas around the dispensaries may be some of the most safest areas of Oakland now because of the level of security, surveillance, etc. since the ordinance passed."
> —Barbara Killey, Oakland

Dispensaries operating with the permission of the city are also more likely to appropriately utilize law enforcement resources themselves, reporting any crimes directly to the appropriate agencies. And dispensary operators and their patient members tend to be more safety conscious than the general public, resulting in greater vigilance and better preemptive measures. The reduction of crime in areas around dispensaries has been reported anecdotally by law enforcement in several communities.

DISPENSARIES CAN BE GOOD NEIGHBORS

Medical cannabis dispensing collectives are typically positive additions to the neighborhoods in which they locate, bringing additional customers to neighboring businesses and reducing crime in the immediate area.

Like any new business that serves a different customer base than the existing businesses in the area, dispensaries increase the revenue of other businesses in the surrounding area simply because new people are coming to access services, increasing foot traffic past other establishments. In many communities, the opening of a dispensary has helped revitalize an area. While patients tend to opt for dispensaries that are close and convenient, particularly since travel can be difficult, many patients will travel to dispensary locations in parts of town they would not otherwise visit. Even if patients are not immediately utilizing the services or purchasing the goods offered by neighboring businesses, they are more likely to eventually patronize those businesses because of convenience.

ASA's survey of officials whose cities have passed dispensary regulations found that the vast majority of businesses either adjoining or near dispensaries had reported no problems associated with a dispensary opening after the implementation of regulations.

Kriss Worthington, longtime councilmember in Berkeley, said in support of a dispensary there, "They have been a responsible neighbor and vital organization to our diverse community. Since their opening, they have done an outstanding job keeping the building clean, neat, organized and safe. In fact, we have had no calls from neighbors complaining about them, which is a sign of respect from the community. In Berkeley, even average restaurants and stores have complaints from neighbors."

Mike Rotkin, councilmember and former mayor of the City of Santa Cruz, said about the dispensary that opened there last year, "The immediately neighboring businesses have been uniformly supportive or neutral. There have been no complaints either about establishing it or running it."

And Dave Turner, mayor of Fort Bragg, noted that before the passage of regulations there were "plenty of complaints from both neighboring businesses and concerned citizens," but since then, it is no longer a problem. Public officials understand that, when it comes to dispensaries, they must balance both the humanitarian needs of patients and the

concerns of the public, especially those of neighboring residents and business owners.

Oakland City Councilmember Nancy J. Nadel wrote in an open letter to her fellow colleagues across the state, "Local government has a responsibility to the medical needs of its people, even when it's not a politically easy choice to make. We have found it possible to build regulations that address the concerns of neighbors, local businesses, law enforcement and the general public, while not compromising the needs of the patients themselves. We've found that by working with all interested parities in advance of adopting an ordinance while keeping the patients' needs foremost, problems that may seem inevitable never arise."

Mike Rotkin of Santa Cruz stated that since the city enacted an ordinance for dispensaries, "Things have calmed down. The police are happy with the ordinance, and that has made things a lot easier. I think the fact that we took the time to give people who wrote us respectful and detailed explanations of what we were doing and why made a real difference."

BENEFITS OF DISPENSARIES TO THE PATIENT COMMUNITY

DISPENSARIES PROVIDE MANY BENEFITS TO THE SICK AND SUFFERING

Safe and legal access to cannabis is the reason dispensaries have been created by patients and caregivers around the state. For many people, dispensaries remove significant barriers to obtaining cannabis. Patients in urban areas with no space to cultivate cannabis, those without the requisite gardening skills to grow their own, and, most critically, those who face the sudden onset of a serious illness or who have suffered a catastrophic illness—all tend to rely on dispensaries as a compassionate, community-based solution as a preferable alternative to potentially dangerous illicit market transactions.

Many elected officials in California recognize the importance of dispensaries to their constituents. As Nathan Miley, former Oakland city councilmember and now Alameda County supervisor said in a letter to his colleagues, "When designing regulations, it is crucial to remember that at its core this is a healthcare issue, requiring the involvement and leadership of local departments of public health. A pro-active healthcare-based approach can effectively address problems before they arise, and communities can design methods for safe, legal access to medical marijuana while keeping the patients' needs foremost."

West Hollywood Mayor John Duran agreed, noting that with the high number of HIV-positive residents in the area, "Some of them require medical marijuana to offset the medications they take for HIV."

Jane Bender, former mayor of Santa Rosa, says, "There are legitimate patients in our community, and I'm glad they have a safe means of obtaining their medicine."

And Mike Rotkin of Santa Cruz said that this is also an important matter for his city's citizens: "The council considers it a high priority and has taken considerable heat to speak out and act on the issue."

It was a similar decision of social conscience

that lead to Placerville's city council putting a regulatory ordinance in place. Former Councilmember Marian Washburn told her colleagues that "as you get older, you know people with diseases who suffer terribly, so that is probably what I get down to after considering all the other components."

"There are legitimate patients in our community, and I'm glad they have a safe means of obtaining their medicine." —Jane Bender, Santa Rosa

While dispensaries provide a unique way for patients to obtain the cannabis their doctors have recommended, they typically offer far more that is of benefit to the health and welfare of those suffering from both chronic and acute medical problems.

Dispensaries are often called "clubs" in part because many of them offer far more than a clinical setting for obtaining cannabis. Recognizing the isolation that many seriously ill and injured people experience, many dispensary operators choose to offer a wider array of social services, including everything from a place to congregate and socialize to help with finding housing and offering meals. The social support patients receive in these settings has far-reaching benefits that also influences the development of other patient-based care models.

RESEARCH SUPPORTS THE DISPENSARY MODEL

A 2006 study by Amanda Reiman, Ph.D. of the School of Social Welfare at the University of California, Berkeley examined the experience of 130 patients spread among seven different dispensaries in the San Francisco Bay Area. Dr. Reiman's study cataloged the patients' demographic information, health status, consumer satisfaction, and use of services, while also considering the dispensaries' environment, staff, and services offered. The study found that "medical cannabis patients have created a system of dispensing medical cannabis that also includes services such as counseling, entertainment and support groups, all important components of coping with chronic illness." She also found that levels of satisfaction with the care received at dispensaries ranked significantly higher than those reported for health care nationally.

Patients who use the dispensaries studied uniformly reported being well satisfied with the services they received, giving an 80% satisfaction rating. The most important factors for patients in choosing a medical cannabis dispensary were: feeling comfortable and secure, familiarity with the dispensary, and having a rapport with the staff. In their comments, patients tended to note the helpfulness and kindness of staff and the support found in the presence of other patients.

MANY DISPENSARIES PROVIDE KEY HEALTH AND SOCIAL SERVICES

Dispensaries offer many cannabis-related services that patients cannot otherwise obtain. Among them is an array of cannabis varieties, some of which are more useful for certain afflictions than others, and staff awareness of what types of cannabis other patients report to be helpful. In other words, one variety of cannabis may be effective for pain control while another may be better for combating nausea. Dispensaries allow for the pooling of information about these differences and the opportunity to access the type of cannabis likely to be most beneficial.

Cannabis-related services include making cannabis available in other forms for patients who cannot or do not want to smoke it. While most patients prefer to have the ability to modulate the dosing that smoking easily allows, for others, the effects of extracts or edible cannabis products are preferable. Dispensaries typically offer a wide array of edible products for those purposes. Many dispensaries also offer classes on how to grow your own

cannabis, classes on legal matters, trainings for health-care advocacy, and other seminars.

Beyond providing safe and legal access to cannabis, the dispensaries studied also offer important social services to patients, including counseling, help with housing and meals, hospice and other care referrals. Among the broader services the study found in dispensaries are support groups, including groups for women, veterans, and men; creativity and art groups, including groups for writers, quilters, crochet, and crafts; and entertainment options, including bingo, open mic nights, poetry readings, internet access, libraries, and puzzles. Clothing drives and neighborhood parties are among the activities that patients can also participate in through their dispensary.

Examples of health services offered at dispensaries across California:

- Naturopathic medicine
- Reiki
- Ayurvedic medicine
- Chinese medicine
- Chiropractic medicine
- Acupuncture
- Massage
- Craniosacral Therapy
- Rolfing Therapy
- Group & Individual Yoga Instruction
- Hypnotherapy
- Homeopathy
- Western Herbalists
- Individual Counseling
- Integrative Health Counseling
- Nutrition & Diet Counseling
- Limited Physical Therapy
- Medication Interaction Counseling
- Condition-based Support Groups

Social services such as counseling and support groups were reported to be the most commonly and regularly used, with two-thirds of patients reporting that they use social services at dispensaries one to two times per week. Additionally, life services such as free food and housing help were used at least once or twice a week by 22% of those surveyed.

"Local government has a responsibility to the medical needs of its people, even when it's not a politically easy choice to make. We have found it possible to build regulations that address the concerns of neighbors, local businesses law enforcement and the general public, while not compromising the needs of the patients themselves. We've found that by working with all interested parties in advance of adopting an ordinance, while keeping the patients' needs foremost, problems that may seem inevitable never arise."

—Nancy Nadel, Oakland

Dispensaries offer chronically ill patients even more than safe and legal access to cannabis and an array of social services. The study found that dispensaries also provided other social benefits for the chronically ill, an important part of the bigger picture:

> Beyond the support that medical cannabis patients receive from services is the support received from fellow patients, some of whom are experiencing the same or similar physical/psychological symptoms… It is possible that the mental health benefits derived from the social support of fellow patients is an important part of the healing process, separate from the medicinal value of the cannabis itself.

Several researchers and physicians who have studied the issue of the patient experience with dispensaries have concluded that there are other important positive effects stemming from a dispensary model that includes a component of social support groups.

Dr. Reiman notes that, "support groups may have the ability to address issues besides the illness itself that might contribute to long-term physical and emotional health outcomes,

such as the prevalence of depression among the chronically ill."

For those who suffer the most serious illnesses, such as HIV/AIDS and terminal cancer, groups of people with similar conditions can also help fellow patients through the grieving process. Many patients who have lost or are losing friends and partners to terminal illness report finding solace with other patients who are also grieving or facing end-of-life decisions. A medical study published in 1998 concluded that the patient-to-patient contact associated with the social club model was the best therapeutic setting for ill people.

Cannabis dispensaries have been operating successfully in California for more than 14

CONCLUSION

After more than 14 years of existence, dispensaries are proving to be an asset to the communities they serve, as well as the larger community in which they operate. This is especially the case when public officials choose to implement local ordinances that recognize the lawful operation of dispensaries. Since the Medical Marijuana Program Act was enacted by the California legislature in 2004, more than 50 localities have adopted ordinances regulating dispensaries.

By surveying local officials and monitoring regulatory activity throughout the State of California, ASA has shown that once working regulatory ordinances are in place, dispensaries are typically viewed favorably by public officials, neighbors, businesses, and the community at large, and that regulatory ordinances can and do improve an area, both socially and economically.

Dispensaries—now expressly legal under California state law—are helping revitalize neighborhoods by reducing crime and bringing new customers to surrounding businesses. They improve public safety by increasing the security presence in neighborhoods, reducing illicit market marijuana sales, and ensuring that any criminal activity gets reported to the appropriate law enforcement authorities.

More importantly, dispensaries benefit the community by providing safe access for those who have the greatest difficulty getting the medicine their doctors recommend: the most seriously ill and injured. Many dispensaries also offer essential services to patients, such as help with food and housing.

Medical and public health studies have also shown that the social-club model of most dispensaries is of significant benefit to the overall health of patients. The result is that medical cannabis patients rate their satisfaction with dispensaries as far greater than the customer satisfaction ratings given to health care agencies in general.

Public officials across the state, in both urban and rural communities, have been outspoken in praise of the dispensary regulatory schemes they enacted and the benefits to the patients and others living in their communities.

As a compassionate, community-based response to the medical needs of more than 300,000 sick and suffering Californians, dispensaries, and the regulations under which they operate, are working.

years with very few problems. And, although the legislature and courts have acted to make dispensaries legal under state law, the question of how to implement appropriate zoning laws and business licensing is still coming before local officials all across the state. What follows are recommendations on matters to consider, based on adopted code as well as ASA's extensive experience working with community leaders and elected officials.

COMMUNITY OVERSIGHT

In order to appropriately resolve conflict in the community and establish a process by which complaints and concerns can be reviewed, it can often be helpful to create a community oversight committee. Such committees, if fair and balanced, can provide a means for the voices of all affected parties to be heard, and to quickly resolve problems.

The Ukiah City Council created such a task force in 2005; what follows is how they defined the group:

> The Ukiah Medical Marijuana Review and Oversight Commission shall consist of seven members nominated and appointed pursuant to this section. The Mayor shall nominate three members to the commission, and the City Council shall appoint, by motion, four other members to the commission…
>
> Of the three members nominated by the Mayor, the Mayor shall nominate one member to represent the interests of City neighborhood associations or groups, one member to represent the interests of medical marijuana patients, and one member to represent the interests of the law enforcement community.
>
> Of the four members of the commission appointed by the City Council, two members shall represent the interests of City neighborhood associations or groups, one member shall represent the interests of the medical marijuana community, and one member shall represent the interests of the public health community.

ADMINISTRATION OF DISPENSARY REGULATIONS ARE BEST HANDLED BY HEALTH OR PLANNING DEPARTMENTS, NOT LAW ENFORCEMENT AGENCIES

Reason: To ensure that qualified patients, caregivers, and dispensaries are protected, general regulatory oversight duties—including permitting, record maintenance, and related protocols—should be the responsibility of the local department of public health (DPH) or planning department. Given the statutory mission and responsibilities of DPH, it is the natural choice and best-suited agency to address the regulation of medical cannabis dispensing collectives. Law enforcement agencies are ill-suited for handling such matters, having little or no expertise in health and medical affairs.

Examples of responsible agencies and officials:

- Angels Camp—City Administrator
- Citrus Heights—City Manager
- Cotati—City Manager
- Dunsmuir—Planning Commission
- Eureka--Dept of Community Development
- Laguna Woods—City Manager
- Long Beach—Financial Management
- Los Angeles—Building and Safety
- Malibu—City Manager
- Napa—City Council
- Palm Springs—City Manager

- Plymouth—City Administrator
- Sebastopol—Planning Department
- San Francisco—Dept. of Public Health
- San Mateo—License Committee
- Santa Barbara—Community Development
- Selma—City Manager
- Stockton—City Manager
- Visalia—City Planner

ARBITRARY CAPS ON THE NUMBER OF DISPENSARIES CAN BE COUNTER-PRODUCTIVE

Reason: Policymakers do not need to set arbitrary limitations on the number of dispensing collectives allowed to operate because, as with other services, competitive market forces and consumer choice will be decisive. Dispensaries that provide quality care and patient services to their memberships will flourish, while those that do not will fail.

Capping the number of dispensaries limits consumer choice, which can result in both decreased quality of care and less affordable medicine. Limiting the number of dispensing collectives allowed to operate may also force patients with limited mobility to travel farther for access than they would otherwise need to.

Artificially limiting the supply for patients can result in an inability to meet demand, which in turn may lead to unintended and undesirable effects such as lines outside of dispensaries, increased prices, and lower quality medicine, in addition to increased illicit-market activity.

Examples of cities and counties without numerical caps on dispensaries:

- Dunsmuir
- Fort Bragg
- Laguna Woods
- Long Beach
- Placerville
- Redding
- Ripon
- San Mateo
- Santa Barbara
- Selma
- Tulare
- Calaveras County
- Kern County
- City and County of San Francisco
- San Mateo County
- Sonoma County

RESTRICTIONS ON WHERE DISPENSARIES CAN LOCATE ARE OFTEN UNNECESSARY AND CAN CREATE BARRIERS TO ACCESS

Reason: As described in this report, regulated dispensaries do not generally increase crime or bring other harm to their neighborhoods, regardless of where they are located. And since travel is difficult for many patients, cities and counties should take care to avoid unnecessary restrictions on where dispensaries can locate. Patients benefit from dispensaries being convenient and accessible, especially if the patients are disabled or have conditions that limit their mobility.

It is unnecessary and burdensome for patients and providers to restrict dispensaries to industrial corners, far away from public transit and other services. Depending on a city's population density, it can also be extremely detrimental to set excessive proximity restrictions (to residences, schools or other facilities) that can make it impossible for dispensaries to locate anywhere within the city limits, thereby establishing a de facto ban on dispensing. It is important to balance patient needs with neighborhood concerns in this process.

PATIENTS BENEFIT FROM ON-SITE CONSUMPTION AND PROPER VENTILATION SYSTEMS

Reason: Dispensaries that allow members to consume medicine on-site have positive psychosocial health benefits for chronically ill people who are otherwise isolated. On-site consumption encourages dispensary members to take advantage of the support services that can improve their quality of life and, in some cases, even prolong it. Researchers have shown that support groups like those offered by dispensaries are effective for patients with a variety of serious illnesses. Participants active

in support services are less anxious and depressed, make better use of their time, and are more likely to return to work than patients who receive only standardized care, regardless of whether they have serious psychiatric symptoms. On-site consumption is also important for patients who face restrictions to off-site consumption, such as those in subsidized or other housing arrangements that prohibit smoking. In addition, on-site consumption provides an opportunity for patients to share information about effective use of cannabis and of specialized delivery methods, such as vaporizers, which do not require smoking.

Examples of localities that permit on-site consumption (many stipulate ventilation requirements):

- Alameda County
- Berkeley
- Kern County
- Laguna Woods
- Richmond
- San Francisco
- San Mateo County
- South El Monte

DIFFERENTIATING DISPENSARIES FROM PRIVATE PATIENT COLLECTIVES IS IMPORTANT

Reason: Private patient collectives, in which several patients grow their medicine collectively at a private location, should not be required to follow the same restrictions that are placed on retail dispensaries, since they are a different type of operation. A too-broadly written ordinance may inadvertently put untenable restrictions on individual patients and caregivers who are providing either for themselves or a few others.

Example: Santa Rosa's adopted ordinance, provision 10-40.030 (F):

> "Medical cannabis dispensing collective," hereinafter "dispensary," shall be construed to include any association, cooperative, affiliation, or collective of persons where multiple "qualified patients" and/or "primary care givers," are organized to provide education, referral, or network services, and facilitation or assistance in the lawful, "retail" distribution of medical cannabis. "Dispensary" means any facility or location where the primary purpose is to dispense medical cannabis (i.e., marijuana) as a medication that has been recommended by a physician and where medical cannabis is made available to and/or distributed by or to two or more of the following: a primary caregiver and/or a qualified patient, in strict accordance with California Health and Safety Code Section 11362.5 et seq. A "dispensary" shall not include dispensing by primary caregivers to qualified patients in the following locations and uses, as long as the location of such uses are otherwise regulated by this Code or applicable law: a clinic licensed pursuant to Chapter 1 of Division 2 of the Health and Safety Code, a health care facility licensed pursuant to Chapter 2 of Division 2 of the Health and Safety Code, a residential care facility for persons with chronic life-threatening illness licensed pursuant to Chapter 3.01 of Division 2 of the Health and Safety Code, residential care facility for the elderly licensed pursuant to Chapter 3.2 of Division 2 of the Health and Safety Code, a residential hospice, or a home health agency licensed pursuant to Chapter 8 of Division 2 of the Health and Safety Code, as long as any such use complies strictly with applicable law including, but not limited to, Health and Safety Code Section 11362.5 et seq., or a qualified patient's or caregiver's place of residence.

PATIENTS BENEFIT FROM ACCESS TO EDIBLES AND MEDICAL CANNABIS CONSUMPTION DEVICES

Reason: Not all patients can or want to smoke cannabis. Many find tinctures (cannabis extracts) or edibles (such as baked goods containing cannabis) to be more effective for their conditions. Allowing dispensaries to

carry these items is vital to patients getting the best level of care possible. For patients who have existing respiration problems or who otherwise have an aversion to smoking, edibles and extracts are essential.

Conversely, for patients who do choose to smoke or vaporize, they need to procure the tools to do so. Prohibiting dispensaries from carrying medical cannabis consumption devices, often referred to as paraphernalia, forces patients to go elsewhere to procure these items. Additionally, when dispensaries do carry these devices, informed dispensary staff can explain their usage, and different functions, to new patients.

Examples of localities allowing dispensaries to carry edibles and delivery devices:

- Albany
- Angels Camp
- Berkeley
- Cotati
- Citrus Heights
- Eureka
- Laguna Woods
- Long Beach
- Los Angeles (city of)
- Malibu
- Napa
- Palm Springs
- Redding
- Richmond
- Santa Barbara
- Santa Cruz
- Sebastopol
- South El Monte
- Stockton
- Sutter Creek
- West Hollywood
- Alameda County
- Kern County
- Sonoma County

RESOURCES FOR MORE INFORMATION

A downloadable PDF of this report is online at AmericansForSafeAccess.org/DispensaryReport

A model dispensary ordinance can be seen at AmericansForSafeAccess.org/ModelOrdinance.

A regularly updated list of ordinances, moratoriums, and bans adopted by California cities and counties can be found at AmericansForSafeAccess.org/regulations.

You can find ASA chapters in your area at AmericansForSafeAccess.org/Chapters.

ASA Blog
AmericansForSafeAccess.org/blog

ASA Forums
AmericansForSafeAccess.org/forum

Medical and Scientific Information
AmericansForSafeAccess.org/medical

Legal Information
AmericansForSafeAccess.org/legal

Become a member of ASA
AmericansForSafeAccess.org/join

Contact ASA to order the DVD "Medical Cannabis in California"—interviews with elected officials and leaders who are implementing safe and effective regulations.

APPENDIX A

CALIFORNIA CITIES AND COUNTIES THAT HAVE ADOPTED ORDINANCES REGULATING DISPENSARIES

(as of February 2011)

For an updated list, go to:
AmericansForSafeAccess.org/regulations

City Ordinances (42)

- Albany
- Angels Camp
- Berkeley
- Citrus Heights
- Cotati
- Diamond Bar
- Dunsmuir
- Eureka
- Fort Bragg
- Jackson
- La Puente
- Laguna Woods
- Long Beach
- Los Angeles
- Malibu
- Mammoth Lakes
- Martinez
- Napa
- Oakland
- Palm Springs
- Placerville
- Plymouth
- Redding
- Richmond
- Ripon
- Sacramento
- San Carlos
- San Francisco
- San Jose
- San Mateo
- Santa Barbara
- Santa Cruz
- Santa Rosa
- Sebastopol
- Selma
- South El Monte
- Stockton
- Tulare
- Visalia
- West Hollywood
- Whittier
- Yucca Valley

County Ordinances (9)

- Alameda
- Calaveras
- Kern
- San Luis Obispo
- San Mateo
- Santa Barbara
- Santa Clara
- Sonoma

APPENDIX B

ASA'S QUICK GUIDE FOR EVALUATING PROPOSED MEDICAL MARIJUANA DISPENSARY ORDINANCES IN CALIFORNIA

This is a quick guide to what should and should not be in city and county ordinances to best support safe access for medical cannabis patients.

What the ordinance MUST include:

- Allowance for over-the-counter/storefront sales (sometimes called reimbursements, contributions, or not-for-profit sales)
- Allowance for patients to medicate on-site
- Allowance for sale of cannabis edibles and concentrated extracts
- Distinction between Medical Cannabis Dispensing Collectives (MCDCs) and private patient collectives or cooperatives

What to look out for in proposed ordinances:

Is the general language and focus framed as a medical or healthcare issue, rather than a criminal justice or law enforcement problem?

Does the ordinance affirm that MCDCs should be organized to serve patients and have a "not-for-profit" business model?

Is there a cap on the number of MCDCs allowed to operate that could negatively impact accessibility, affordability and quality?

- How was the MCDC cap number determined (per capita, per pharmacy)?
- What criteria will be used to approve and license MCDCs?
- Will quality through competition be supported?

Zoning considerations:

- Will each MCDC be required to apply for a conditional use permit, or does the ordinance specify MCDCs as an enumerated business?
- Are there proximity restrictions or "buffer zones" from so-called "sensitive uses" which will make locating a dispensary onerous?
- Has a map been prepared that shows where the ordinance will require MCDCs to locate?

.

Does the ordinance provide for a community oversight committee tasked with any licensing or appeals processes?

- Will the oversight committee include patients, activists, MCDC operators, and members of the local community?

.

What are the MCDC requirements for book-keeping and records disclosure?

- Does the ordinance allow MCDCs to keep identifying information about its members off-site, to protect patient identities?
- Does law enforcement have unfettered access to patient records or is a subpoena required?

.

Are there caps on the number of patient-members an MCDC can serve?

Is on-site cultivation prohibited for MCDCs?

APPENDIX C

ATTORNEY GENERAL, STATE OF CALIFORNIA, GUIDELINES FOR THE SECURITY AND NON-DIVERSION OF MARIJUANA GROWN FOR MEDICAL USE

August 2008

GUIDELINES REGARDING COLLECTIVES AND COOPERATIVES

Under California law, medical marijuana patients and primary caregivers may "associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes" (§ 11362.775) .The following guidelines are meant to apply to qualified patients and primary caregivers who come together to collectively or cooperatively cultivate physician-recommended marijuana.

A. **Business Forms**: Any group that is collectively or cooperatively cultivating and distributing marijuana for medical purposes should be organized and operated in a manner that ensures the security of the crop and safeguards against diversion for non-medical purposes. The following are guidelines to help cooperatives and collectives operate within the law, and to help law enforcement determine whether they are doing so.

1. **Statutory Cooperatives**: A cooperative must file articles of incorporation with the state and conduct its business for the mutual benefit of its members (Corp. Code, § 12201, 12300). No business may call itself a "cooperative" (or "coop") unless it is properly organized and registered as such a corporation under the Corporations or Food and Agricultural Code (Id. at § 12311(b)). Cooperative corporations are "democratically controlled and are not organized to make a profit for themselves, as such, or for their members, as such, but primarily for their members as patrons" (Id. at § 12201). The earnings and savings of the business must be used for the general welfare of its members or equitably distributed to members in the form of cash, property, credits, or services. (Ibid.) Cooperatives must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from individual members each year (id. at § 12200, et seq). Agricultural cooperatives are likewise nonprofit corporate entities "since they are not organized to make profit for themselves, as such, or for their members, as such, but only for their members as producers" (Food & Agric. Code, § 54033). Agricultural cooperatives share many characteristics with consumer cooperatives (e.g., id. at § 54002, et seq). Cooperatives should not purchase marijuana from, or sell to, non-members; instead, they should only provide a means for facilitating or coordinating transactions between members.

2. **Collectives**: California law does not define collectives, but they are commonly defined as "a business, farm, etc., jointly owned and operated by the members of a group." Applying this definition, a collective should be an organization that merely facilitates the collaborative efforts of patient and caregiver members—including the allocation of costs and revenues. As such, a collective is not a statutory entity, but as a practical matter it might have to organize as some form of business to carry out its activities. The collective should not purchase marijuana from, or sell to, non-members; instead, it should only provide a means for facilitating or coordinating transactions among members.

B. **Guidelines for the Lawful Operation of a Cooperative or Collective**: Collectives and cooperatives should be organized with sufficient structure to ensure security, non-diversion of marijuana to illicit markets, and compliance with all state and local laws. The following are some suggested guidelines and practices for operating collective growing

operations to help ensure lawful operation. 1. Non-Profit Operation: Nothing in Proposition 215 or the MMP authorizes collectives, cooperatives, or individuals to profit from the sale or distribution of marijuana. (See, e.g., § 11362.765(a) ["nothing in this section shall authorize . . . any individual or group to cultivate or distribute marijuana for profit"].

2. **Business Licenses, Sales Tax, and Sellers' Permits**: The State Board of Equalization has determined that medical marijuana transactions are subject to sales tax, regardless of whether the individual or group makes a profit, and those engaging in transactions involving medical marijuana must obtain a Seller's Permit. Some cities and counties also require dispensing collectives and cooperatives to obtain business licenses.

3. **Membership Application and Verification**: When a patient or primary caregiver wishes to join a collective or cooperative, the group can help prevent the diversion of marijuana for non-medical use by having potential members complete a written membership application. The following application guidelines should be followed to help ensure that marijuana grown for medical use is not diverted to illicit markets:

a) Verify the individual's status as a qualified patient or primary caregiver. Unless he or she has a valid state medical marijuana identification card, this should involve personal contact with the recommending physician (or his or her agent), verification of the physician's identity, as well as his or her state licensing status. Verification of primary caregiver status should include contact with the qualified patient, as well as validation of the patient's recommendation. Copies should be made of the physician's recommendation or identification card, if any;
b) Have the individual agree not to distribute marijuana to non-members;
c) Have the individual agree not to use the marijuana for other than medical purposes;
d) Maintain membership records on-site or have them reasonably available;
e) Track when members' medical marijuana recommendation and/or identification cards expire; and
f) Enforce conditions of membership by excluding members whose identification card or physician recommendation are invalid or have expired, or who are caught diverting marijuana for non-medical use.

4. **Collectives Should Acquire, Possess, and Distribute Only Lawfully Cultivated Marijuana**: Collectives and cooperatives should acquire marijuana only from their constituent members, because only marijuana grown by a qualified patient or his or her primary caregiver may lawfully be transported by, or distributed to, other members of a collective or cooperative (§§ 11362.765, 11362.775). The collective or cooperative may then allocate it to other members of the group. Nothing allows marijuana to be purchased from outside the collective or cooperative for distribution to its members. Instead, the cycle should be a closed circuit of marijuana cultivation and consumption with no purchases or sales to or from non-members. To help prevent diversion of medical marijuana to nonmedical markets, collectives and cooperatives should document each member's contribution of labor, resources, or money to the enterprise. They also should track and record the source of their marijuana.

5. **Distribution and Sales to Non-Members are Prohibited**: State law allows primary caregivers to be reimbursed for certain services (including marijuana cultivation), but nothing allows individuals or groups to sell or distribute marijuana to non-members. Accordingly, a collective or cooperative may not distribute medical marijuana to any person who is not a member in good standing of the organization. A dispensing collective or cooperative may credit its members for marijuana they provide to the collective, which it may then allocate to other members (§ 11362.765(c)). Members also may reimburse the collective or cooperative for marijuana that has been allocated to them. Any monetary reimbursement that members provide to the collective or cooperative should only be an amount necessary to cover overhead costs and operating expenses.

6. **Permissible Reimbursements and Allocations**: Marijuana grown at a collective or cooperative for medical purposes may be:

a) Provided free to qualified patients and

primary caregivers who are members of the collective or cooperative;

b) Provided in exchange for services rendered to the entity;

c) Allocated based on fees that are reasonably calculated to cover overhead costs and operating expenses; or d) Any combination of the above.

7. **Possession and Cultivation Guidelines**: If a person is acting as primary caregiver to more than one patient under section 11362.7(d)(2), he or she may aggregate the possession and cultivation limits for each patient. For example, applying the MMP's basic possession guidelines, if a caregiver is responsible for three patients, he or she may possess up to 24 oz. of marijuana (8 oz. per patient) and may grow 18 mature or 36 immature plants. Similarly, collectives and cooperatives may cultivate and transport marijuana in aggregate amounts tied to its membership numbers. Any patient or primary caregiver exceeding individual possession guidelines should have supporting records readily available when:

a) Operating a location for cultivation;
b) Transporting the group's medical marijuana; and
c) Operating a location for distribution to members of the collective or cooperative.

8. **Security**: Collectives and cooperatives should provide adequate security to ensure that patients are safe and that the surrounding homes or businesses are not negatively impacted by nuisance activity such as loitering or crime. Further, to maintain security, prevent fraud, and deter robberies, collectives and cooperatives should keep accurate records and follow accepted cash handling practices, including regular bank runs and cash drops, and maintain a general ledger of cash transactions.

C. **Enforcement Guidelines**: Depending upon the facts and circumstances, deviations from the guidelines outlined above, or other indicia that marijuana is not for medical use, may give rise to probable cause for arrest and seizure. The following are additional guidelines to help identify medical marijuana collectives and cooperatives that are operating outside of state law.

1. **Storefront Dispensaries**: Although medical marijuana "dispensaries" have been operating in California for years, dispensaries, as such, are not recognized under the law. As noted above, the only recognized group entities are cooperatives and collectives (§ 11362.775). It is the opinion of this Office that a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law, but that dispensaries that do not substantially comply with the guidelines set forth in sections IV(A) and (B), above, are likely operating outside the protections of Proposition 215 and the MMP, and that the individuals operating such entities may be subject to arrest and criminal prosecution under California law. For example, dispensaries that merely require patients to complete a form summarily designating the business owner as their primary caregiver—and then offering marijuana in exchange for cash "donations" - are likely unlawful (*Peron*, supra, 59 Cal.App.4th at p. 1400 [cannabis club owner was not the primary caregiver to thousands of patients where he did not consistently assume responsibility for their housing, health, or safety]).

2. **Indicia of Unlawful Operation**: When investigating collectives or cooperatives, law enforcement officers should be alert for signs of mass production or illegal sales, including (a) excessive amounts of marijuana, (b) excessive amounts of cash, (c) failure to follow local and state laws applicable to similar businesses, such as maintenance of any required licenses and payment of any required taxes, including sales taxes, (d) weapons, (e) illicit drugs, (f) purchases from, or sales or distribution to, non-members, or (g) distribution outside of California.

APPENDIX D — MODEL ORDINANCE

MODEL ORDINANCE FOR COLLECTIVES

WHEREAS voters approved Proposition 215 in 1996 to ensure that seriously ill Californians have the right to obtain and use cannabis for medical purposes and to encourage elected officials to implement a plan for the safe and affordable distribution of medicine; and

WHEREAS the California State Legislature adopted Senate Bill 420, the Medical Marijuana Program Act, in 2003 to help clarify and further implement Proposition 215 in part by authorizing qualified patients and primary caregivers to associate within the State of California in order to collectively or cooperatively cultivate cannabis for medical purposes; and

WHEREAS the California Attorney General published "Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Purposes" in 2008, acknowledging that "a properly organized and operated collective of cooperative that dispenses medical marijuana through a storefront may be lawful under California law," provided the facility substantially complies with state law; and

WHEREAS crime statistics and the accounts of local officials surveyed by Americans for Safe Access indicate that crime is actually reduced by the presence of a Medical Cannabis Dispensing Collective (MCDC); and complaints from citizens and surrounding businesses are either negligible or are significantly reduced with the implementation of sensible regulations; and

WHEREAS California courts have upheld the legality of MCDCs under state law, including *People v. Hochanadel*, 98 Cal.Rptr.3d 347, and *People v. Urziceanu*, 132 Cal.App.4th 747;

THEREFORE, BE IT RESOLVED That ______ does hereby enact the following:

Purposes and Intent

(1) To implement the provisions of California Health and Safety Code Sections 11362.5 and 11362.7, et seq., as described by the California Attorney General in "Guidelines For The Security And Non-diversion Of Marijuana Grown For Medical Use," published August 2008, which states in Section IV(C)(1) that "a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law," provided the facility substantially complies with the guidelines.

(2) To help ensure that seriously ill ______ residents can obtain and use cannabis for medical purposes where that medical use has been deemed appropriate by a physician in accordance with California law.

(3) To help ensure that the qualified patients and their primary caregivers who obtain or cultivate cannabis solely for the qualified patient's medical treatment are not subject to arrest, criminal prosecution, or sanction.

(4) To protect citizens from the adverse impacts of unregulated medical cannabis distribution, storage, and use practices.

(5) To establish a new section in the ______ code pertaining to the permitted distribution of medical cannabis in ______ consistent with state law.

Nothing in this ordinance purports to permit activities that are otherwise illegal under state or local law.

Definitions

The following phrases, when used in this Chapter, shall be construed as defined in California Health and Safety Code Sections 11362.5 and 11362.7:

"Person with an identification card;"
"Identification card;"
"Primary caregiver;" and
"Qualified patient."

The following phrases, when used in this Chapter, shall be construed as defined below:

"Medical Cannabis Dispensing Collective" or "MCDC". Qualified p atients, persons with identification cards and designated primary caregivers of qualified patients and persons with identification cards who associate, as an incorporated or unincorporated association, within ______, in order to collectively or cooperatively provide medical marijuana from a licensed or permitted location pursuant to this Chapter, for use exclusively by their registered members, in strict accordance with California Health and Safety Code Sections 11362.5 and 11362.7, et seq.

"Director." The Director of Planning or other person authorized to issue a Conditional Use Permit pursuant to ______ code.

Cities and counties may issue a business license or a Conditional Use Permit (CUP) to regulate MCDCs. If a jurisdiction opts for a business license model, the language in the following sections may be replaced with language authorizing the issuance of a business license by amending the appropriate code Sections: Conditional Use Permit Required, Application Procedures, and Findings.

Conditional Use Permit Required

A Conditional Use Permit shall be required to establish or operate a Medical Cannabis Dispensing Collective (MCDC) in compliance with the requirements of this Chapter when located in Commercial, Manufacturing, or Retail Zones.

Application Procedure

(1) In addition to ensuring compliance with the application procedures specified in Section ______, the Director shall send copy of the application and related materials to all other relevant City departments for their review and comment.

(2) A disclaimer shall be put on the MCDC zoning application forms that shall include the following:

   a. A warning that the MCDC operators and their employees may be subject to prosecution under federal law; and

   b. A disclaimer that the City will not accept any legal liability in the connection with any approval and/or subsequent operation of an MCDC.

Findings

In addition to the findings required to establish compliance with the provisions of Section ______, approval of a Conditional Use Permit for an MCDC shall require the following findings:

(1) That the requested use at the proposed location will not adversely affect the economic welfare of the community in which it is located;

(2) That the requested use at the proposed location is outside a Residential Zone;

(3) That the exterior appearance of the structure will be consistent with the exterior appearance of structures already constructed or under construction within the immediate neighborhood, so as to prevent blight or deterioration, or substantial diminishment or impairment of property values within the neighborhood.

Location

The location at which an MCDC distributes medical cannabis must meet the following requirements:

(1) The location must be in a Non-Residential Zone appropriate for Commercial, Manufacturing, or Retail uses, including health care use;

(2) The location must not be within a 600-foot radius of a school, as measured in Section 11362.768 of the California Health and Safety Code;

(3) The location must not be within 1,000 feet of another MCDC.

Police Department Procedures and Training

(1) Within six months of the date that this Chapter becomes effective, the training materials, handbooks, and printed procedures of the Police Department shall be updated to reflect its provisions. These updated materials shall be made available to police officers in the regular course of their training and service.

(2) Medical cannabis-related activities shall be the lowest possible priority of the Police Department.

(3) Qualified patients, their primary caregivers, and MCDCs who come into contact with law enforcement shall not be cited or arrested and dried cannabis or cannabis plants in their possession shall not be seized if they are in compliance with the provisions of this Chapter.

(4) Qualified patients, their primary caregivers, and MCDCs who come into contact with law enforcement and cannot establish or demonstrate their status as a qualified patient, primary caregiver, or MCDC, but are otherwise in compliance with the provisions of this Chapter, shall not be cited or arrested and dried cannabis or cannabis plants in their possession shall not be seized if (1) based on the activity and circumstances, the officer determines that there is no evidence of criminal activity; (2) the claim by a qualified patient, primary caregiver, or MCDC is credible; and (3) proof of status as a qualified patient, primary caregiver, or MCDC can be provided to the Police Department within three (3) business days of the date of contact with law enforcement.

Operational Standards

(1) Signs displayed on the exterior of the property shall conform to existing regulations;

(2) The location shall be monitored at all times by a closed circuit video recording system for security purposes. The camera and recording system must be of adequate quality, color rendition, and resolution to allow the ready identification of any individual committing a crime anywhere on the site;

(3) The location shall have a centrally-monitored alarm system;

(4) Interior building lighting, exterior building lighting and parking area lighting must be in compliance with applicable regulations, and must be of sufficient brightness and color rendition so as to allow the ready identification of any individual committing a crime on site at a distance of no less than 40 feet (a distance that should allow a person reasonable reaction time upon recognition of a viable threat);

(5) Adequate overnight security shall be maintained so as to prevent unauthorized entry;

(6) Absolutely no cannabis product may be visible from the building exterior;

(7) Any beverage or edible produced, provided, or sold at the MCDC containing cannabis shall be so identified, as part of the packaging, with a prominent and clearly legible warning advising that the product contains cannabis and that is it to be consumed only by qualified patients;

(8) No persons under the age of 18 shall be allowed on site, unless the individual is a qualified patient and accompanied by his or her parent or documented legal guardian;

(9) At any given time, no MCDC may possess more cannabis or cannabis plants than would reasonably meet the needs of its registered patient members;

(10) A sign shall be posted in a conspicuous location inside the structure advising: "The diversion of cannabis (marijuana) for non-medical purposes is a violation of state law and will result in membership expulsion. Loitering at the location of a Medical Cannabis Dispensing Collective is also grounds for expulsion. The use of cannabis may impair a person's ability to drive a motor vehicle or operate heavy machinery.;

(11) No MCDC may provide medical cannabis to any persons other than qualified patients and designated primary caregivers who are registered members of the MCDC and whose status to possess cannabis pursuant to state law has been verified. No medical cannabis provided to a primary caregiver may be supplied to any person(s) other than the qualified patient(s) who designated the primary caregiver;

(12) No outdoor cultivation shall occur at an MCDC location unless it is: a) not visible from anywhere outside of the MCDC property and b) secured from public access by means of a locked gate and any other security measures necessary to prevent unauthorized entry;

(13) No MCDC shall cause or permit the establishment or maintenance of the sale or dispensing of alcoholic beverages for consumption on the premises or off-site of the premises;

(14) No dried medical cannabis shall be stored in structures without at least four walls and a roof, or stored in an unlocked vault or safe, or other unsecured storage structure; nor shall any dried medical cannabis be stored in a safe or vault that is not bolted to the floor or structure of the facility; and

(15) Medical cannabis may be consumed on-site only as follows:

a. The smoking or vaporizing of medical cannabis shall be allowed provided that appropriate seating, restrooms, drinking water, ventilation, air purification system, and patient supervision are provided in a room or enclosed area separate from other MCDC service areas.

b. The maximum occupancy of the on-site consumption area shall meet applicable occupancy requirements.

c. The MCDC shall use an activated charcoal filter, or other device sufficient to eliminate all odors associated with medical cannabis use from adjoining businesses and public walkways. The fan used to move air through the filter shall have the capacity sufficient to ventilate the square footage of the separate room or enclosed area in which medical cannabis use is permitted.

(16) MCDCs must verify that each member (1) is legally entitled to posses or consume medical cannabis pursuant to state law; and (2) is a resident of the State of California.

(17) All MCDC operators, employees, managers, members, or agents shall be qualified patients or the designated primary caregivers of qualified patients. MCDC operators, employees, managers, members, or agents shall not sell, barter, give away, or furnish medicine to anyone who is not a qualified patient or primary caregiver, registered as a member of the MCDC, and entitled to possess cannabis under state law.

(18) MCDCs shall maintain accurate patient records necessary to demonstrate patient eligibility under the law for every MCDC member, including (1) a copy of a valid driver's license or Department of Motor Vehicle identification card, (2) a patient registration form, and (3) a current valid letter of recommendation for the use of medical cannabis written by a state-licensed physician. All patient records shall be kept in a secure location, regarded as strictly confidential, and shall not be provided to law enforcement without a valid subpoena or court order.

(19) Operating hours for MCDCs shall not exceed the hours between 8:00 AM and 10:00 PM daily.

(20) MCDCs must have at least one security guard with a Guard Card issued by the California Department of Consumer Affairs on duty during operating hours.

Severability

If any section, sub-section, paragraph, sentence, or word of this Article is deemed to be invalid, the invalidity of such provision shall not affect the validity of any other sections, sub-sections, paragraphs, sentences, or words of this Article, or the application thereof; and to that end, the sections, sub-sections, paragraphs, sentences, and words of this Article shall be deemed severable.

The Medical Cannabis Advocate's Handbook

PATIENT CULTIVATION
The Seed of Safe Access

AmericansFor SafeAccess

Advancing Legal Medical Marijuana Therapeutics and Research

PATIENT CULTIVATION: The Seed of Safe Access

PATIENT CULTIVATION PROTECTS PATIENT RIGHTS AND OPTIONS

Restricting patients to a centralized cultivation and distribution system limits their choice and freedom, jeopardizes access in rural areas, subjects large-scale cultivators to lengthy federal sentencing guidelines, and makes medical cannabis unaffordable and out of reach for many qualified patients. Because not all patients have the skill, time or space to cultivate their own cannabis, patients need both centralized and localized cultivation. We must strive to provide the most healthcare options for patients and to empower them to make their own decisions regarding medical treatment.

Although some states are implementing systems of centralized production and distribution, almost all of these states also allow patients to cultivate their own medical cannabis. Relying exclusively on centralized production and distribution is untested and will likely fail to address patients' needs. In addition, federal law frowns on large-scale cultivation (imposing harsh mandatory minimum prison sentences for more than 100 plants), whereas the federal government rarely goes after individual patient cultivators. Do we really want to rely exclusively on an untested, vulnerable system that is unable to meet patients' needs?

DID YOU KNOW?

- Although most patients prefer to purchase their medication from a local distribution center or have it grown for them, for a state law to work effectively, patients need the right to cultivate as a safety net in case centralized cultivation and the dispensary model do not work.
- Cannabis is not a complicated pharmaceutical product; it is a plant that, like a tomato plant, will thrive with appropriate care. While the cultivation of cannabis requires time, resources, and skill, cannabis is still relatively easy to grow. In fact, people have been successfully cultivating cannabis for therapeutic use for thousands of years.
- Of the 15 states that regulate medical cannabis, only one program prohibits patient cultivation: New Jersey.
- Personal cultivation policies allow knowledgeable patients to select cannabis strains that meet their needs and guarantees reliable, affordable, and consistent access to cannabis, especially for patients in rural communities or locales without a dispensing center nearby.
- Large-scale cultivation operations are vulnerable to federal scrutiny and could result in arrests and prosecutions. Under federal statute, a conviction for possession of 250 grams (about eight ounces) of cannabis or fewer carries with it a sentencing range of up to six months. However, a defendant convicted under the same statute for possession of 30,000 kilograms (about 1,000 ounces) or more, is subject to a range of 15-25 years.
- Restricting patients to a centralized supply with high overhead costs, increases the price of medical cannabis and makes it unaffordable for many patients. Patient cultivation ensures prices will be kept low by increasing the options available to patients, which in turn leads to fair and competitive pricing in the medical cannabis market.

MYTHS AND FACTS

Myth: Unregulated cultivation will breed diversion and abuse of the medical cannabis program.

Fact: There has been little evidence of diversion among legitimate medical cannabis

patients because accountability is inherent in the medical cannabis system. Medical cannabis patients are sick and need their medication, and typically do not wish to risk losing that privilege by diverting their medication to the illicit market.

Myth: Dispensaries alone will satisfy the demands of the patient community.

Fact: Many patients cannot afford the expensive prices set by the dispensary model. Patients need options and the right to affordably grow their own medicine. In addition, by allowing patients to grow their own medication, they can control its production, quality, and consistency. New Mexico's medical cannabis program, which relies heavily on centralized production and distribution, has been operating for more than two years, but has so far failed to meet patient demand. Without the ability to personally cultivate, patients in New Mexico would still be without medication.

Myth: Pharmacological testing is necessary to ensure safe, unadulterated, and consistent medication.

Fact: While pharmacological testing would improve safety and consistency, at this time it is unrealistic for a number of reasons. Because of the Federal Government's strict control over cannabis research studies and testing, there is no practical way to carry out such a policy. Given that people have benefited from the therapeutic use of cannabis for thousands of years without pharmacological testing, patients should not have to now suffer because of new, unrealistic standards.

Myth: Patient cultivation increases home invasions and related crimes.

Fact: Concerns over crime associated with patient cultivation are real, but they are often exaggerated by opponents of this issue. The vast majority of medical cannabis crime is connected to dispensaries and outdoor cultivation, and public officials have found that the best way to deal with it is on a case-by-case basis. Furthermore, reasonable regulations can be put in place to better protect patients cultivating in their homes.

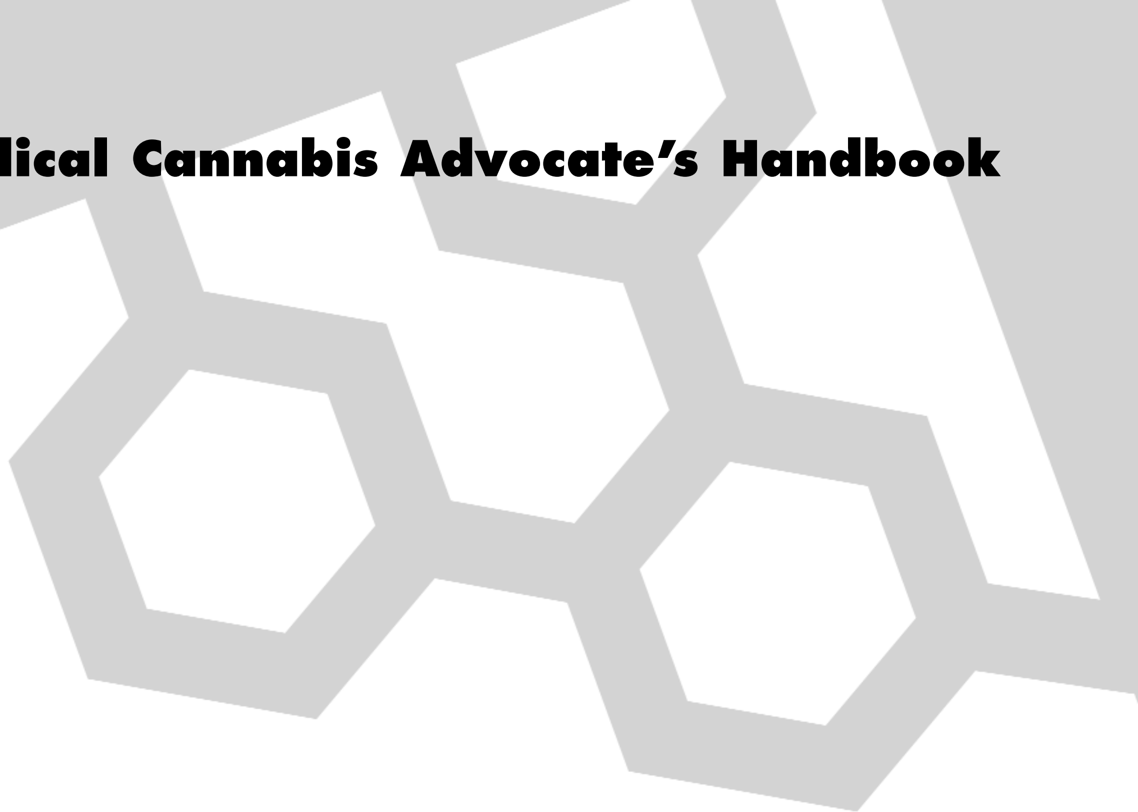
Myth: Patient cultivation creates safety and fire hazards.

Fact: The evidence of house fires related to patient cultivation is marginal when considering the amount of cultivation that is actually occurring. Furthermore, the risk of fire hazards can be mitigated by requiring that patients meet certain safety and operational measures prior to their approval to cultivate.

Medical cannabis patients need patient cultivation as a safety net, not only to create a functional program, but also to catch members of our community when:

1. The dispensary model does not work for low-income patients who cannot afford expensive dispensary pricing or for rural patients who have to drive hours to the closest dispensary.
2. The Drug Enforcement Administration or other Federal Agencies attempt to interfere with centralized production and distribution centers.
3. There is a crop failure jeopardizing all of the medication at a centralized cultivation center or pharmacological testing deems all of the medication is unusable.
4. The implementation of the program is stalled or otherwise interrupted, leaving patients without medication.

ASA recommends registered patients and their designated caregiver(s) be granted the option to cultivate a small amount of cannabis individually or in small groups so long as they comport with reasonable standards and restrictions set by the appropriate state agency.



ASA FACT SHEETS & ADS

AmericansFor SafeAccess

Advancing Legal Medical Marijuana Therapeutics and Research

MYTHS & FACTS

ABOUT MEDICAL MARIJUANA

MYTH #1
Marijuana has no accepted medical use.

FACT The federal government insists that marijuana has no medical value and a high potential for abuse, but only by ignoring the scientific evidence that clearly shows marijuana is safe and effective. Controlled clinical studies have confirmed marijuana's therapeutic benefit in relieving an array of symptoms for people living with Cancer, HIV/AIDS, Multiple Sclerosis, Alzheimer's, Hepatitis, Arthritis, and Chronic Pain, among many other conditions.

MYTH #2
Marijuana is addictive.

FACT The National Academy of Sciences noted in a 1999 report that, "millions of Americans have tried marijuana, but most are not regular users [and] few marijuana users become dependent on it." They conclude that "although [some] marijuana users develop dependence, they appear to be less likely to do so than users of other drugs (including alcohol and nicotine), and marijuana dependence appears to be less severe than dependence on other drugs."

MYTH #3
Research has not shown smoked marijuana can treat pain.

FACT Two recently published studies have confirmed that smoking marijuana is effective in treating not just chronic musculo-skeletal pain but neuropathy, a type of nerve pain that often does not respond to other drugs. To date, four placebo-controlled clinical studies have demonstrated that marijuana can control nerve pain better than available alternatives.

MYTH #4
Medical marijuana is unnecessary since doctors can prescribe Marinol, an FDA-approved drug.

FACT Marinol is a synthetic copy of THC, one of the more than 100 known cannabinoids found in marijuana. Marinol is expensive, does not work for everybody, has inconsistent results, creates more adverse side effects, and does not relieve symptoms as quickly or effectively as whole-plant therapies. The Institute of Medicine (IOM) reports "it is well recognized that Marinol's oral route of administration hampers its effectiveness because of slow absorption and patients' desire for more control over dosing."

MYTH #5
The medical community does not support medical marijuana. Only groups that want to legalize drugs do.

FACT Among the organizations that support access for medical use and research are: American Medical Association, Institute of Medicine, American College of Physicians, American Academy of Family Physicians, American Public Health Association, American Nurses Association, Leukemia & Lymphoma Society, American Academy of Addiction Psychiatry, American Academy of HIV Medicine, and National Women's Health Network.

MYTH #6
Marijuana causes cancer. Smoking one joint produces the same carcinogens as smoking five cigarettes.

FACT A comprehensive study funded by the National Institute on Drug Abuse (NIDA) found that even regular, heavy smoking of marijuana does not lead to lung cancer. Marijuana users have also been shown to have a markedly lower rate of head, neck and throat cancers.

MYTH #7
Today's marijuana has high levels of THC that make it more dangerous than marijuana of the past.

FACT According to the government's Marijuana Potency Monitoring Project, average marijuana potency is only 8.52%. Differences in how marijuana was tested in the 1960s and 1970s makes it difficult to compare the THC levels of that time period to the THC levels of today. Potency may be inching up but there is no evidence that this makes it more dangerous. In fact, more potent marijuana means people use less and so are exposed to fewer byproducts such as tar.

AmericansFor SafeAccess
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MYTHS & FACTS

ABOUT MEDICAL MARIJUANA

MYTH #8

Marijuana is a gateway drug. People who use it are more likely to then use drugs such as heroin.

FACT The Institute of Medicine (IOM) found no conclusive evidence linking the use of marijuana with the subsequent abuse of other illicit drugs. It is the effects of prohibition and the interaction with drug dealers that provides patients with easy access to other more potent and harmful drugs.

MYTH #9

Medical marijuana laws are a way to legalize marijuana for recreational use.

FACT The legalization of marijuana for recreational use is an entirely separate issue from medical marijuana. Patients should not be denied access to medical marijuana because of debate over whether recreational use should be legal.

MYTH #10

New Policies Have Ended State and Federal Conflict

FACT While the Obama Administration's stated intention to respect state laws marks a reversal from previous administrations, medical cannabis is still illegal under federal law. A Justice Department memo directed U.S. Attorneys not to expend resources prosecuting individuals who are in compliance with state medical cannabis laws, but much is left to the discretion of individual prosecutors. The DEA has continued to raid and arrest patients and their providers in medical cannabis states, and federal prosecutors and judges have continued to incarcerate patients convicted under rules of evidence that do not permit mention of state law, medical conditions, or the advice of physicians.

MYTH #11

Federal Law Trumps State Law

FACT While the 'Supremacy Clause' of the U.S. Constitution defers to federal law when conflicts between federal and state laws occur, no direct conflict exists that would invalidate state medical marijuana laws. Even when the U.S. Supreme Court ruled in *Gonzales v. Raich* (2005) that the federal government could enforce federal marijuana laws even in medical marijuana states, the Court did not overturn the laws of those states. Furthermore, landmark state court decisions have firmly established that federal law does not preempt state law and local officials have an obligation to uphold state, not federal, law.

MYTH #12

Individual Patients Do Not Get Raided by the DEA

FACT Spokespersons for federal law enforcement agencies routinely tell the public that they are not targeting individual patients or caregivers. Yet federal agents continue to seize property and intimidate patients in paramilitary raids. Patients are still being arrested for relatively small amounts of cannabis, and federal prosecutors continue to seek harsh prison sentences, even in states with medical cannabis programs. Michael Teague, the owner of a pool-cleaning service in California who is allergic to conventional painkillers, was arrested by federal agents for growing a handful of cannabis plants in the back of his garage; he was sent to federal prison even though his doctor had told him cannabis was his best treatment option for chronic pain. Diane Monson, whose case went to the U.S. Supreme Court, had her California home raided for half-a-dozen plants she used to treat a chronic back condition. Leonard French, a wheelchair-bound, licensed medical marijuana patient in New Mexico, was the victim of a federal paramilitary raid shortly after his state established its medical cannabis program.

#1 Abrams, DI. "Cannabis in Painful HIV-associated Sensory Neuropathy." Neurology. 2007;68:515-521.

#2 King LA, et al. "Cannabis Potency in Europe." Addiction. July 2005; 100(7):884-6.

#3 Journal of Pain, 2008 Jun; 9(6):506-21. Neuropsychopharmacology, 2008; DOI: 10.1038/npp.2008.120. Neurology, 2007, 68:515-521. Anesthesiology, 2007, 107(5):785-796.

#4 Joy JE, et al. "Marijuana and Medicine: Assessing the Science Base," Institute of Medicine, Washington, DC: National Academy Press, 1999.

#6 Biello D. "Large Study Finds No Link Between Marijuana and Lung Cancer." Scientific American, May 24, 2006.

#7 ElSohly MA. National Center for Natural Products Research, School of Pharmacy, University of Mississippi, Potency Monitoring Project, Report #87, 2004.

#8 Joy JE, et al.

#9 Ibid.

#11 Eddy M. Medical Marijuana: Review and Analysis of Federal and State Policies. Congressional Research Service. Washington, DC, 2007.

MY DOCTOR RECOMMENDS IT.
MY FAMILY SUPPORTS IT.
MY STATE ALLOWS IT.
AND MY HEALTH REQUIRES IT.

SO WHY DOES MY DISTRICT ATTORNEY TREAT ME LIKE A CRIMINAL?

San Diegans, you can fix it. It’s time to reallocate our valuable law enforcement resources away from prosecuting medical cannabis patients and providers who are abiding by state law.

TELL SAN DIEGO OFFICIALS TO RESPECT PATIENT RIGHTS

Advancing Legal Medical Marijuana Therapeutics and Research

Please help us implement California’s medical cannabis law in San Diego. We can’t do it without you. For more information about medical marijuana patients, providers, or policies, contact us at **www.AmericansForSafeAccess.org** or call our toll-free hotline at **1-888-929-4367**.

COMING TO A COURTROOM NEAR YOU

You've just been diagnosed with cancer. Your doctor knows of something that will help you. He could lose his license if he tells you...

Attorney General John Ashcroft wants to penalize any physician who even mentions the word "marijuana" to you -- even if that would have been his best medical advice. Despite impressive evidence that marijuana helps people with epilepsy, multiple sclerosis, AIDS wasting, and chemotherapy, John Ashcroft refuses to face the facts and he's willing to destroy your health to prove it.

Help us stop the war on patients.

AMERICANS FOR SAFE ACCESS
www.SafeAccessNow.org
888-929-4367

COMING TO A COURTROOM NEAR YOU

John Ashcroft doesn't want anyone defending medical marijuana.
Not you. Not your lawyer. Not even the judge.

Despite impressive evidence that marijuana helps people with epilepsy, multiple sclerosis, AIDS wasting, and chemotherapy, Attorney General John Ashcroft refuses to face the facts and he's willing to send you to prison to prove it. The U.S. Justice Dept. is putting care-givers on trial for supplying medicine to the sick and dying. They are not allowed to mention "medical marijuana" in their defense. They are tried as if they were drug kingpins. When a San Francisco jury realized they had convicted one of these good Samaritans, they were outraged. "I feel like I made the biggest mistake of my life," said juror Marney Craig. "We convicted a man who was not a criminal."

Help us stop the war on patients.

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COMING TO A COURTROOM NEAR YOU

Jim Parks has Cancer. His doctor recommended marijuana to ease the pain.
The friends who grew it are facing 10 years in prison.
And Jim won't be allowed to say a word in their defense.

The Bush Administration is fighting a war on medical marijuana. They are raiding and prosecuting patients and care-givers. An overwhelming majority of Americans support marijuana for medical use. But under current federal law, jurors are not allowed to hear about medical necessity laws or defendants' illnesses. The words "medical marijuana" are outlawed. Bryan Epis was sentenced to 10 years in prison and the jury never knew he was growing marijuana to treat desperately ill patients. It is time for our elected officials to fix this problem in Washington D.C. ***Please call Sen. Barbara Boxer - (916) 448-2787 and Sen. Dianne Feinstein - (415) 393-0707. Ask them to help stop the war on patients.***

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FOR CA ATTORNEY GENERAL

WRONG ON MEDICAL MARIJUANA. WRONG ON MARRIAGE EQUALITY.
WRONG ON THE ENVIRONMENT. WRONG FOR CALIFORNIA.

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MODEL STATEWIDE LEGISLATION

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Advancing Legal Medical Marijuana Therapeutics and Research

MEDICAL CANNABIS PROGRAM ACT

THE PEOPLE OF THE STATE DO ENACT AS FOLLOWS:

The definitions in this apply throughout this chapter unless the context clearly requires otherwise.

"Defined relationship" means that the parties have agreed to become collective members and shall cultivate, manufacture, sell, dispense, distribute, transport, or deliver cannabis and cannabis products on behalf of other members who are qualified patients and/or designated caregivers, as provided by as provided for under this Chapter.

"Designated Caregiver" means a person, over the age of 18, who has been designated by a qualified patient to assist in the cultivation, procurement, production, transportation, storage, and administration of medical cannabis, and has received an Identification Card issued by the STATE DEPARTMENT OF PUBLIC HEALTH.

"Dispense" means the selection, measuring, packaging, labeling, delivery, or distribution or sale of cannabis by a Medical Cannabis Dispensing Center, a Medical Cannabis Delivery Service, a Medical Cannabis Manufacturer, or a Medical Cannabis Cultivator, as defined by this act, to a qualifying patient or a designated caregiver.

"Labeling" means all labels and other written, printed, or graphic matter (a) upon any cannabis intended for medical use, or (b) accompanying such cannabis.

"Cannabis Plant" means a plant of the species Cannabis Sativa that has flowers and/or is greater than 12 inches in height and 12 inches in diameter.

"Medical Cannabis Cultivator" means any individual or not for profit entity organized to cultivate, dispense, and deliver cannabis and cannabis products for medical use to Medical Cannabis Delivery Services, Medical Cannabis Dispensing Centers, or Medical Cannabis Product Manufacturers, or their own qualifying patients and/or designated caregiver members.

"Medical Cannabis Delivery Service" means any not for profit entity organized to cultivate, dispense, and deliver cannabis and cannabis products for medical use to patients and their designated caregivers who are members.

"Medical Cannabis Dispensing Center" means any not for profit entity organized to cultivate and dispense cannabis and cannabis products through storefronts for medical use to patients and their designated caregivers who are members.

"Medical Cannabis Laboratory" means any non-residential facility licensed by the

Department of Public Health to analyze dried, extracted, cured, food-based and other forms of cannabis for: a) contaminants such as mold and insects, and/or b) concentrations of cannabinoids such as Tetrahydrocannabinol (THC) and Cannabidiol (CBD) and other chemical constituents.

"Medical cannabis products" means products that contain cannabis or cannabis extracts, and are intended for human consumption or application, including, but not limited to, edible products, tinctures, and lotions.

"Medical Cannabis Product Manufacturer" means any person or not for profit entity organized to manufacture medical cannabis products meant for dispensing within Medical Cannabis Dispensing Center and/or Medical Cannabis Delivery Service and/or directly to the manufacturer's qualified patient and/or designated caregiver members, if organized as a collective. Medical Cannabis Product Manufacturers shall be members or have a defined relationship with Medical Cannabis Dispensing Centers and/or Medical Cannabis Delivery Services, as provided for under this Chapter. Medical Cannabis Product Manufacturers may be members or have a defined relationship with Medical Cannabis Cultivators. Medical Cannabis Product Manufacturers do not include qualified patients and designated caregivers who produce medical cannabis products for their own individual use or for the use of a patient under their care.

"Qualified Patient" means a person who has been diagnosed with a serious medical condition and, having been examined by a physician, it has been determined would benefit from the use of cannabis and has obtained an Identification Card from the STATE DEPARTMENT OF PUBLIC HEALTH.

"Seedling" means a cannabis plant that has no flowers and/or that is less than 12 inches in height and/or less than 12 inches in diameter.

"Serious Medical Condition" means all of the following medical conditions:

(1) Acquired immune deficiency syndrome (AIDS).

(2) Anorexia.

(3) Arthritis.

(4) Cachexia.

(5) Cancer.

(6) Chronic pain.

(7) Glaucoma.

(8) Migraine.

(9) Persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis.

(10) Seizures, including, but not limited to, seizures associated with epilepsy.

(11) Severe nausea.

(12) Any other chronic or persistent medical symptom that either:

(A) Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336).

(B) If not alleviated, may cause serious harm to the patient's safety or physical or mental health.

"Visiting Qualified Patient" means a person with a medical condition who is currently participating in another state's medical cannabis program, and is in possession of a valid out-of-state medical cannabis program identification card or its equivalent.

CRIMINAL EXEMPTIONS

STATE CRIMINAL PENAL CODE relating to the possession of marijuana, and STATE CRIMINAL PENAL CODE relating to the cultivation of marijuana, shall not apply to a qualified patient, or to a patient's designated caregiver, who possesses or cultivates cannabis for the personal medical purposes of the qualified patient upon the written recommendation or approval of a physician.

Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended cannabis to a patient for medical purposes.

LIMITS

(A) A qualified patient or designated caregiver may possess no more than eight ounces of dried cannabis per qualified patient. In addition, a qualified patient or primary caregiver may also maintain no more than 12 cannabis plants per qualified patient.

(B) If a qualified patient or designated caregiver has a doctor's recommendation that

this quantity does not meet the qualified patient' s medical needs, the qualified patient or designated caregiver may possess an amount of cannabis consistent with the patient's needs.

(C) Only the dried mature processed flowers of female cannabis plant or the plant conversion shall be considered when determining allowable quantities of cannabis under this section.

Qualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients and persons with identification cards, who associate within the STATE in order collectively or cooperatively to cultivate cannabis for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions under THE STATE'S PENAL CODE.

A state or local law enforcement agency or officer shall not refuse to accept an identification card issued by the department unless the state or local law enforcement agency or officer has reasonable cause to believe that the information contained in the card is false or fraudulent, or the card is being used fraudulently.

ID PROGRAM

A. The STATE'S DEPARTMENT OF PUBLIC HEALTH shall establish and maintain a program for the issuance of identification cards to qualified patients who satisfy the requirements of this article and apply to the identification card program.

B. The department shall establish and maintain a 24-hour, toll-free telephone number that will enable state and local law enforcement officers to have immediate access to information necessary to verify the validity of an identification card issued by the department, as well as a secure, web-based verification system.

C. Every county health department, or the county's designee, shall do all of the following:

(1) Provide applications upon request to individuals seeking to join the identification card program.

(2) Receive and process completed applications.

(3) Maintain records of identification card programs.

(4) Utilize protocols developed by the STATE'S PUBLIC HEALTH DEPARTMENT.

(5) Issue identification cards developed by the STATE'S PUBLIC HEALTH DEPART-

MENT to approved applicants and designated primary caregivers.

D. The STATE'S PUBLIC HEALTH DEPARTMENT shall develop all of the following:

(1) Protocols that shall be used by a county health department or the county's designee to implement the responsibilities described in subdivision B, including, but not limited to, protocols to confirm the accuracy of information contained in an application and to protect the confidentiality of program records.

(2) Application forms that shall be issued to requesting applicants.

(3) An identification card that identifies a person authorized to engage in the medical use of cannabis and an identification card that identifies the person's designated caregiver, if any. The two identification cards developed pursuant to this paragraph shall be easily distinguishable from each other.

E. No person or designated caregiver in possession of a valid identification card shall be subject to arrest for possession, transportation, delivery, or cultivation of medical cannabis in an amount established pursuant to this article, unless there is reasonable cause to believe that the information contained in the card is false or falsified, the card has been obtained by means of fraud, or the person is otherwise in violation of the provisions of this article.

F. A person who seeks an identification card shall pay the fee, and provide all of the following to the county health department or the county's designee on a form developed and provided by the department:

(1) The name of the person, and proof of his or her residency within the county.

(2) Written documentation by the attending physician in the person' s medical records stating that the person has been diagnosed with a serious medical condition and that the medical use of cannabis is appropriate.

(3) The name, office address, office telephone number, and medical license number of the person's attending physician.

(4) The name of up to 2 designated caregivers, if any.

(5) A government-issued photo identification card of the person and of the designated caregiver(s), if any. If the applicant is a person under 18 years of age, a certified copy of a birth certificate shall be deemed sufficient proof of identity.

G. Within 30 days of receipt of an application for an identification card, a county health department or the county's designee shall do all of the following:

(1) For purposes of processing the application, verify that the information contained in the application is accurate. If the person is less than 18 years of age, the county health department or its designee shall also contact the parent with legal authority to make medical decisions, legal guardian, or other person or entity with legal authority to make medical decisions, to verify the information.

(2) Verify with the Medical Board of THE STATE or the Osteopathic Medical Board of THE STATE that the attending physician has a license in good standing to practice medicine or osteopathy in the state; or the licensing board for Naturopathic Doctors, Physicians Assistants, Chiropractors, Acupuncturists, or other medical professional with diagnostic and treatment responsibilities.

(3) Contact the attending physician by facsimile, telephone, or mail to confirm that the medical records submitted by the patient are a true and correct copy of those contained in the physician's office records. When contacted by a county health department or the county's designee, the attending physician shall confirm or deny that the contents of the medical records are accurate.

(4) Take a photograph or otherwise obtain an electronically transmissible image of the applicant and of the designated caregiver(s), if any.

(5) Approve or deny the application. During the application process, a certified copy of the application shall be acceptable as a temporary Identification Card and shall provide the applicant with all rights and privileges provided by an Identification Card.

(b) If the county health department or the county's designee approves the application, it shall, within 24 hours, or by the end of the next working day of approving the application, electronically transmit the following information to the STATE'S PUBLIC HEALTH DEPARTMENT:

(1) A unique user identification number of the applicant.

(2) The date of expiration of the identification card.

(3) The name and telephone number of the county health department or the county's designee that has approved the application.

(c) The county health department or the county's designee shall issue an identification card to the applicant and to his or her designated caregiver(s), if any, within five work-

ing days of approving the application.

(d) In any case involving an incomplete application, the applicant shall assume responsibility for rectifying the deficiency. The county shall have 14 days from the receipt of information from the applicant pursuant to this subdivision to approve or deny the application.

H. An identification card issued by the county health department shall be serially numbered and shall contain all of the following:

(1) A unique user identification number of the cardholder.

(2) The date of expiration of the identification card.

(3) The name and telephone number of the county health department or the county's designee that has approved the application.

(4) A 24-hour, toll-free telephone number, to be maintained by the department, that will enable state and local law enforcement officers to have immediate access to information necessary to verify the validity of the card, and the address of the secure website maintained for the same purposes.

(5) Photo identification of the cardholder.

(b) A separate identification card shall be issued to the person's designated caregiver(s), if any, and shall include a photo identification of the caregiver.

I. The county health department or the county's designee may deny an application only for any of the following reasons:

(1) The applicant did not provide the information required, and upon notice of the deficiency did not provide the information within 30 days.

(2) The county health department or the county's designee determines that the information provided was false.

(3) The applicant does not meet the criteria set forth in this article.

J. Any person whose application has been denied pursuant to subdivision may appeal that decision to the department. The county health department or the county's designee shall make available a telephone number or address to which the denied applicant can direct an appeal.

K. An identification card shall be valid for a period of two years.

L. Upon renewal of an identification card, the county health department or its designee shall verify all new information and may verify any other information that has not changed. The county health department or the county's designee shall transmit its determination of approval or denial of a renewal to the department.

M. The department shall establish application and renewal fees for persons seeking to obtain or renew identification cards that are sufficient to cover the expenses incurred by the department, including the startup cost, the cost of reduced fees for those who qualify, the cost of identifying and developing a cost-effective Internet Web-based system, and the cost of maintaining the 24-hour toll-free telephone number. Each county health department or the county's designee may charge an additional fee for all costs incurred by the county or the county's designee for administering the program pursuant to this article.

N. Upon satisfactory proof of participation and eligibility in a social services program, each beneficiary shall receive a 50 percent reduction in the fees established pursuant to this section.

O. A person who possesses an identification card shall:

(1) Within seven days, notify the county health department or the county's designee of any change in the person's attending physician or designated primary caregiver, if any.

(2) If the designated caregiver has been changed, the previous designated caregiver shall return his or her identification card to the department or to the county health department or the county's designee.

EMPLOYMENT

A. Nothing in this article shall require any accommodation of any medical use of cannabis on the property or premises of any place of employment or during the hours of employment, or on the property or premises of any jail, correctional facility, or other type of penal institution in which prisoners reside or persons under arrest are detained.

B. Nothing in this article shall require a governmental, private, or any other health insurance provider or health care service plan to be liable for any claim for reimbursement for the medical use of cannabis.

C. It is unlawful for an employer to discriminate against a person in hiring, termination, or any term or condition of employment or otherwise penalize a person, if the discrimi-

nation is based solely upon either of the following:

(1) The person's status as a qualified patient or a designated caregiver.

(2) The person's positive drug test for cannabis, provided the person is a qualified patient and the medical use of cannabis does not occur on the property or premises of the place of employment or during the hours of employment.

D. A person who has suffered discrimination in violation of subdivision (C) may institute and prosecute in his or her own name and on his or her own behalf a civil action for damages, injunctive relief, and any other appropriate equitable relief to protect the peaceable exercise of the right or rights secured.

E. Paragraph (2) of subdivision (C) shall not apply when an employer employs a person in a safety-sensitive position. For purposes of this section, a safety-sensitive position means a position in law enforcement, or a position in which medical cannabis-affected performance could clearly endanger the health and safety of others. A safety-sensitive position shall have all of the following general characteristics:

(1) Its duties involve a greater than normal level of trust, responsibility for, or impact on the health and safety of others.

(2) Errors in judgment, inattentiveness, or diminished coordination, dexterity, or composure while performing its duties could clearly result in mistakes that would endanger the health and safety of others.

(3) An employee in a position of this nature works independently, or performs tasks of a nature that it cannot safely be assumed that mistakes like those described in subparagraph (2) could be prevented by a supervisor or another employee.

DUI MJ

Nothing in this chapter shall authorize the operation of a vehicle while under the influence of cannabis.

A qualified patient shall not be considered to be operating a vehicle under the influence solely for having cannabis metabolites in his or her system, being a qualified patient, or being in possession of cannabis.

HOUSING

A qualified patient or designated caregiver shall not be subject to any civil penalty, including but not limited to the loss of property, or eviction solely for one or more of

the following:

1) testing positive for cannabis use, or

2) for being a qualified patient or designated caregiver, or

3) for exercising rights as defined by Section XX of this Chapter, or

4) for use of cannabis, or

5) as an employee or agent of a Medical Cannabis Dispensing Center, Medical Cannabis Delivery Service, Medical Cannabis Cultivator, or Medical Cannabis Product Manufacturer.

CHILD CUSTODY

As used in this subdivision, "habitual or continual illegal use of controlled substances" does not include the following:

1) testing positive for cannabis use, or

2) for being a qualified patient or designated caregiver, or

3) for exercising rights as defined by Section XX of this Chapter, or

4) for use of cannabis, or

5) acting as an employee or agent of a Medical Cannabis Dispensing Center, Medical Cannabis Delivery Service, Medical Cannabis Cultivator, or Medical Cannabis Product Manufacturer.

RECIPROCITY

A visiting qualified patient shall have the same rights and privileges under STATE law as a qualified patient.

SEARCH, SEIZURE, FORFEITURE

The fact that a person is a qualified patient or designated caregiver, or is the employee or agent of a Medical Cannabis Dispensing Center, Medical Cannabis Delivery Service, Medical Cannabis Cultivator, or Medical Cannabis Product Manufacturer does not, alone:

(1) Constitute probable cause to search the person or the person's property; or

(2) Subject the person or the person's property to inspection by any governmental agency.

Except as otherwise provided in this subsection, if officers of a state or local law enforcement agency seize cannabis, drug paraphernalia or other related property from a person engaged or assisting in the medical use of cannabis:

(1) The law enforcement agency shall ensure that the cannabis, drug paraphernalia or other related property is not destroyed while in the possession of the law enforcement agency.

(2) Any property interest of the person from whom the cannabis, drug paraphernalia or other related property was seized must not be forfeited pursuant to any provision of law providing for the forfeiture of property, except as part of a sentence imposed after conviction of a criminal offense.

Upon a determination by the district attorney of the county in which the cannabis, drug paraphernalia or other related property was seized, or the district attorney's designee, that the person from whom the cannabis, drug paraphernalia or other related property was seized is engaging in or assisting in the medical use of cannabis in accordance with the provisions of this chapter, the law enforcement agency shall immediately return to that person any usable cannabis, cannabis plants, drug paraphernalia or other related property that was seized.

The determination of a district attorney or the district attorney's designee that a person is engaging in or assisting in the medical use of cannabis in accordance with the provisions of this chapter shall be deemed to be evidenced by:

(a) A decision not to prosecute;

(b) The dismissal of charges; or

(c) Acquittal.

TRANSPLANTS

For the purposes of medical care, including organ and tissue transplants, a qualified patient's authorized use of cannabis shall be considered the equivalent of the authorized use of any other medication used at the direction of a physician, and shall not constitute the use of an illicit substance.

COLLECTIVE MEMBERS' DUTIES

Qualified patients and designated caregivers who associate within the STATE in order to collectively or cooperatively cultivate cannabis for medical purposes, may share responsibility for acquiring and supplying the resources required to produce and process cannabis for medical use such as, for example, money, a location for a collective garden; equipment, supplies, and labor necessary to plant, grow, and harvest cannabis; cannabis plants, seeds, and cuttings; and equipment, supplies, and labor necessary for proper construction, plumbing, wiring, and ventilation of a garden of cannabis plants. It is the sole discretion of the collective or cooperative to determine the requirements for membership within the collective or cooperative, and responsibilities and duties may be carried out by any or all members of the collective or cooperative. It is also within the discretion of the collective or cooperative to determine allocation of the costs and benefits of the efforts of the collective or cooperative, including the allocation of reasonable compensation for services rendered amongst those associated. Testing by a medical cannabis laboratory shall remain voluntary.

FEES

Any and all governmental fees and taxes related to the registration or regulation of qualified patients and designated caregivers or Medical Cannabis Dispensing Centers or Medical Cannabis Delivery Services shall be used only to recover the cost of the services provided, including education, inspections, and civil enforcement of standards under this article. No fees or taxes may be levied to generate funds for any other service or program within the STATE.

MEDICAL CANNABIS DISPENSING CENTERS

Cities and counties within the STATE may enact regulations and ordinances governing Medical Cannabis Dispensing Centers, and the manufacture and labeling of medical cannabis products. These regulations and ordinances shall not ban, either explicitly or implicitly, the operation of Medical Cannabis Dispensing Centers. Testing by a medical cannabis laboratory shall remain voluntary. Any violation of these regulations and ordinances shall not be deemed a violation of the Medical Marijuana Program Act.

Nothing in this article shall prevent a city or other local governing body from adopting and enforcing laws consistent with this article.

SALES

Retail sales between Medical Cannabis Dispensing Centers, Medical Cannabis

Delivery Services, Medical Cannabis Cultivators, Medical Cannabis Product Manufacturers, and qualified patients and designated caregivers shall be permitted under this chapter.

MEDICAL CANNABIS DELIVERY COLLECTIVES

Cities and counties within the STATE may enact regulations and ordinances governing Medical Cannabis Delivery Services. These regulations and ordinances shall not ban, either explicitly or implicitly, the operation of Medical Cannabis Delivery Services. Testing by a medical cannabis laboratory shall remain voluntary. Any violation of these regulations and ordinances shall not be deemed a violation of the Medical Marijuana Program Act.

Nothing in this article shall prevent a city or other local governing body from adopting and enforcing laws consistent with this article.

MEDICAL CANNABIS PRODUCT MANUFACTURING

A. Cities and counties within the STATE may enact regulations and ordinances governing the manufacturing and labeling of medical cannabis products. Testing by a medical cannabis laboratory shall remain voluntary.

B. The manufacture of edible medical cannabis products shall be regulated as the type of food or beverage being manufactured, and no additional requirements made.

C. Enforcement shall be determined by STATE RETAIL FOOD CODE. Any violation of these regulations and ordinances shall not be deemed a violation of the Medical Marijuana Program Act.

Nothing in this article shall prevent a city or other local governing body from adopting and enforcing laws consistent with this article.

CULTIVATION

A. Medical Cannabis Cultivators fall within three classes. Class 2 and Class 3 registration shall be renewable annually. Registration classes are as follows:

(1) Class 1. Less than 25 qualified patients and designated caregivers wishing to collectively cultivate cannabis plants and manufacture medical cannabis products for exclusive use by their members are exempt from registration.

(b)Class 2. Collectives of qualified patients and designated caregivers with between 25 and 50 members, the collective shall register with the STATE'S DEPARTMENT Of

AGRICULTURE.

The application for a Class 2 registration shall include the name of at least 1 collective or cooperative member, the address and contact information for that member, a statement that the collective wishes to cultivate collectively and is seeking a Class 2 registration, and any accompanying fees necessary, as determined by the STATE'S DEPARTMENT Of AGRICULTURE. Accompanying this application, the collective shall submit each collective member's Identification Number, or, in the alternative, documentation of a defined relationship with one or more Medical Cannabis Dispensing Center(s) and/or Medical Cannabis Delivery Service(s) and/or Medical Cannabis Product Manufacturer(s). Renewal procedures shall be determined by the STATE'S DEPARTMENT Of AGRICULTURE.

(c)Class 3. Collectives of qualified patients and designated caregivers with more than 51 members, the collective shall register with the STATE'S DEPARTMENT Of AGRICULTURE.

The application for a Class 3 registration shall include the name of at least 5 collective or cooperative members, the address and contact information for those members, a statement that the collective wishes to cultivate collectively and is seeking a Class 3 registration, and any accompanying fees necessary, as determined by the STATE'S DEPARTMENT Of AGRICULTURE. The STATE'S DEPARTMENT Of AGRICULTURE shall determine a graduated fee scale for Class 3 registration applicants. Accompanying this application, the collective shall submit each collective member's Identification Number, or, in the alternative, documentation of a defined relationship with one or more Medical Cannabis Dispensing Center(s) and/or Medical Cannabis Delivery Service(s) and/or Medical Cannabis Product Manufacturer(s).

The STATE'S DEPARTMENT Of AGRICULTURE shall promulgate regulations in order to regulate Class 3 registrations. These regulations may include inspections and quality controls as well as requirements for defined contractual relationships with Medical Cannabis Dispensing Centers and security requirements.

TESTING

The Department of Health Services shall promulgate regulations to authorize and license medical cannabis laboratories in the testing of dried, extracted, cured, food-based and other forms of cannabis. Such testing may include the analysis of contaminants and chemical composition, or other methods of investigation intended to advance the understanding of cannabis's therapeutic benefits and to improve the health and welfare of qualified patients in the state.

RESCHEDULING

The State Board of Pharmacy shall classify cannabis as a controlled substance in Schedule III, IV or V. The State Board of Pharmacy shall classify cannabis no later than 180 days after the effective date of this chapter.

SEVERABILITY

If any provision of this measure or the application thereof to any person or circumstance is held invalid, that invalidity shall not affect other provisions or applications of the measure which can be given effect without the invalid provision or application, and to this end the provisions of this measure are severable.

The Medical Cannabis Advocate's Handbook

MODEL ORDINANCE FOR REGULATING MEDICAL CANNABIS DISPENSING CENTERS

AmericansFor SafeAccess

Advancing Legal Medical Marijuana Therapeutics and Research

SAMPLE ORDINANCE
REGULATING MEDICAL CANNABIS DISPENSING CENTERS

Purposes and Intent

(1) To implement the provisions of state law such that local distribution of medical cannabis can be effectively regulated and licensed, and thereby protected from unnecessary law enforcement actions.

(2) To help ensure that seriously ill residents can obtain and use cannabis for medical purposes where that medical use has been deemed appropriate by a physician in accordance with State law.

(3) To help ensure that the qualified patients and their designated caregivers who obtain or cultivate cannabis solely for the qualified patient's medical treatment are not subject to arrest, criminal prosecution, or sanction.

(4) To protect citizens from the adverse impacts of unregulated medical cannabis distribution, storage, and use practices.

(5) To establish a new code section pertaining to the permitted distribution of medical cannabis consistent with state law.

Nothing in this ordinance purports to permit activities that are otherwise illegal under state or local law.

Definitions

See state law for relevant definitions.

The following phrases, when used in this chapter, shall be construed as defined below:

"Medical Cannabis Dispensing Center" or "Dispensing Center". Qualified patients and designated caregivers of qualified patients who associate, as an incorporated or unincorporated association in order to lawfully provide medical cannabis for use exclusively by their registered members, in strict accordance with state law.

"Director." The Director of Planning or other person authorized to issue a Conditional Use Permit pursuant to _____ code.

Conditional Use Permit Required

A Conditional Use Permit shall be required to establish or operate a Medical Marijuana

Dispensing Center in compliance with the requirements of this section when located in the _____ Zones.

Application Procedure

(1) In addition to ensuring compliance with the application procedures specified in Section _____, the Director shall send copy of the application and related materials to all other relevant City departments for their review and comment.

(2) A disclaimer shall be put on the Medical Marijuana Dispensing Center zoning application forms that shall include the following:

a. A warning that the Medical Marijuana Dispensing Center operators and their employees may be subject to prosecution under federal law; and

b. A disclaimer that the City will not accept any legal liability in the connection with any approval and/or subsequent operation of a Medical Marijuana Dispensing Center.

Findings. In addition to the findings required to establish compliance with the provisions of Section _____, approval of a Conditional Use Permit for a Medical Marijuana Dispensing Center shall require the following findings:

(1) That the requested use at the proposed location will not adversely affect the economic welfare of the nearby community;

(2) That the requested use at the proposed location is sufficiently buffered in relation to any residential area in the immediate vicinity so as not to adversely affect said area; and

(3) That the exterior appearance of the structure will be consistent with the exterior appearance of structures already constructed or under constructing within the immediate neighborhood, so as to prevent blight or deterioration, or substantial diminishment or impairment of property values within the neighborhood.

Location.

The location at which a Dispensing Center distributes medical cannabis must meet the following requirements:

(1) The location must be in a non-residential zone appropriate for retail or health care use;

(2) The location must not be within 500 feet of a K-12 public school to be measured by a straight line between the two locations;

(3) The location must not be within 1,000 feet of another Dispensing Center.

Police Department Procedures and Training.

(1) Within six months of the date that this chapter becomes effective, the training materials, handbooks, and printed procedures of the Police Department shall be updated to reflect its provisions. These updated materials shall be made available to police officers in the regular course of their training and service.

(2) Medical cannabis-related activities shall be the lowest possible priority of the Police Department.

(3) Qualified patients, their designated caregivers, and Dispensing Centers who come into contact with law enforcement shall not be cited or arrested and dried cannabis or cannabis plants in their possession shall not be seized if they are in compliance with the provisions of this chapter.

(4) Qualified patients, their designated caregivers, and Dispensing Centers who come into contact with law enforcement and cannot establish or demonstrate their status as a qualified patient, designated caregiver, or Dispensing Center, but are otherwise in compliance with the provisions of this chapter, shall not be cited or arrested and dried cannabis or cannabis plants in their possession shall not be seized if (1) based on the activity and circumstances, the officer determines that there is no evidence of criminal activity; (2) the claim by a qualified patient, designated caregiver, or Dispensing Center is credible; and (3) proof of status as a qualified patient, designated caregiver, or Dispensing Center can be provided to the Police Department within three business days of the date of contact with law enforcement.

Operational Standards.

(1) Signs displayed on the exterior of the property shall conform to existing regulations;

(2) The location shall be monitored at all times by closed circuit video recording system for security purposes. The camera and recording system must be of adequate quality, color rendition and resolution to allow the ready identification of any individual committing a crime anywhere on the site;

(3) The location shall have a centrally-monitored alarm system;

(4) Interior building lighting, exterior building lighting and parking area lighting must be in compliance with applicable regulations, and must be of sufficient brightness and color rendition so as to allow the ready identification of any individual committing a crime on site at a distance of no less than forty feet (a distance that should allow a person reasonable reaction time upon recognition of a viable threat);

(5) Adequate overnight security shall be maintained so as to prevent unauthorized entry;

(6) Absolutely no cannabis product may be visible from the building exterior;

(7) Any beverage or edible produced, provided or sold at the Dispensing Center containing cannabis shall be so identified, as part of the packaging, with a prominent and clearly legible warning advising that the product contains cannabis and that is it to be consumed only by qualified patients;

(8) No persons under the age of eighteen shall be allowed on site, unless the individual is a qualified patient and accompanied by his or her parent or documented legal guardian;

(9) At any given time, no Dispensing Center may possess more cannabis or cannabis plants than would reasonably meet the needs of its registered patient members;

(10) A sign shall be posted in a conspicuous location inside the structure advising: "The diversion of cannabis for non-medical purposes is a violation of state law and will result in membership expulsion. Loitering at the location of a Dispensing Center is also grounds for expulsion. The use of cannabis may impair a person's ability to drive a motor vehicle or operate heavy machinery;

(11) No Dispensing Center may provide medical cannabis to any persons other than qualified patients and designated designated caregivers who are registered members of the Dispensing Center and whose status to possess cannabis pursuant to state law has been verified. No medical cannabis provided to a designated caregiver may be supplied to any person(s) other than the designated caregiver's qualified patient(s);

(12) No outdoor cultivation shall occur at a Dispensing Center location unless: a) it is not visible from anywhere outside of the Dispensing Center property; and b) secured from public access by means of a locked gate and any other security

measures necessary to prevent unauthorized entry;

(13) No Dispensing Center shall cause or permit the establishment or maintenance of the sale or dispensing of alcoholic beverages for consumption on the premises or off-site of the premises;

(14) No dried medical cannabis shall be stored in structures without at least four walls and a roof, or stored in an unlocked vault or safe, or other unsecured storage structure; nor shall any dried medical cannabis be stored in a safe or vault that is not bolted to the floor or structure of the facility; and

(15) Medical cannabis may be consumed on-site only as follows:

a. The smoking or vaporizing of medical cannabis shall be allowed provided that appropriate seating, restrooms, drinking water, ventilation, air purification system, and patient supervision are provided in a room or enclosed area separate from other Dispensing Center service areas.

b. The maximum occupancy of the on-site consumption area shall meet applicable occupancy requirements.

c. The Dispensing Center shall use an activated charcoal filter, or other device sufficient to eliminate all odors associated with medical cannabis use from adjoining businesses and public walkways. The fan used to move air through the filter shall have the capacity sufficient to ventilate the square footage of the separate room or enclosed area in which medical cannabis use is permitted.

(16) Dispensing Centers must verify that each member (1) is legally entitled to posses or consume medical cannabis pursuant to state law; and (2) is a resident of the State of _____.

(17) All Dispensing Center operators, employees, managers, members, or agents shall be qualified patients or the designated designated caregivers of qualified patients. Dispensing Center operators, employees, managers, members, or agents shall not sell, barter, give away, or furnish medicine to anyone who is not a qualified patient or designated caregiver, registered as a member of the Dispensing Center, and entitled to possess cannabis under state law.

(18) Dispensing Centers shall maintain accurate patient records necessary to demonstrate patient eligibility under the law for every Dispensing Center member, including (1) a copy of a valid driver's license or Department of Motor Vehicle

identification card, (2) a patient registration form, (3) a current valid letter of recommendation for the use of medical cannabis written by a state-licensed physician. All patient records shall be kept in a secure location, regarded as strictly confidential, and shall not be provided to law enforcement without a valid subpoena or court order.

(19) Operating hours for Dispensing Centers shall not exceed the hours between 8:00 AM and 10:00 PM daily.

(20) Dispensing Centers must have at least one licensed security guard on duty during operating hours.

Severability.

If any section, sub-section, paragraph, sentence, or word of this Article is deemed to be invalid, the invalidity of such provision shall not affect the validity of any other sections, sub-sections, paragraphs, sentences, or words of this Article, or the application thereof; and to that end, the sections, sub-sections, paragraphs, sentences, and words of this Article shall be deemed severable.