Financial Impact Estimating Conference

Use of Marijuana for Certain Medical Conditions

Serial Number 13-02

Reference Materials

Financial Impact Estimating Conference

Use of Marijuana for Certain Medical Conditions
Serial Number 13-02

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Official Notification

Official Notification

Letter from the Florida Department of State to the Financial Impact Estimating Conference (FIEC) dated September 26, 2013, to initiate an analysis and financial impact statement per Florida Statutes 100.371.

The 45-day window began on September 26th when the official transmittal letter was hand-delivered to EDR. This means that all of the FIEC work has to be completed by November 10th. Since that day is a Sunday and the following Monday is a state holiday, EDR plans to finish no later than Friday, November 8th.

The notice of workshops and conference for the FIEC is also enclosed.

FLORIDA DEPARTMENT of STATE

RICK SCOTT
Governor

KEN DETZNER
Secretary of State

September 26, 2013

Financial Impact Estimating Conference
c/o Ms. Amy Baker, Coordinator
Office of Economic and Demographic Research
111 West Madison Street, Suite 574
Tallahassee, Florida 32399-6588

Dear Ms. Baker:

Section 15.21, Florida Statutes, provides that the Secretary of State shall submit an initiative petition to the Financial Impact Estimating Conference when the sponsoring political committee has obtained ten percent of the signatures in one fourth of the Congressional Districts, as required by section 3, Article XI of the Florida Constitution, and has met registration and submission requirements.

People United for Medical Marijuana has successfully met the requirements of Section 15.21, Florida Statutes, for the initiative petition titled *Use of Marijuana for Certain Medical Conditions*, Serial Number 13-02. Therefore, I am submitting the proposed constitutional amendment for your review, along with a status update for the initiative petition, and a current county-by-county signature count.

Sincerely,

Ken Detzner
Secretary of State

KD/am

pc: John Morgan, Chairperson
People United for Medical Marijuana

Enclosures

RECEIVED
September 26, 2013 3:12 PM
Office of Economic & Demographic Research
Ann Jordon

R.A. Gray Bldg., Rm. 316 • 500 S Bronough St. • Tallahassee, Florida 32399-0250
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CONSTITUTIONAL AMENDMENT PETITION FORM

Note:
- All information on this form, including your signature, becomes a public record upon receipt by the Supervisor of Elections.
- Under Florida law, it is a first degree misdemeanor, punishable as provided in s. 775.082 or s. 775.083, Florida Statutes, to knowingly sign more than one petition for a candidate, a minor political party, or an issue. [Section 104.185, Florida Statutes]
- If all requested information on this form is not completed, the form will not be valid.

Your name_____
Please print name as it appears on your Voter Information Card

Your residential street address_____

City_____ Zip_____ County_____

Voter Registration Number_____ **OR** Date of Birth_____

I am a registered voter of Florida and hereby petition the Secretary of State to place the following proposed amendment to the Florida Constitution on the ballot in the general election:

BALLOT TITLE: Use of Marijuana for Certain Medical Conditions

BALLOT SUMMARY: Allows the medical use of marijuana for individuals with debilitating diseases as determined by a licensed Florida physician. Allows caregivers to assist patients' medical use of marijuana. The Department of Health shall register and regulate centers that produce and distribute marijuana for medical purposes and shall issue identification cards to patients and caregivers. Applies only to Florida law. Does not authorize violations of federal law or any non-medical use, possession or production of marijuana.

ARTICLE AND SECTION BEING AMENDED OR CREATED: Article X, Section 29

Full text of proposed constitutional amendment is as follows:

ARTICLE X, SECTION 29. Medical marijuana production, possession and use.—

(a) PUBLIC POLICY.

(1) The medical use of marijuana by a qualifying patient or personal caregiver is not subject to criminal or civil liability or sanctions under Florida law except as provided in this section.

(2) A physician licensed in Florida shall not be subject to criminal or civil liability or sanctions under Florida law for issuing a physician certification to a person diagnosed with a debilitating medical condition in a manner consistent with this section.

(3) Actions and conduct by a medical marijuana treatment center registered with the Department, or its employees, as permitted by this section and in compliance with Department regulations, shall not be subject to criminal or civil liability or sanctions under Florida law except as provided in this section.

(b) DEFINITIONS. For purposes of this section, the following words and terms shall have the following meanings:

(1) "Debilitating Medical Condition" means cancer, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis or other conditions for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for a patient.

(2) "Department" means the Department of Health or its successor agency.

(3) "Identification card" means a document issued by the Department that identifies a person who has a physician certification or a personal caregiver who is at least twenty-one (21) years old and has agreed to assist with a qualifying patient's medical use of marijuana.

(4) "Marijuana" has the meaning given cannabis in Section 893.02(3), Florida Statutes (2013).

(5) "Medical Marijuana Treatment Center" means an entity that acquires, cultivates, possesses, processes (including development of related products such as food, tinctures, aerosols, oils, or ointments), transfers, transports, sells, distributes, dispenses, or administers marijuana, products containing marijuana, related supplies, or educational materials to qualifying patients or their personal caregivers and is registered by the Department.

(6) "Medical use" means the acquisition, possession, use, delivery, transfer, or administration of marijuana or related supplies by a qualifying patient or personal caregiver for use by a qualifying patient for the treatment of a debilitating medical condition.

(7) "Personal caregiver" means a person who is at least twenty-one (21) years old who has agreed to assist with a qualifying patient's medical use of marijuana and has a caregiver identification card issued by the Department. A personal caregiver may assist no more than five (5) qualifying patients at one time. An employee of a hospice provider, nursing, or medical facility may serve as a personal caregiver to more than five (5) qualifying patients as permitted by the Department. Personal caregivers are prohibited from consuming marijuana obtained for the personal, medical use by the qualifying patient.

(8) "Physician" means a physician who is licensed in Florida.

(Continues on next page)

(Continued from previous page)

(9) "Physician certification" means a written document signed by a physician, stating that in the physician's professional opinion, the patient suffers from a debilitating medical condition, that the potential benefits of the medical use of marijuana would likely outweigh the health risks for the patient, and for how long the physician recommends the medical use of marijuana for the patient. A physician certification may only be provided after the physician has conducted a physical examination of the patient and a full assessment of the patient's medical history.

(10) "Qualifying patient" means a person who has been diagnosed to have a debilitating medical condition, who has a physician certification and a valid qualifying patient identification card. If the Department does not begin issuing identification cards within nine (9) months after the effective date of this section, then a valid physician certification will serve as a patient identification card in order to allow a person to become a "qualifying patient" until the Department begins issuing identification cards.

(c) LIMITATIONS.

(1) Nothing in this section shall affect laws relating to non-medical use, possession, production or sale of marijuana.

(2) Nothing in this section authorizes the use of medical marijuana by anyone other than a qualifying patient.

(3) Nothing in this section allows the operation of a motor vehicle, boat, or aircraft while under the influence of marijuana.

(4) Nothing in this law section requires the violation of federal law or purports to give immunity under federal law.

(5) Nothing in this section shall require any accommodation of any on-site medical use of marijuana in any place of education or employment, or of smoking medical marijuana in any public place.

(6) Nothing in this section shall require any health insurance provider or any government agency or authority to reimburse any person for expenses related to the medical use of marijuana.

(d) DUTIES OF THE DEPARTMENT. The Department shall issue reasonable regulations necessary for the implementation and enforcement of this section. The purpose of the regulations is to ensure the availability and safe use of medical marijuana by qualifying patients. It is the duty of the Department to promulgate regulations in a timely fashion.

(1) Implementing Regulations. In order to allow the Department sufficient time after passage of this section, the following regulations shall be promulgated no later than six (6) months after the effective date of this section:

a. Procedures for the issuance of qualifying patient identification cards to people with physician certifications, and standards for the renewal of such identification cards.

b. Procedures for the issuance of personal caregiver identification cards to persons qualified to assist with a qualifying patient's medical use of marijuana, and standards for the renewal of such identification cards.

c. Procedures for the registration of Medical Marijuana Treatment Centers that include procedures for the issuance, renewal, suspension, and revocation of registration, and standards to ensure security, record keeping, testing, labeling, inspection, and safety.

d. A regulation that defines the amount of marijuana that could reasonably be presumed to be an adequate supply for qualifying patients' medical use, based on the best available evidence. This presumption as to quantity may be overcome with evidence of a particular qualifying patient's appropriate medical use.

(2) Issuance of identification cards and registrations. The Department shall begin issuing qualifying patient and personal caregiver identification cards, as well as begin registering Medical Marijuana Treatment Centers no later than nine months (9) after the effective date of this section.

(3) If the Department does not issue regulations, or if the Department does not begin issuing identification cards and registering Medical Marijuana Treatment Centers within the time limits set in this section, any Florida citizen shall have standing to seek judicial relief to compel compliance with the Department's constitutional duties.

(4) The Department shall protect the confidentiality of all qualifying patients. All records containing the identity of qualifying patients shall be confidential and kept from public disclosure other than for valid medical or law enforcement purposes.

(e) LEGISLATION. Nothing in this section shall limit the legislature from enacting laws consistent with this provision.

(f) SEVERABILITY. The provisions of this section are severable and if any clause, sentence, paragraph or section of this measure, or an application thereof, is adjudged invalid by any court of competent jurisdiction other provisions shall continue to be in effect to the fullest extent possible.

DATE OF SIGNATURE

X_____

SIGNATURE OF REGISTERED VOTER

Include below the name and address of paid petition circulator if one was used to obtain signature (Section 106.19(3), F.S.)

Name of paid circulator (if applicable)

Address

RETURN TO:

People United for Medical Marijuana
Post Office Box 560296
Orlando, FL 32856

For official use only: *Serial number* 13-02

Date approved 7/10/2013

Pd. pol. adv. paid for and sponsored by People United for Medical Marijuana, P.O. Box 560296, Orlando, FL 32856

Attachment for Initiative Petition
Use of Marijuana for Certain Medical Conditions
Serial Number 13-02

1. **Name and address of the sponsor of the initiative petition:** People United for Medical Marijuana, 20 North Orange Avenue, Suite 1600, Orlando, Florida 32801; Chairperson is John Morgan, Esq.

2. **Name and address of the sponsor's attorney, if the sponsor is represented:** Unknown

3. **A statement as to whether the sponsor has obtained the requisite number of signatures on the initiative petition to have the proposed amendment put on the ballot:** As of September 26, 2013, the sponsor has not obtained the requisite number of signatures to have the proposed amendment placed on the ballot. A total of 683,149 valid signatures is required for placement on the 2014 general election ballot.

4. **If the sponsor has not obtained the requisite number of signatures on the initiative petition to have the proposed amendment put on the ballot, the current status of the signature-collection process:** As of September 26, 2013, the Supervisors of Elections have certified a total of 94,541 valid petition signatures to the Division of Elections for this initiative petition. This number represents more than 10% of the total number of valid signatures needed from electors statewide and in at least one-fourth of the congressional districts in order to have the initiative placed on the 2014 general election ballot.

5. **The date of the election during which the sponsor is planning to submit the proposed amendment to the voters:** Unknown. The earliest date of election that this proposed amendment can be placed on the ballot is November 4, 2014, provided the sponsor successfully obtains the requisite number of valid signatures by February 1, 2014.

6. **The last possible date that the ballot for the target election can be printed in order to be ready for the election:** September 4, 2014, if amendment is to be placed on November 2014 Ballot.

7. **A statement identifying the date by which the Financial Impact Statement will be filed, if the Financial Impact Statement is not filed concurrently with the request:** Unknown (The Secretary of State forwarded a letter to the Financial Impact Estimating Conference in the care of the coordinator on September 26, 2013.)

8. **The names and complete mailing addresses of all of the parties who are to be served:** This information is unknown at this time.

FLORIDA DEPARTMENT OF STATE
DIVISION OF ELECTIONS

SUMMARY OF PETITION SIGNATURES

Political Committee: **People United for Medical Marijuana**

Amendment Title: **Use of Marijuana for Certain Medical Conditions**

Congressional District	Voting Electors in 2012 Presidential Election	For Review 10% of 8% Required By Section 15.21 Florida Statutes	For Ballot 8% Required By Article XI, Section 3 Florida Constitution	Signatures Certified
FIRST	356,435	2,851	28,515	0
SECOND	343,558	2,748	27,485	2,022
THIRD	329,165	2,633	26,333	1,277
FOURTH	351,564	2,813	28,125	3,307
FIFTH	279,598	2,237	22,368	4,986
SIXTH	363,402	2,907	29,072	4,624
SEVENTH	333,990	2,672	26,719	2,912
EIGHTH	365,738	2,926	29,259	2,168
NINTH	277,101	2,217	22,168	1,995
TENTH	329,366	2,635	26,349	1,749
ELEVENTH	359,004	2,872	28,720	1,166
TWELFTH	345,407	2,763	27,633	3,723
THIRTEENTH	344,500	2,756	27,560	4,298
FOURTEENTH	295,917	2,367	23,673	6,340
FIFTEENTH	304,932	2,439	24,395	2,472
SIXTEENTH	360,734	2,886	28,859	2,383
SEVENTEENTH	299,464	2,396	23,957	790
EIGHTEENTH	345,399	2,763	27,632	2,568
NINETEENTH	323,317	2,587	25,865	949
TWENTIETH	264,721	2,118	21,178	8,271
TWENTY-FIRST	326,392	2,611	26,111	2,927
TWENTY-SECOND	329,816	2,639	26,385	5,110
TWENTY-THIRD	290,042	2,320	23,203	5,694
TWENTY-FOURTH	263,367	2,107	21,069	13,000
TWENTY-FIFTH	240,521	1,924	19,242	1,932
TWENTY-SIXTH	268,898	2,151	21,512	4,441
TWENTY-SEVENTH	247,023	1,976	19,762	3,437
TOTAL:	**8,539,371**	**68,314**	**683,149**	**94,541**

Date: 9/26/2013 11:18:06 AM

Official Notification

The notice of workshops and conference for the FIEC.

NOTICE OF WORKSHOPS AND CONFERENCE
FINANCIAL IMPACT ESTIMATING CONFERENCE

The Financial Impact Estimating Conference (FIEC) will be holding workshops and a conference on the petition initiative entitled "*Use of Marijuana for Certain Medical Conditions"*. Unless otherwise indicated on the schedule below, all meetings will begin at 9:00 a.m. in Room 117, Knott Building, 415 W. St. Augustine Street, Tallahassee, Florida. They will continue until completion of the agenda.

The FIEC is required by s. 100.371, Florida Statutes, to review, analyze, and estimate the financial impact of amendments to or revisions of the State Constitution proposed by initiative. In this regard, the FIEC is now in the process of preparing financial impact statements to be placed on the ballot that show the estimated increase or decrease in any revenues or costs to state and local governments resulting from proposed initiatives.

The purpose of the Public Workshop is to provide an opportunity for proponents and opponents of the initiative to make formal presentations to the FIEC regarding the probable financial impact of the initiative. In addition to the workshop, proponents and opponents may submit information at any time to the FIEC by contacting the Legislative Office of Economic and Demographic Research (contact information below).

Use of Marijuana for Certain Medical Conditions

- Public Workshop – October 21, 2013
- Principals' Workshop – October 28, 2013
- Formal Conference – November 4, 2013

For additional information regarding the meetings, please contact the Florida Legislature's Office of Economic and Demographic Research at (850) 487-1402.

Address for submitting information to the FIEC:

The Florida Legislature
Office of Economic and Demographic Research
111 West Madison, Suite 574
Tallahassee, FL 32399-6588
Email:edrcoordinator@leg.state.fl.us
FAX: (850)922-6436

For additional information regarding the Financial Impact Estimating Conference process and the Initiative Petition process, please visit the Florida Legislature's Office of Economic and Demographic Research's website at: http://edr.state.fl.us/Content/constitutional-amendments/index.cfm and the Florida Department of State, Division on of Elections' website at: http://election.dos.state.fl.us/initiatives/initiativelist.asp

Tab 2

Statutory Authorization for FIEC

Statutory Authorization for FIEC

Section 100.371, Florida Statutes: Initiatives; procedure for placement on ballot.

100.371 Initiatives; procedure for placement on ballot.—

(1) Constitutional amendments proposed by initiative shall be placed on the ballot for the general election, provided the initiative petition has been filed with the Secretary of State no later than February 1 of the year the general election is held. A petition shall be deemed to be filed with the Secretary of State upon the date the secretary determines that valid and verified petition forms have been signed by the constitutionally required number and distribution of electors under this code.

(2) The sponsor of an initiative amendment shall, prior to obtaining any signatures, register as a political committee pursuant to s. 106.03 and submit the text of the proposed amendment to the Secretary of State, with the form on which the signatures will be affixed, and shall obtain the approval of the Secretary of State of such form. The Secretary of State shall adopt rules pursuant to s. 120.54 prescribing the style and requirements of such form. Upon filing with the Secretary of State, the text of the proposed amendment and all forms filed in connection with this section must, upon request, be made available in alternative formats.

(3) An initiative petition form circulated for signature may not be bundled with or attached to any other petition. Each signature shall be dated when made and shall be valid for a period of 2 years following such date, provided all other requirements of law are met. The sponsor shall submit signed and dated forms to the supervisor of elections for the county of residence listed by the person signing the form for verification of the number of valid signatures obtained. If a signature on a petition is from a registered voter in another county, the supervisor shall notify the petition sponsor of the misfiled petition. The supervisor shall promptly verify the signatures within 30 days after receipt of the petition forms and payment of the fee required by s. 99.097. The supervisor shall promptly record, in the manner prescribed by the Secretary of State, the date each form is received by the supervisor, and the date the signature on the form is verified as valid. The supervisor may verify that the signature on a form is valid only if:

(a) The form contains the original signature of the purported elector.

(b) The purported elector has accurately recorded on the form the date on which he or she signed the form.

(c) The form sets forth the purported elector's name, address, city, county, and voter registration number or date of birth.

(d) The purported elector is, at the time he or she signs the form and at the time the form is verified, a duly qualified and registered elector in the state.

The supervisor shall retain the signature forms for at least 1 year following the election in which the issue appeared on the ballot or until the Division of Elections notifies the supervisors of elections that the committee that circulated the petition is no longer seeking to obtain ballot position.

(4) The Secretary of State shall determine from the signatures verified by the supervisors of elections the total number of verified valid signatures and the distribution of such signatures by congressional districts. Upon a determination that the requisite number and distribution of valid signatures have been obtained, the secretary shall issue a certificate of ballot position for that proposed amendment and shall assign a designating number pursuant to s. 101.161.

(5)(a) Within 45 days after receipt of a proposed revision or amendment to the State Constitution by initiative petition from the Secretary of State, the Financial Impact Estimating Conference shall complete an analysis and financial impact statement to be placed on the ballot of the estimated increase or decrease in any revenues or costs to state or local governments resulting from the proposed initiative. The Financial Impact Estimating Conference shall submit the financial impact statement to the Attorney General and Secretary of State.

(b) The Financial Impact Estimating Conference shall provide an opportunity for any proponents or opponents of the initiative to submit information and may solicit information or analysis from any other entities or agencies, including the Office of Economic and Demographic Research.

(c) All meetings of the Financial Impact Estimating Conference shall be open to the public. The President of the Senate and the Speaker of the House of Representatives, jointly, shall be the sole judge for the interpretation, implementation, and enforcement of this subsection.

1. The Financial Impact Estimating Conference is established to review, analyze, and estimate the financial impact of amendments to or revisions of the State Constitution proposed by initiative. The Financial Impact Estimating Conference shall consist of four principals: one person from the Executive Office of the Governor; the coordinator of the Office of Economic and Demographic Research, or his or her designee; one person from the professional staff of the Senate; and one person from the professional staff of the House of Representatives. Each principal shall have appropriate fiscal expertise in the subject matter of the initiative. A Financial Impact Estimating Conference may be appointed for each initiative.

2. Principals of the Financial Impact Estimating Conference shall reach a consensus or majority concurrence on a clear and unambiguous financial impact statement, no more than 75 words in length, and immediately submit the statement to the Attorney General. Nothing in this subsection prohibits the Financial Impact Estimating Conference from setting forth a range of potential impacts in the financial impact statement. Any financial impact statement that a court finds not to be in accordance with this section shall be remanded solely to the Financial Impact Estimating Conference for redrafting. The Financial Impact Estimating Conference shall redraft the financial impact statement within 15 days.

3. If the members of the Financial Impact Estimating Conference are unable to agree on the statement required by this subsection, or if the Supreme Court has rejected the initial submission by the Financial Impact Estimating Conference and no redraft has been approved by the Supreme Court by 5 p.m. on the 75th day before the election, the following statement shall appear on the ballot pursuant to s. 101.161(1): “The financial impact of this measure, if any, cannot be reasonably determined at this time.”

(d) The financial impact statement must be separately contained and be set forth after the ballot summary as required in s. 101.161(1).

(e)1. Any financial impact statement that the Supreme Court finds not to be in accordance with this subsection shall be remanded solely to the Financial Impact Estimating Conference for redrafting, provided the court’s advisory opinion is rendered at least 75 days before the election at which the question of ratifying the amendment will be presented. The Financial Impact Estimating Conference shall prepare and adopt a revised financial impact statement no later than 5 p.m. on the 15th day after the date of the court’s opinion.

2. If, by 5 p.m. on the 75th day before the election, the Supreme Court has not issued an advisory opinion on the initial financial impact statement prepared by the Financial Impact Estimating Conference for an initiative amendment that otherwise meets the legal requirements for ballot placement, the financial impact statement shall be deemed approved for placement on the ballot.

3. In addition to the financial impact statement required by this subsection, the Financial Impact Estimating Conference shall draft an initiative financial information statement. The initiative financial information statement should describe in greater detail than the financial impact statement any projected increase or decrease in revenues or costs that the state or local governments would likely experience if the ballot measure were approved. If appropriate, the initiative financial information statement may include both estimated dollar amounts and a description placing the estimated dollar amounts into context. The initiative financial information statement must include both a summary of not more than 500 words and additional detailed information that includes the assumptions that were made to develop the financial impacts, workpapers, and any other information deemed relevant by the Financial Impact Estimating Conference.

4. The Department of State shall have printed, and shall furnish to each supervisor of elections, a copy of the summary from the initiative financial information statements. The supervisors shall have the summary from the initiative financial information statements available at each polling place and at the main office of the supervisor

of elections upon request.

5. The Secretary of State and the Office of Economic and Demographic Research shall make available on the Internet each initiative financial information statement in its entirety. In addition, each supervisor of elections whose office has a website shall post the summary from each initiative financial information statement on the website. Each supervisor shall include the Internet addresses for the information statements on the Secretary of State's and the Office of Economic and Demographic Research's websites in the publication or mailing required by s. 101.20.

(6) The Department of State may adopt rules in accordance with s. 120.54 to carry out the provisions of subsections (1)-(5).

(7) No provision of this code shall be deemed to prohibit a private person exercising lawful control over privately owned property, including property held open to the public for the purposes of a commercial enterprise, from excluding from such property persons seeking to engage in activity supporting or opposing initiative amendments.

History.—s. 15, ch. 79-365; s. 12, ch. 83-251; s. 30, ch. 84-302; s. 22, ch. 97-13; s. 9, ch. 2002-281; s. 3, ch. 2002-390; s. 3, ch. 2004-33; s. 28, ch. 2005-278; s. 4, ch. 2006-119; s. 25, ch. 2007-30; s. 1, ch. 2007-231; s. 14, ch. 2008-95; s. 23, ch. 2011-40.

Tab 3

Information on States with Medical Marijuana Laws

Information on States with Medical Marijuana Laws

A listing of states with medical marijuana laws from the National Conference of State Legislatures (NCSL), updated September 2013.

State Medical Marijuana Laws

Updated September 2013

In 1996, California voters passed Proposition 215, making the Golden State the first in the union to allow for the medical use of marijuana. Since then, 19 more states, and the District of Columbia have enacted similar laws, **for a total of 20 states and the District of Columbia with public medical marijuana programs**.**

Medical Uses of Marijuana

In response to California's Prop 215, the Institute of Medicine issued a report that examined potential therapeutic uses for marijuana. The report found that:
"Scientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of nausea and vomiting, and appetite stimulation; smoked marijuana, however, is a crude THC delivery system that also delivers harmful substances. The psychological effects of cannabinoids, such as anxiety reduction, sedation, and euphoria can influence their potential therapeutic value. Those effects are potentially undesirable for certain patients and situations and beneficial for others. In addition, psychological effects can complicate the interpretation of other aspects of the drug's effect."
Further studies have found that marijuana is effective in relieving some of the symptoms of HIV/AIDS, cancer, glaucoma, and multiple sclerosis.[1]

State Vs Federal Perspective

At the federal level, marijuana remains classified as a Schedule I substance under the Controlled Substances Act, where Schedule I substances are considered to have a high potential for dependency and no accepted medical use, making distribution of marijuana a federal offense. In October of 2009, the Obama Administration sent a memo to federal prosecutors encouraging them not to prosecute people who distribute marijuana for medical purposes in accordance with state law.

In late August of 2013, the U.S. Department of Justice announced an update to their marijuana enforcement policy. The statement reads that while marijuana remains illegal federally, the USDOJ expects states like Colorado and Washington to create "strong, state-based enforcement efforts.... and will defer the right to challenge their legalization laws at this time." The department also reserves the right to challenge the states at any time they feel it's necessary.

Arizona and the District of Columbia voters passed initiatives to allow for medical use, only to have them overturned. In 1998, voters in the District of Columbia passed Initiative 59. However, Congress blocked the initiative from becoming law. In 2009, Congress reversed its previous decision, allowing the initiative to become law. The D.C. Council then put Initiative 59 on hold temporarily and unanimously approved modifications to the law.

Before passing Proposition 203 in 2010, Arizona voters originally passed a ballot initiative in 1996. However, the initiative stated that doctors would be allowed to write a "prescription" for marijuana. Since marijuana is still a Schedule I substance, federal law prohibits its prescription, making the initiative invalid. Medical marijuana "prescriptions" are more often called "recommendations" or "referrals" because of the federal prescription prohibition.

States with medical marijuana laws generally have some form of patient registry, which may provide some protection against arrest for possession up to a certain amount of marijuana for personal medicinal use. The primary exception is Maryland, whose statute simply allows for medical purposes as a defense against arrest and prosecution of marijuana possession, but does not provide a means for patients to actually obtain the drug. As of April, 2011, people in Maryland with a debiliating medical condition cannot be prosecuted for non-public use or possession of one ounce or less of marijuana.

Some of the most common policy questions regarding medical marijuana include how to regulate its recommendation, dispensing, and registration of approved patients. Some states and localities without dispensary regulation are experiencing a boom in new businesses, in hopes of being approved before presumably stricter regulations are made. Medical marijuana growers or dispensaries are often called "caregivers" and may be limited to a certain number of plants or products per patient. This issue may also be regulated on a local level, in addition to any state regulation.

Resources

- Comparison of all state medical marijuana programs with contact information. Prepared by the Network for Public Health Law as of May 2012.
- "State Legalization of **Recreational** Marijuana: Selected Legal Issues." Congressional Research Service, April 2013.
- Analysis of CO Amendment 64 (rec use initiative) by Colorado State University, April 2013.
- "Marijuana and Medicine: Assessing the Science Base," Institute of Medicine, 1999.
- Treatment Research Institute's (TRI) policy position statement regarding medical marijuana.
- ProCon.org's resources on medical marijuana. Medical Marijuana ProCon.org presents laws, studies, statistics, surveys, government reports, and pro and con statements on questions related to marijuana as medicine.
- "Exposing the Myth of Smoked Medical Marijuana," U.S. Drug Enforcement Administration.
- "State-by-State Medical Marijuana Laws: How to Remove the Threat of Arrest," Marijuana Policy Project, 2011.
- Statement by ONDCP Director Gil Kerlikowske regarding Federal guidelines for medical marijuana prosecution.
- "How to Become a Legal Medical Marijuana Patient," Americans for Safe Access.
- "Marinol: The Legal Medical Use for the Marijuana Plant," U.S. Drug Enforcement Administration

NCSL Contact

- Contact Karmen Hanson, program manager (Denver)

State	Statutory Language (year)	Patient Registry	Allow Dispensaries	Specify Conditions	Recognize Patients from other states	State Allows for Recreational Use
Alaska	Measure 8 (1998) SB 94 (1999) Statute Title 17, Chapter 37	Yes	No	Yes		
Arizona	Proposition 203 (2010)	Yes	Yes	Yes	Yes	
California	Proposition 215 (1996) SB 420 (2003)	Yes	Yes	No		
Colorado	Amendment 20 (2000)	Yes	Yes	Yes		Amendment 64 (2012) Task Force Implementation Recommendations (2013) Analysis of CO Amendment 64 (2013)
Connecticut	HB 5387 (2012)	Yes	Yes	Yes		

State	Statutory Language (year)	Patient Registry	Allow Dispensaries	Specify Conditions	Recognize Patients from other states	State Allows for Recreational Use
Delaware	SB 17 (2011)	Yes	Yes	Yes	Yes	
District of Columbia	Initiative 59 (1998) LR 720 (2010)	Yes	Yes	TBD		
Hawaii	SB 862 (2000)	Yes	No	Yes		
Illinois	HB 1 (2013) *Eff. 1/1/2014*	Yes	Yes	Yes	No	
Maine	Question 2 (1999) LD 611 (2002) Question 5 (2009) LD 1811 (2010) LD 1296 (2011)	Yes	Yes	Yes	Yes	
Maryland (NOT a fully functioning public program, see below)	HB 702 (2003) SB 308 (2011) HB 180/SB 580 (2013) HB 1101-Chapter 403 (2013)	**No**	**No**	**No (legal defense only-state only has limited medical marijuana program for research)**		
Massachusetts	Question 3 (2012) Regulations (2013)	Yes	Yes	Yes		
Michigan	Proposal 1 (2008)	Yes	No	Yes	Yes	
Montana	Initiative 148 (2004) SB 423 (2011)	Yes	No***	Yes	No	
Nevada	Question 9 (2000) NRS 453A NAC 453A	Yes	No	Yes		
New Hampshire	HB 573 (2013)	Yes	Yes	Yes	Yes, with a note from their home state, but they cannot purchase or grow their own in NH.	
New Jersey	SB 119 (2009)	Yes	Yes	Yes		
New Mexico	SB 523 (2007)	Yes	Yes	Yes		
Oregon	Oregon Medical Marijuana Act (1998) SB 161 (2007)	Yes	No	Yes		
Rhode Island	SB 791 (2007) SB 185 (2009)	Yes	Yes	Yes	Yes	
Vermont	SB 76 (2004) SB 7 (2007) SB 17 (2011)	Yes	Yes	Yes		
Washington	Initiative 692 (1998) SB 5798 (2010) SB 5073 (2011)	No	No	Yes		Initiative 502 (2012)

**The links and resources are provided for information purposes only. NCSL does not endorse the views expressed in any of the articles linked from this page.*

** As of 4/22/13: Maryland's law allows for medical marijuana use as a legal defense in court. **Possession of more than one ounce of marijuana and public consumption for medical reasons is still illegal. 2013 bill allows caregivers to be included in the affirmative legal defense category. HB 1101 legalized a medical use RESEARCH program and was signed by the governor on 5/3/2013 as Chapter 403.**

*** While Montana's revised medical marijuana law limits caregivers to three patients, caregivers may serve an unlimited number of patients due to an injunction issued on January 16, 2013.

Denver Office
Tel: 303-364-7700 | Fax: 303-364-7800 | 7700 East First Place | Denver, CO 80230

Washington Office
Tel: 202-624-5400 | Fax: 202-737-1069 | 444 North Capitol Street, N.W., Suite 515 | Washington, D.C. 20001

Information on States with Medical Marijuana Laws

A listing of states with medical marijuana laws from ProCon.org, updated September 16, 2013.

Medical Marijuana
ProCon.org

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20 Legal Medical Marijuana States and DC
Laws, Fees, and Possession Limits

I. Summary Chart II. Details by State III. Sources

I. Summary Chart: 20 states and DC have enacted laws to legalize medical marijuana

State	Year Passed	How Passed (Yes Vote)	Fee	Possession Limit	Accepts other states' registry ID cards?
1. Alaska	1998	Ballot Measure 8 (58%)	$25/ $20	1 oz usable; 6 plants (3 mature, 3 immature)	unknown[1]
2. Arizona	2010	Proposition 203 (50.13%)	$150/ $75	2.5 oz usable; 0-12 plants[2]	Yes[3]
3. California	1996	Proposition 215 (56%)	$66/ $33	8 oz usable; 6 mature or 12 immature plants[4]	No
4. Colorado	2000	Ballot Amendment 20 (54%)	$35	2 oz usable; 6 plants (3 mature, 3 immature)	No
5. Connecticut	2012	House Bill 5389 (96-51 House, 21-13 Senate)	TBD*	One-month supply (exact amount to be determined)	No
6. DC	2010	Amendment Act B18-622 (13-0 vote)	$100/ $25	2 oz dried; limits on other forms to be determined	No
7. Delaware	2011	Senate Bill 17 (27-14 House, 17-4 Senate)	$125	6 oz usable	Yes[5]
8. Hawaii	2000	Senate Bill 862 (32-18 House; 13-12 Senate)	$25	3 oz usable; 7 plants (3 mature, 4 immature)	No
9. Illinois	2013	House Bill 1 (61-57 House; 35-21 Senate)	TBD*	2.5 ounces of usable cannabis during a period of 14 days	No
10. Maine	1999	Ballot Question 2 (61%)	No fee	2.5 oz usable; 6 plants	Yes[6]
11. Massachusetts	2012	Ballot Question 3 (63%)	TBD[7]	Sixty day supply for personal medical use	unknown
12. Michigan	2008	Proposal 1 (63%)	$100/ $25	2.5 oz usable; 12 plants	Yes
13. Montana	2004	Initiative 148 (62%)	$25/ $10	1 oz usable; 4 plants (mature); 12 seedlings	No
14. Nevada	2000	Ballot Question 9 (65%)	$200[8]	1 oz usable; 7 plants (3 mature, 4 immature)	Yes[9]
15. New Hampshire	2013	House Bill 573 (284-66 House; 18-6 Senate)	TBD*	Two ounces of usable cannabis during a 10-day period	Yes

16. **New Jersey**	2010	Senate Bill 119 (48-14 House; 25-13 Senate)	$200/ $20	2 oz usable	No
17. **New Mexico**	2007	Senate Bill 523 (36-31 House; 32-3 Senate)	$0	6 oz usable; 16 plants (4 mature, 12 immature)	No
18. **Oregon**	1998	Ballot Measure 67 (55%)	$200/ $100[10]	24 oz usable; 24 plants (6 mature, 18 immature)	No
19. **Rhode Island**	2006	Senate Bill 0710 (52-10 House; 33-1 Senate)	$75/ $10	2.5 oz usable; 12 plants	Yes
20. **Vermont**	2004	Senate Bill 76 (22-7) HB 645 (82-59)	$50	2 oz usable; 9 plants (2 mature, 7 immature)	No
21. **Washington**	1998	Initiative 692 (59%)	**	24 oz usable; 15 plants	No

Notes:

a. **Residency Requirement** - 18 of the 20 states require proof of residency to be considered a qualifying patient for medical marijuana use. Only Oregon has announced that it will accept out-of-state applications. The Illinois law does not appear to have a residency requirement, but it is unknown whether the program rules will address this matter.

b. **Home Cultivation** - Karen O'Keefe, JD, Director of State Policies for Marijuana Policy Project (MPP), told ProCon.org in a August 5, 2013 email that "Some or all patients and/or their caregivers can cultivate in 15 of the 20 states. Home cultivation is not allowed in Connecticut, Delaware, Illinois, New Hampshire, New Jersey, or the District of Columbia and a special license is required in New Mexico. In Arizona, patients can only cultivate if they lived 25 miles or more from a dispensary when they applied for their card. In Massachusetts, patients can only cultivate if they have a hardship waiver. In Nevada, patients can cultivate if they live more than 25 miles from a dispensary, if they are not able to reasonably travel to a dispensary, or if no dispensaries in the patients' counties are able to supply the strains they need. In addition, Nevada patients who were growing by July 1, 2013 may continue grow until March 31, 2016."

c. **Patient Registration** - Karen O'Keefe stated the following in an Aug. 5, 2013 email to ProCon.org:

> "Affirmative defenses, which protect from conviction but not arrest, are or may be available in several states even if the patient doesn't have an ID card: Rhode Island, Michigan, Colorado, Nevada, Oregon, and, in some circumstances, Delaware. Hawaii also has a separate 'choice of evils' defense. Patient ID cards are voluntary in Maine and California, but in California they offer the strongest legal protection. In Delaware, the defense is only available between when a patient submits a valid application and receives their ID card.
>
> The states with no protection unless you're registered are: Alaska (except for that even non-medical use is protected in one's home due to the state constitutional right to privacy), Arizona, Connecticut, Montana, New Hampshire, Vermont, New Mexico, and New Jersey. Washington, D.C. also requires registration."

d. **Maryland** - Maryland passed two laws that, although favorable to medical marijuana, do not legalize its use. **Senate Bill 502** (72 KB), the "Darrell Putman Bill" (Resolution #0756-2003) was approved in the state senate by a vote of 29-17, signed into law by Gov. Robert L. Ehrlich, Jr. on May 22, 2003, and took effect on Oct. 1, 2003. The law allows defendants being prosecuted for the use or possession of marijuana to introduce evidence of medical necessity and physician approval, to be considered by the court as a mitigating factor. If the court finds that the case involves medical necessity, the maximum penalty is a fine not exceeding $100. The law does not protect users of medical marijuana from arrest nor does it establish a registry program.

On May 10, 2011, Maryland Governor Martin O'Malley signed **SB 308** (500 KB), into law. SB 308 removed criminal penalties for medical marijuana patients who meet the specified conditions, but

patients are still subject to arrest. The bill provides an affirmative defense for defendants who have been diagnosed with a debilitating medical condition that is "severe and resistant to conventional medicine." The affirmative defense does not apply to defendants who used medical marijuana in public or who were in possession of more than one ounce of marijuana. The bill also created a Work Group to "develop a model program to facilitate patient access to marijuana for medical purposes."

Maryland passed two medical marijuana-related laws in 2013. HB 180 (150 KB), signed into law by Governor O'Malley on Apr. 9, 2013, provides an affirmative defense to a prosecution for caregivers of medical marijuana patients. HB 1101 (200 KB), signed into law by Governor O'Malley on May 2, 2013, allows for the investigational use of marijuana for medical purposes by "academic medical centers." The University of Maryland Medical System and Johns Hopkins University indicated they would not participate (230 KB).

e. Several states with legal medical marijuana received **letters from their respective United States Attorney's offices** (2 MB) explaining that marijuana is a Schedule I substance and that the federal government considers growing, distribution, or possession of marijuana to be a federal crime regardless of the state laws. An Aug. 29, 2013 (525 KB) Department of Justice memo clarified the government's prosecutorial priorities and stated that the federal government would rely on state and local law enforcement to "address marijuana activity through enforcement of their own narcotics laws."

f. Between Mar. 27, 1979 and July 23, 1991, five US states enacted laws that legalized medical marijuana with a physician's prescription, however, those laws are considered symbolic because federal law prohibits physicians from "prescribing" marijuana, a schedule I drug.

The five states were Virginia (25 KB) (Mar. 27, 1979), New Hampshire (Apr. 23, 1981), Connecticut (July 1, 1981), Wisconsin (Apr. 20, 1988), and Louisiana (July 23, 1991).

II. Details by State: 20 states and DC that have enacted laws to legalize medical marijuana	
State and Relevant Medical Marijuana Laws	**Contact and Program Details**
1. Alaska **Ballot Measure 8** (100 KB) -- Approved Nov. 3, 1998 by 58% of voters **Effective:** Mar. 4, 1999 Removed state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physician advising that they "might benefit from the medical use of marijuana." **Approved Conditions:** Cachexia, cancer, chronic pain, epilepsy and other disorders characterized by seizures, glaucoma, HIV or AIDS, multiple sclerosis and other disorders characterized by muscle spasticity, and nausea. Other conditions are subject to approval by the Alaska Department of Health and Social Services. **Possession/Cultivation:** Patients (or their primary caregivers) may legally possess no more than one ounce of usable marijuana, and may cultivate no more than six marijuana plants, of which no more than three may be mature. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. **Amended**: **Senate Bill 94** **Effective:** June 2, 1999	**Alaska Bureau of Vital Statistics** Marijuana Registry P.O. Box 110699 Juneau, AK 99811-0699 Phone: 907-465-5423 BVSSpecialServices@health.state.ak.us AK Marijuana Registry Online **Information provided by the state on sources for medical marijuana:** None found **Patient Registry Fee:** $25 new application/$20 renewal **Accepts other states' registry ID cards?** [1:] Unknown [**Editor's Note:** Four phone calls made Jan. 5-8, 2010 and an email sent on Jan. 6, 2010 by ProCon.org to the Alaska Marijuana Registry have not yet been returned and the information is not available on the state's website (as of Jan. 11, 2010).]

Mandates all patients seeking legal protection under this act to enroll in the state patient registry and possess a valid identification card. Patients not enrolled in the registry will no longer be able to argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges. **Update:** Alaska Statute Title 17 Chapter 37 (36 KB) Creates a confidential statewide registry of medical marijuana patients and caregivers and establishes identification card.	**Registration:** Mandatory
2. Arizona **Ballot Proposition 203** (300 KB) "Arizona Medical Marijuana Act" -- Approved Nov. 2, 2010 by 50.13% of voters Allows registered qualifying patients (who must have a physician's written certification that they have been diagnosed with a debilitating condition and that they would likely receive benefit from marijuana) to obtain marijuana from a registered nonprofit dispensary, and to possess and use medical marijuana to treat the condition. Requires the Arizona Department of Health Services to establish a registration and renewal application system for patients and nonprofit dispensaries. Requires a web-based verification system for law enforcement and dispensaries to verify registry identification cards. Allows certification of a number of dispensaries not to exceed 10% of the number of pharmacies in the state (which would cap the number of dispensaries around 124). Specifies that a registered patient's use of medical marijuana is to be considered equivalent to the use of any other medication under the direction of a physician and does not disqualify a patient from medical care, including organ transplants. Specifies that employers may not discriminate against registered patients unless that employer would lose money or licensing under federal law. Employers also may not penalize registered patients solely for testing positive for marijuana in drug tests, although the law does not authorize patients to use, possess, or be impaired by marijuana on the employment premises or during the hours of employment. **Approved Conditions:** Cancer, glaucoma, HIV/AIDS, Hepatitis C, ALS, Crohn's disease, Alzheimer's disease, cachexia or wasting syndrome, severe and chronic pain, severe nausea, seizures (including epilepsy), severe or persistent muscle spasms (including multiple sclerosis). **Possession/Cultivation:** Qualified patients or their registered designated caregivers may obtain up to 2.5 ounces of marijuana in a 14-day period from a registered nonprofit medical marijuana dispensary. [2:] If the patient lives more than 25 miles from the nearest dispensary, the patient or caregiver may cultivate up to 12 marijuana plants in an enclosed, locked facility. **Amended:** Senate Bill 1443 (20 KB) **Effective:** Signed by Governor Jan Brewer on May 7, 2013	**Arizona Department of Health Services (ADHS)** Medical Marijuana Program 150 North 18th Avenue Phoenix, Arizona 85007 Phone: 602-542-1023 Prop 203 Information Hub **Information provided by the state on sources for medical marijuana:** "Qualifying patients can obtain medical marijuana from a dispensary, the qualifying patient's designated caregiver, another qualifying patient, or, if authorized to cultivate, from home cultivation. When a qualifying patient obtains or renews a registry identification card, the Department will provide a list of all operating dispensaries to the qualifying patient." ADHS, "Qualifying Patients FAQs," (150 KB) Mar. 25, 2010 **Patient Registry Fee:** $150 / $75 for Supplemental Nutrition Assistance Program participants **Accepts other states' registry ID cards?** [3:] Yes, but does not permit visiting patients to obtain marijuana from an Arizona dispensary **Registration:** Mandatory

"Specifies the prohibition to possess or use marijuana on a postsecondary educational institution campus does not apply to medical research projects involving marijuana that are conducted on the campus, as authorized by applicable federal approvals and on approval of the applicable university institutional review board."

[**Editor's Note:** On Apr. 11, 2012, the Arizona Department of Health Services (ADHS) announced the revised rules (1.1 MB) for regulating medical marijuana and set the application dates for May 14 through May 25.

On Nov. 15, 2012, the first dispensary was awarded "approval to operate." ADHS Director Will Humble stated on his blog that, "[W]e'll be declining new 'requests to cultivate' among new cardholders in most of the metro area… because self-grow (12 plants) is only allowed when the patient lives more than 25 miles from the nearest dispensary. The vast majority of the Valley is within 25 miles of this new dispensary."

On Dec. 6, 2012, the state's first dispensary, Arizona Organix, opened in Glendale.]

3. California

Ballot Proposition 215 (45 KB) -- Approved Nov. 5, 1996 by 56% of voters
Effective: Nov. 6, 1996

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a "written or oral recommendation" from their physician that he or she "would benefit from medical marijuana." Patients diagnosed with any debilitating illness where the medical use of marijuana has been "deemed appropriate and has been recommended by a physician" are afforded legal protection under this act.

Approved Conditions: AIDS, anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, persistent muscle spasms, including spasms associated with multiple sclerosis, seizures, including seizures associated with epilepsy, severe nausea; Other chronic or persistent medical symptoms.

Amended: Senate Bill 420 (70 KB)
Effective: Jan. 1, 2004

Imposes statewide guidelines outlining how much medicinal marijuana patients may grow and possess.

Possession/Cultivation: Qualified patients and their primary caregivers may possess no more than eight ounces of dried marijuana and/or six mature (or 12 immature) marijuana plants. However, S.B. 420 allows patients to possess larger amounts of marijuana when recommended by a physician. The legislation also allows counties and municipalities to approve and/or maintain local ordinances permitting patients to possess larger quantities of medicinal pot than allowed under the new state guidelines.

S.B. 420 also grants implied legal protection to the state's medicinal marijuana dispensaries, stating, "Qualified patients, persons with

California Department of Public Health
Office of County Health Services
Attention: Medical Marijuana Program Unit
MS 5203
P.O. Box 997377
Sacramento, CA 95899-7377
Phone: 916-552-8600
Fax: 916-440-5591

mmpinfo@dhs.ca.gov

CA Medical Marijuana Program

Guidelines for the Security and Non-diversion of Marijuana Grown for Medical Use (55 KB)

Information provided by the state on sources for medical marijuana:
"Dispensaries, growing collectives, etc., are licensed through local city or county business ordinances and the regulatory authority lies with the State Attorney General's Office. Their number is 1-800-952-5225." (accessed Jan. 11, 2010)

Patient Registry Fee:
$66 non Medi-Cal / $33 Medi-Cal, plus additional county fees (varies by location)

Accepts other states' registry ID cards?
No

valid identification cards, and the designated primary caregivers of qualified patients ... who associate within the state of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions."

4: [**Editor's Note:** On Jan. 21, 2010, the California Supreme Court affirmed (S164830 (300 KB)) the May 22, 2008 Second District Court of Appeals ruling (50 KB) in the Kelly Case that the possession limits set by SB 420 violate the California constitution because the voter-approved Prop. 215 can only be amended by the voters.

ProCon.org contacted the California Medical Marijuana Program (MMP) on Dec. 6, 2010 to ask 1) how the ruling affected the implementation of the program, and 2) what instructions are given to patients regarding possession limits. A California Department of Public Health (CDPH) Office of Public Affairs representative wrote the following in a Dec. 7, 2010 email to ProCon.org: "The role of MMP under Senate Bill 420 is to implement the State Medical Marijuana ID Card Program in all California counties. CDPH does not oversee the amounts that a patient may possess or grow. When asked what a patient can possess, patients are referred to www.courtinfo.ca.gov, case S164830 which is the Kelly case, changing the amounts a patient can possess from 8 oz, 6 mature plants or 12 immature plants to 'the amount needed for a patient's personal use.' MMP can only cite what the law says."

According to a Jan. 21, 2010 article titled "California Supreme Court Further Clarifies Medical Marijuana Laws," by Aaron Smith, California Policy Director at the Marijuana Policy Project, the impact of the ruling is that people growing more than 6 mature or 12 immature plants are still subject to arrest and prosecution, but they will be allowed to use a medical necessity defense in court.]

Attorney General's Guidelines:
On Aug. 25, 2008, California Attorney General Jerry Brown issued guidelines for law enforcement and medical marijuana patients to clarify the state's laws. Read more about the guidelines here.

Registration:
Voluntary

4. Colorado

Ballot Amendment 20 -- Approved Nov. 7, 2000 by 54% of voters
Effective: June 1, 2001

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physician affirming that he or she suffers from a debilitating condition and advising that they "might benefit from the medical use of marijuana." (Patients must possess this documentation prior to an arrest.)

Approved Conditions: Cancer, glaucoma, HIV/AIDS positive, cachexia; severe pain; severe nausea; seizures, including those that are characteristic of epilepsy; or persistent muscle spasms, including those that are characteristic of multiple sclerosis. Other conditions are subject to approval by the Colorado Board of Health.

Medical Marijuana Registry
Colorado Department of Public Health and Environment
HSVR-ADM2-A1
4300 Cherry Creek Drive South
Denver, CO 80246-1530
Phone: 303-692-2184

medical.marijuana@state.co.us

CO Medical Marijuana Registry

Information provided by the state on sources for medical marijuana:
"The Colorado Medical Marijuana amendment, statutes and regulations are silent on the issue of dispensaries. While the Registry is aware that a number of such businesses have been

Possession/Cultivation: A patient or a primary caregiver who has been issued a Medical Marijuana Registry identification card may possess no more than two ounces of a usable form of marijuana and not more than six marijuana plants, with three or fewer being mature, flowering plants that are producing a usable form of marijuana. Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges. **Amended:** House Bill 1284 (236 KB) and Senate Bill 109 (50 KB) **Effective:** June 7, 2010 Colorado Governor Bill Ritter signed the bills into law and stated the following in a June 7, 2010 press release: "House Bill 1284 provides a regulatory framework for dispensaries, including giving local communities the ability to ban or place sensible and much-needed controls on the operation, location and ownership of these establishments. Senate Bill 109 will help prevent fraud and abuse, ensuring that physicians who authorize medical marijuana for their patients actually perform a physical exam, do not have a DEA flag on their medical license and do not have a financial relationship with a dispensary."	established across the state, we do not have a formal relationship with them." (accessed Jan. 11, 2010) **Patient Registry Fee:** $35 **Accepts other states' registry ID cards?** No **Registration:** Mandatory
5. **Connecticut** **HB 5389** (310 KB) -- Signed into law by Gov. Dannel P. Malloy (D) on May 31, 2012 **Approved:** By House 96-51, by Senate 21-13 **Effective:** Some sections from passage (May 4, 2012), other sections on Oct. 1, 2012 "A qualifying patient shall register with the Department of Consumer Protection... prior to engaging in the palliative use of marijuana. A qualifying patient who has a valid registration certificate... shall not be subject to arrest or prosecution, penalized in any manner,... or denied any right or privilege." Patients must be Connecticut residents at least 18 years of age. "Prison inmates, or others under the supervision of the Department of Corrections, would not qualify, regardless of their medical condition." **Approved Conditions:** "Cancer, glaucoma, positive status for human immunodeficiency virus or acquired immune deficiency syndrome [HIV/AIDS], Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, posttraumatic stress disorder, or... any medical condition, medical treatment or disease approved by the Department of Consumer Protection..." **Possession/Cultivation:** Qualifying patients may possess "an amount of usable marijuana reasonably necessary to ensure	**Medical Marijuana Program** Department of Consumer Protection (DCP) 165 Capitol Avenue Hartford, CT 06106 Phone: 860-713-6006 Toll-Free: 800-842-2649 dcp.mmp@ct.gov The DCP will "issue temporary patient registration certificates starting on October 1, 2012." CT Medical Marijuana Program **Information provided by the state on sources for medical marijuana:** "The Commissioner of Consumer Protection shall determine the number of dispensaries appropriate to meet the needs of qualifying patients in this state." **Patient Registry Fee:** ***The Commissioner of Consumer Protection will establish a "reasonable fee."

uninterrupted availability for a period of one month, as determined by the Department of Consumer Protection."

The Connecticut Medical Marijuana Program website posted an update on Sep. 23, 2012 with instructions on how to register for the program starting on Oct. 1, 2012. "Patients who are currently receiving medical treatment for a debilitating medical conditions set out in the law may qualify for a temporary registration certificate beginning October 1, 2012. To qualify, a patient must also be at least 18 years of age and a Connecticut resident."

Draft Regulations on Medical Marijuana (482 KB) were posted on Jan. 16, 2013.

Accepts other states' registry ID cards?
No

Registration:
Mandatory

6. District of Columbia (DC)

Amendment Act B18-622 (80KB) "Legalization of Marijuana for Medical Treatment Amendment Act of 2010" -- Approved 13-0 by the Council of the District of Columbia on May 4, 2010; signed by the Mayor on May 21, 2010|

Effective: July 27, 2010 [After being signed by the Mayor, the law underwent a 30-day Congessional review period. Neither the Senate nor the House acted to stop the law, so it became effective when the review period ended.]

Approved Conditions: HIV, AIDS, glaucoma, multiple sclerosis, cancer, other conditions that are chronic, long-lasting, debilitating, or that interfere with the basic functions of life, serious medical conditions for which the use of medical marijuana is beneficial, patients undergoing treatments such as chemotherapy and radiotherapy.

Possession/Cultivation: The maximum amount of medical marijuana that any qualifying patient or caregiver may possess at any moment is two ounces of dried medical marijuana. The Mayor may increase the quantity of dried medical marijuana that may be possessed up to four ounces; and shall decide limits on medical marijuana of a form other than dried.

On Apr. 14, 2011, Mayor Vincent C. Gray announced the adoption of an emergency amendment (450 KB) to title 22 of the District of Columbia Municipal Regulations (DCMR), which added a new subtitle C entitled "Medical Marijuana." The emergency amendment "will set forth the process and procedure" for patients, caregivers, physicians, and dispensaries, and "implement the provisions of the Act that must be addressed at the onset to enable the Department to administer the program." The final rulemaking (800 KB) was posted online on Jan. 3, 2012.

On Feb. 14, 2012, the DC Department of Health's Health Regulation and Licensing Administration posted a revised timeline for the dispensary application process (180 KB), which listed June 8, 2012 as the date by which the Department intends to announce dispensary applicants available for registration.

The first dispensary, Capital City Care, was licensed in Apr. 2013.

Medical Marijuana Program
Health Regulation and Licensing Administration
899 N. Capitol Street, NE
2nd Floor
Washington, DC 20002
Phone: 202-442-5955

doh.mmp@dc.gov

The law establishes a medical marijuana program to "regulate the manufacture, cultivation, distribution, dispensing, purchase, delivery, sale, possession, and administration of medical marijuana and the manufacture, possession, purchase, sale, and use of paraphernalia. The Program shall be administered by the Mayor."

Patient Registry Fee:
$100 initial or renewal fee /$25 for low income patients

Accepts other states' registry ID cards?
No

Registration:
Mandatory

7. Delaware

Senate Bill 17 (100 KB) -- Signed into law by Gov. Jack Markell (D) on May 13, 2011
Approved: By House 27-14, by Senate 17-4
Effective: July 1, 2011

Under this law, a patient is only protected from arrest if his or her physician certifies, in writing, that the patient has a specified debilitating medical condition and that the patient would receive therapeutic benefit from medical marijuana. The patient must send a copy of the written certification to the state Department of Health and Social Services, and the Department will issue an ID card after verifying the information. As long as the patient is in compliance with the law, there will be no arrest.

The law does not allow patients or caregivers to grow marijuana at home, but it does allow for the state-regulated, non-profit distribution of medical marijuana by compassion centers.

Approved Conditions: Approved for treatment of debilitating medical conditions, defined as cancer, HIV/AIDS, decompensated cirrhosis, ALS, Alzheimer's disease, post-traumatic stress disorder; or a medical condition that produces wasting syndrome, severe debilitating pain that has not responded to other treatments for more than three months or for which other treatments produced serious side effects, severe nausea, seizures, or severe and persistent muscle spasms.

Possession/Cultivation: Patients 18 and older with certain debilitating conditions may possess up to six ounces of marijuana with a doctor's written recommendation. A registered compassion center may not dispense more than 3 ounces of marijuana to a registered qualifying patient in any fourteen-day period, and a patient may register with only one compassion center. Home cultivation is not allowed. Senate Bill 17 contains a provision that allows for an affirmative defense for individuals "in possession of no more than six ounces of usable marijuana."

On Feb. 12, 2012, Gov. Markell released the following statement (presented in its entirety), available on delaware.gov, in response to a letter from US District Attorney Charles Oberly (2 MB):

"I am very disappointed by the change in policy at the federal department of justice, as it requires us to stop implementation of the compassion centers. To do otherwise would put our state employees in legal jeopardy and I will not do that. Unfortunately, this shift in the federal position will stand in the way of people in pain receiving help. Our law sought to provide that in a manner that was both highly regulated and safe."

On Aug. 15, 2013, Gov. Markell announced in a letter to Delaware lawmakers (175 KB) his intention to relaunch the state's medical marijuana program, despite his previous decision to stop implementation. Markell wrote that the Department of Health and Social Services "will proceed to issue a request for proposal for a pilot compassion center to open in Delaware next year."

Delaware Department of Health and Social Services
Division of Public Health
Phone: 302-744-4749
Fax: 302-739-3071

MedicalMarijuanaDPH@state.de.us

DE Medical Marijuana Program

Information provided by the state on sources for medical marijuana:
The Delaware Medical Marijuana Program website states (as of Aug. 5, 2013), "The creation of the state-licensed, privately owned compassion centers has been suspended by the state. Based on guidance from the US Attorney, the compassion centers concept conflicts with federal law. As a result there is no plan to open compassion centers at this time." On Aug. 15, 2013, Gov. Markell announced that he will seek approval to open one compassion center in 2014.

Patient Registry Fee:
$125 (a sliding scale fee is available based on income)

Accepts other states' registry ID cards?
[5:] Yes (a visiting qualifying patient is not subject to arrest if a visitor ID card is obtained)

Registration:
Mandatory

8. Hawaii

Senate Bill 862 (40 KB) -- Signed into law by Gov. Ben Cayetano on June 14, 2000
Approved: By House 32-18, by Senate 13-12
Effective: Dec. 28, 2000

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a signed statement from their physician affirming that he or she suffers from a debilitating condition and that the "potential benefits of medical use of marijuana would likely outweigh the health risks." The law establishes a mandatory, confidential state-run patient registry that issues identification cards to qualifying patients.

Approved conditions: Cancer, glaucoma, positive status for HIV/AIDS; A chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome, severe pain, severe nausea, seizures, including those characteristic of epilepsy, or severe and persistent muscle spasms, including those characteristic of multiple sclerosis or Crohn's disease. Other conditions are subject to approval by the Hawaii Department of Health.

Possession/Cultivation: The amount of marijuana that may be possessed jointly between the qualifying patient and the primary caregiver is an "adequate supply," which shall not exceed three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.

Amended: HB 668 (240 KB)
Effective: June 25, 2013

Establishes a medical marijuana registry special fund to pay for the program and transfers the medical marijuana program from the Department of Public Safety to the Department of Public Health by no later than Jan. 1, 2015.

Amended: SB 642 (95 KB)
Effective: Jan. 2, 2015

Redefines "adequate supply" as seven marijuana plants, whether immature or mature, and four ounces of usable marijuana at any given time; stipulates that physician recommendations will have to be made by the qualifying patient's primary care physician.

Department of Public Safety
Narcotics Enforcement Division
3375 Koapaka Street, Suite D-100
Honolulu, HI 96819
Phone: 808-837-8470
Fax: 808-837-8474

HI Medical Marijuana Application info

Information provided by the state on sources for medical marijuana:
"Hawaii law does not authorize any person or entity to sell or dispense marijuana... Hawaii law authorizes the medical use of marijuana, it does not authorize the distribution of marijuana (Dispensaries) other than the transfer from a qualifying patient's primary caregiver to the qualifying patient." (accessed Jan. 11, 2010)

Patient Registry Fee:
$25

Accepts other states' registry ID cards?
No

Registration:
Mandatory

9. Illinois

House Bill 1 (385 KB)
Approved: Apr. 17, 2013 by House, 61-57 and May 17, 2013 by Senate, 35-21
Signed into law by Gov. Pat Quinn on Aug. 1, 2013
Effective: Jan. 1, 2014

The Compassionate Use of Medical Cannabis Pilot Program Act establishes a patient registry program, protects registered qualifying patients and registered designated caregivers from "arrest, prosecution, or denial of any right or privilege," and allows

Medical Marijuana Program
Illinois Department of Public Health

http://www.idph.state.il.us/

Information provided by the state on sources for medical marijuana:
Cultivation centers and dispensing organizations will be registered by the Department of Agriculture and Department of Financial and Professional Regulation, respectively.

for the registration of cultivation centers and dispensing organizations. Once the act goes into effect, "a tax is imposed upon the privilege of cultivating medical cannabis at a rate of 7% of the sales price per ounce."

Approved Conditions: Cancer, glaucoma, positive status for HIV, AIDS, hepatitis C, ALS, muscular dystrophy, Crohn's disease, agitation of Alzheimer's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, or "one or more injuries that significantly interferes with daily activities as documented by the patient's provider; and a severely debilitating or terminal medical condition or its treatment that has produced at least one of the following: elevated intraocular pressure, cachexia, chemotherapy induced anorexia, wasting syndrome, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms."

Possession/Cultivation: "Adequate supply" is defined as "2.5 ounces of usable cannabis during a period of 14 days and that is derived solely from an intrastate source." The law does not allow patients or caregivers to cultivate cannabis.

Governor Pat Quinn's Aug. 1, 2013 signing statement (25 KB) explains key points of the law and notes that it is a four-year pilot program.

Patient Registry Fee:
To be determined during the rulemaking process

Accepts other states' registry ID cards?
No

Registration:
Mandatory

10. Maine

Ballot Question 2 -- Approved Nov. 2, 1999 by 61% of voters
Effective: Dec. 22, 1999

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess an oral or written "professional opinion" from their physician that he or she "might benefit from the medical use of marijuana." The law does not establish a state-run patient registry.

Approved diagnosis: epilepsy and other disorders characterized by seizures; glaucoma; multiple sclerosis and other disorders characterized by muscle spasticity; and nausea or vomiting as a result of AIDS or cancer chemotherapy.

Possession/Cultivation: Patients (or their primary caregivers) may legally possess no more than one and one-quarter (1.25) ounces of usable marijuana, and may cultivate no more than six marijuana plants, of which no more than three may be mature. Those patients who possess greater amounts of marijuana than allowed by law are afforded a "simple defense" to a charge of marijuana possession.

Amended: Senate Bill 611
Effective: Signed into law on Apr. 2, 2002

Increases the amount of useable marijuana a person may possess from one and one-quarter (1.25) ounces to two and one-half (2.5) ounces.

Amended: Question 5 (135 KB) -- Approved Nov. 3, 2009 by 59%

Department of Health and Human Services
Division of Licensing and Regulatory Services
John Thiele, Program Manager
11 State House Station
Augusta, ME 04333
207-287-9300

Maine Medical Marijuana Program

Information provided by the state on sources for medical marijuana:
"The patient may either cultivate or designate a caregiver or dispensary to cultivate marijuana." ("Program Bulletin," Maine.gov, Sep. 28, 2011)

Patient Registry Fee:
$0
Caregivers pay $300/patient (limit of 5 patients; if not growing marijuana, there is no fee)

Accepts other states' registry ID cards?
Yes
[6]: "Law enforcement will accept appropriate authorization from a participating state, but that patient cannot purchase marijuana in Maine without registering here. That requires a

of voters List of approved conditions changed to include cancer, glaucoma, HIV, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, Alzheimer's, nail-patella syndrome, chronic intractable pain, cachexia or wasting syndrome, severe nausea, seizures (epilepsy), severe and persistent muscle spasms, and multiple sclerosis. Instructs the Department of Health and Human Services (DHHS) to establish a registry identification program for patients and caregivers. Stipulates provisions for the operation of nonprofit dispensaries. [**Editor's Note:** An Aug. 19, 2010 email to ProCon.org from Catherine M. Cobb, Director of Maine's Division of Licensing and Regulatory Services, stated: "We have just set up our interface to do background checks on caregivers and those who are associated with dispensaries. They may not have a disqualifying drug offense."] **Amended:** LD 1062 (25 KB) **Effective:** Enacted without the governor's signature on June 26, 2013 Adds post-traumatic stress disorder (PTSD) to the list of approved conditions for medical marijuana use.	Maine physician and a Maine driver license or other picture ID issued by the state of Maine. The letter from a physician in another state is only good for 30 days." (Aug. 19, 2010 email from Maine's Division of Licensing and Regulatory Services) **Registration:** Voluntary "In addition to either a registry ID card or a physician certification form, all patients, including both non-registered and voluntarily registered patients, must also present their Maine driver license or other Maine-issued photo identification card to law enforcement, upon request." ("Program Bulletin," Maine.gov, Sep. 28, 2011)
11. Massachusetts **Ballot Question 3** -- Approved Nov. 6, 2012 by 63% of voters **Effective:** Jan. 1, 2013 "The citizens of Massachusetts intend that there should be no punishment under state law for qualifying patients, physicians and health care professionals, personal caregivers for patients, or medical marijuana treatment center agents for the medical use of marijuana... In the first year after the effective date, the Department shall issue registrations for up to thirty-five non-profit medical marijuana treatment centers, provided that at least one treatment center shall be located in each county, and not more than five shall be located in any one county." **Approved diagnosis:** "Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis and other conditions as determined in writing by a qualifying patient's physician." **Possession/Cultivation:** Patients may possess "no more marijuana than is necessary for the patient's personal, medical use, not exceeding the amount necessary for a sixty-day supply... Within 120 days of the effective date of this law, the department shall issue regulations defining the quantity of marijuana that could	**Department of Public Health of the Commonwealth of Massachusetts** One Ashburton Place 11th Floor Boston, MA 02108 617-573-1600 www.mass.gov/medicalmarijuana **Information provided by the state on sources for medical marijuana:** The state will issue registrations for up to 35 nonprofit medical marijuana treatment centers **Patient Registry Fee:** [7]To be determined by DPH within 120 days of the effective date of Jan. 1, 2013. **Accepts other states' registry ID cards?** Unknown **Registration:** Mandatory "Until the approval of final regulations, written certification by a physician shall constitute a registration card for a qualifying patient."

reasonably be presumed to be a sixty-day supply for qualifying patients, based on the best available evidence."

"The Department shall issue a cultivation registration to a qualifying patient whose access to a medical treatment center is limited by verified financial hardship, a physical incapacity to access reasonable transportation, or the lack of a treatment center within a reasonable distance of the patient's residence. The Department may deny a registration based on the provision of false information by the applicant. Such registration shall allow the patient or the patient's personal caregiver to cultivate a limited number of plants, sufficient to maintain a 60-day supply of marijuana, and shall require cultivation and storage only in an enclosed, locked facility.

The department shall issue regulations consistent with this section within 120 days of the effective date of this law. Until the department issues such final regulations, the written recommendation of a qualifying patient's physician shall constitute a limited cultivation registration."

12. Michigan

Proposal 1 (60 KB) "Michigan Medical Marihuana Act" -- Approved by 63% of voters on Nov. 4, 2008
Approved: Nov. 4, 2008
Effective: Dec. 4, 2008

Approved Conditions: Approved for treatment of debilitating medical conditions, defined as cancer, glaucoma, HIV, AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease, nail patella, cachexia or wasting syndrome, severe and chronic pain, severe nausea, seizures, epilepsy, muscle spasms, and multiple sclerosis.

Possession/Cultivation: Patients may possess up to two and one-half (2.5) ounces of usable marijuana and twelve marijuana plants kept in an enclosed, locked facility. The twelve plants may be kept by the patient only if he or she has not specified a primary caregiver to cultivate the marijuana for him or her.

Amended: HB 4856 (40 KB)
Effective: Dec. 31, 2012

Makes it illegal to "transport or possess" usable marijuana by car unless the marijuana is "enclosed in a case that is carried in the trunk of the vehicle." Violation of the law is a misdemeanor "punishable by imprisonment for not more than 93 days or a fine of not more than $500.00, or both."

Amended: HB 4834 (40 KB)
Effective: Apr. 1, 2013

Requires proof of Michigan residency when applying for a registry ID card (driver license, official state ID, or valid voter registration) and makes cards valid for two years instead of one.

Michigan Medical Marihuana Program
Bureau of Health Professions,
Department of Licensing and Regulatory Affairs
P.O. Box 30083
Lansing, MI 48909
Phone: 517-373-0395

BHP-MMMPINFO@michigan.gov

MI Medical Marihuana Program

Information provided by the state on sources for medical marijuana:
"The MMMP is not a resource for the growing process and does not have information to give to patients." (accessed Jan. 7, 2013)

Patient Registry Fee:
$100 new or renewal application / $25 Medicaid patients

Accepts other states' registry ID cards?
Yes

Registration:
Mandatory

Amended: HB 4851 (40 KB)
Effective: Apr. 1, 2013

Requires a "bona fide physician-patient relationship," defined in part as one in which the physician "has created and maintained records of the patient's condition in accord with medically accepted standards" and "will provide follow-up care;" protects patient from arrest only with registry identification card and valid photo ID.

Amended: State of Michigan vs. McQueen (90 KB)
Decided: Feb. 8, 2013

The Michigan Supreme Court ruled 4-1 that dispensaries are illegal. As a result, medical marijuana patients in Michigan will have to grow their own marijuana or get it from a designated caregiver who is limited to five patients.

13. Montana

Initiative 148 (76 KB) -- Approved by 62% of voters on Nov. 2, 2004
Effective: Nov. 2, 2004

Approved Conditions: Cancer, glaucoma, or positive status for HIV/AIDS, or the treatment of these conditions; a chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome, severe or chronic pain, severe nausea, seizures, including seizures caused by epilepsy, or severe or persistent muscle spasms, including spasms caused by multiple sclerosis or Chrohn's disease; or any other medical condition or treatment for a medical condition adopted by the department by rule.

Possession/Cultivation: A qualifying patient and a qualifying patient's caregiver may each possess six marijuana plants and one ounce of usable marijuana. "Usable marijuana" means the dried leaves and flowers of marijuana and any mixture or preparation of marijuana.

Amended: SB 423 (100 KB) -- Passed on Apr. 28, 2011 and transmitted to the Governor on May 3, 2011
Effective: July 1, 2011

SB 423 changes the application process to require a Montana driver's license or state issued ID card. A second physician is required to confirm a chronic pain diagnosis.

"A provider or marijuana-infused products provider may assist a maximum of three registered cardholders..." and "may not accept anything of value, including monetary remuneration, for any services or products provided to a registered cardholder."

Approved Conditions: Cancer, glaucoma, or positive status for HIV/AIDS when the condition or disease results in symptoms that seriously and adversely affect the patient's health status; Cachexia or wasting syndrome; Severe, chronic pain that is persistent pain of severe intensity that significantly interferes with daily activities as documented by the patient's treating physician; Intractable nausea or vomiting; Epilepsy or intractable seizure disorder; Multiple

Medical Marijuana Program
Montana Department of Health and Human Services
Licensure Bureau
2401 Colonial Drive, 2nd Floor
P.O. Box 202953
Helena, MT 59620-2953
Phone: 406-444-2676

jbuska@mt.gov

MT Medical Marijuana Program

Medical Marijuana Program FAQs (35 KB)

Information provided by the state on sources for medical marijuana:
"The Medical Marijuana Act... allows a patient or caregiver to grow up to six plants or possess up to one ounce of usable marijuana. The department cannot give advice or referrals on how to obtain a supply of marijuana... State law is silent on where grow sites can be located." (accessed Jan. 11, 2010)

Patient Registry Fee:
$25 new application/$10 renewal
(reduced from $50 as of Oct. 1, 2009)

Accepts other states' registry ID cards?
No (reciprocity ended when SB 423 took effect)

Registration:
Mandatory

sclerosis; Chron's Disease; Painful peripheral neuropathy; A central nervous system disorder resulting in chronic, painful spasticity or muscle spasms; Admittance into hospice care.

Possession/Cultivation: Amended to 12 seedlings (less than 12"), four mature flowering plants, and one ounce of usable marijuana.

On Nov. 6, 2012, Montana voters approved initiative referendum No. 124 by a vote of 56.5% to 43.5%, upholding SB 423.

14. Nevada

Ballot Question 9 -- Approved Nov. 7, 2000 by 65% of voters
Effective: Oct. 1, 2001

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who have "written documentation" from their physician that marijuana may alleviate his or her condition.

Approved Conditions: AIDS; cancer; glaucoma; and any medical condition or treatment to a medical condition that produces cachexia, persistent muscle spasms or seizures, severe nausea or pain. Other conditions are subject to approval by the health division of the state Department of Human Resources.

Possession/Cultivation: Patients (or their primary caregivers) may legally possess no more than one ounce of usable marijuana, three mature plants, and four immature plants.

Registry: The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges. Legislators added a preamble to the legislation stating, "[T]he state of Nevada as a sovereign state has the duty to carry out the will of the people of this state and regulate the health, medical practices and well-being of those people in a manner that respects their personal decisions concerning the relief of suffering through the medical use of marijuana." A separate provision requires the Nevada School of Medicine to "aggressively" seek federal permission to establish a state-run medical marijuana distribution program.

Amended: Assembly Bill 453 (25 KB)
Effective: Oct. 1, 2001

Created a state registry for patients whose physicians recommend medical marijuana and tasked the Department of Motor Vehicles with issuing identification cards. No state money will be used for the program, which will be funded entirely by donations.

Amended: Senate Bill 374 (280 KB)
Signed into law by Gov. Brian Sandoval on June 12, 2013

"Provides for the registration of medical marijuana establishments authorized to cultivate or dispense marijuana or manufacture edible marijuana products or marijuana-infused products for sale to

Nevada State Health Division
4150 Technology Way, Suite 104
Carson City, Nevada
Phone: 775-687-7594
Fax: 775-684-4156

NV Medical Marijuana Program

Information provided by the state on sources for medical marijuana:
"The NMMP is not a resource for the growing process and does not have information to give to patients."

Patient Registry Fee:
$50 application fee, plus $150 for the card (new or renewal), plus $15-42 in additional related costs
[8:] SB 374 requires the fee to be reduced at least by half before Apr. 1, 2014

Accepts other states' registry ID cards?
[9:] Yes, starting Apr. 1, 2014 with an affidavit

Registration:
Mandatory

persons authorized to engage in the medical use of marijuana... From April 1, 2014, through March 31, 2016, a nonresident purchaser must sign an affidavit attesting to the fact that he or she is entitled to engage in the medical use of marijuana in his or her state or jurisdiction of residency. On and after April 1, 2016, the requirement for such an affidavit is replaced by computer cross-checking between the State of Nevada and other jurisdictions." Patients who were growing before July 1, 2013 are allowed to continue home cultivation until March 31, 2016.	
15. New Hampshire **House Bill 573** (215 KB) **Approved:** May 23, 2013 by Senate, 18-6 and June 26, 2013 by House, 284-66 Signed into law by Gov. Maggie Hassan on July 23, 2013 **Effective:** Upon passage The bill authorizes the use of therapeutic cannabis in New Hampshire, establishes a registry identification card system, allows for the registration of up to four non-profit alternative treatment centers in the state, and establishes an affirmative defense for qualified patients and designated caregivers with valid registry ID cards. HB 573 also calls for the creation of a Therapeutic Use of Cannabis Advisory Council, which in five years will be required to "issue a formal opinion on whether the program should be continued or repealed." A valid ID card from another medical marijuana state will be recognized as allowing the visiting patient to possess cannabis for therapeutic purposes, but the "visiting qualifying patient shall not cultivate or purchase cannabis in New Hampshire or obtain cannabis from alternative treatment centers..." **Approved Conditions:** Cancer, glaucoma, positive status for HIV, AIDS, hepatitis C, ALS, muscular dystrophy, Crohn's disease, agitation of Alzheimer's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, or "one or more injuries that significantly interferes with daily activities as documented by the patient's provider; and a severely debilitating or terminal medical condition or its treatment that has produced at least one of the following: elevated intraocular pressure, cachexia, chemotherapy induced anorexia, wasting syndrome, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms." **Possession/Cultivation:** "A qualifying patient shall not obtain more than 2 ounces of usable cannabis directly or through the qualifying patient's designated caregiver during a 10-day period." A patient may possess two ounces of usable cannabis and any amount of unusable cannabis.	**Medical Marijuana Program** New Hampshire Department of Health and Human Services http://www.dhhs.state.nh.us **Information provided by the state on sources for medical marijuana:** HB 537 requires DHHS to register two nonprofit alternative treatment centers within 18 months of the bill's effective date, provided that at least two applicants are qualified. There can be no more than four alternative treatment centers at one time. **Patient Registry Fee:** To be determined during the rulemaking process **Accepts other states' registry ID cards?** Yes **Registration:** Mandatory

16. New Jersey

Senate Bill 119 (175 KB)
Approved: Jan. 11, 2010 by House, 48-14; by Senate, 25-13
Signed into law by Gov. Jon Corzine on Jan. 18, 2010
Effective: Six months from enactment

Protects "patients who use marijuana to alleviate suffering from debilitating medical conditions, as well as their physicians, primary caregivers, and those who are authorized to produce marijuana for medical purposes" from "arrest, prosecution, property forfeiture, and criminal and other penalties."

Also provides for the creation of alternative treatment centers, "at least two each in the northern, central, and southern regions of the state. The first two centers issued a permit in each region shall be nonprofit entities, and centers subsequently issued permits may be nonprofit or for-profit entities."

Approved Conditions: Seizure disorder, including epilepsy, intractable skeletal muscular spasticity, glaucoma; severe or chronic pain, severe nausea or vomiting, cachexia, or wasting syndrome resulting from HIV/AIDS or cancer; amyotrophic lateral sclerosis (Lou Gehrig's Disease), multiple sclerosis, terminal cancer, muscular dystrophy, or inflammatory bowel disease, including Crohn's disease; terminal illness, if the physician has determined a prognosis of less than 12 months of life or any other medical condition or its treatment that is approved by the Department of Health and Senior Services.

Possession/Cultivation: Physicians determine how much marijuana a patient needs and give written instructions to be presented to an alternative treatment center. The maximum amount for a 30-day period is two ounces.

The New Jersey Department of Health and Senior Services released draft rules (385 KB) outlining the registration and application process on Oct. 6, 2010. A public hearing to discuss the proposed rules was held on Dec. 6, 2010 at at the New Jersey Department of Health and Senior Services, according to the *New Jersey Register*.

On Dec. 20, 2011, Senator Nicholas Scutari (D), lead sponsor of the medical marijuana bill, submitted Senate Concurrent Resolution (SCR) 140 (25 KB) declaring that the "Board of Medical Examiners proposed medicinal marijuana program rules are inconsistent with legislative intent." The New Jersey Senate Health, Human Services and Senior Citizens committee held a public hearing to discuss SCR 140 and a similar bill, SCR 130, on Jan. 20, 2010.

On Feb. 3, 2011, DHSS proposed new rules (200 KB) that streamlined the permit process for cultivating and dispensing, prohibited home delivery by alternative treatment centers, and required that "conditions originally named in the Act be resistant to conventional medical therapy in order to qualify as debilitating medical conditions."

On Aug. 9, 2012, the New Jersey Medical Marijuana Program opened the patient registration system on its website. Patients must

S119 was supposed to become effective six months after it was enacted on Jan. 18, 2010, but the legislature, DHHS, and New Jersey Governor Chris Christie did not agree on the details of how the program would be run.

The **Department of Health and Senior Services (DHSS)**, the state agency in charge of the program, issued its first dispensary permit on Oct. 16, 2012.

Medicinal Marijuana Program

Information provided by the state on sources for medical marijuana:
Patients are not allowed to grow their own marijuana. On Mar. 21, 2011, the New Jersey DHHS announced the locations of six nonprofit alternative treatment centers (ATCs) (100 KB) from which medical marijuana may be obtained.

Medical marijuana is not covered by Medicaid.

Patient Registry Fee:
$200 (valid for two years). Reduced fee of $20 for patients qualifying for state or federal assistance programs

Accepts other states' registry ID cards?
No ("[T]o be eligible for the New Jersey Medicinal Marijuana program you must... hold a valid patient identification card issued by the New Jersey Medicinal Marijuana Program.")

Registration:
Mandatory

have a physician's recommendation, a government-issued ID, and proof of New Jersey residency to register. The first dispensary is expected to be licensed to open in September. On Oct. 16, 2012, the Department of Health issued the first dispensary permit (24 KB) to Greenleaf Compassion Center, allowing it to operate as an Alternative Treatment Center and dispense marijuana. The center opened on Dec. 6, 2012, becoming New Jersey's first dispensary. Five other treatment centers are "in various stages of finalizing locations or background examinations of the principals of their organizations." **Amended:** SB 2842 (40 KB) Signed into law by Gov. Chris Christie on Sep. 10, 2013 following legislative adoption of his conditional veto (10 KB) Allows edible forms of marijuana only for qualifying minors, who must receive approval from a pediatrician and a psychiatrist.	
17. New Mexico **Senate Bill 523** (71 KB) "The Lynn and Erin Compassionate Use Act" **Approved:** Mar. 13, 2007 by House, 36-31; by Senate, 32-3 **Effective:** July 1, 2007 Removes state-level criminal penalties on the use and possession of marijuana by patients "in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments." The New Mexico Department of Health designated to administer the program and register patients, caregivers, and providers. **Approved Conditions:** The 15 current qualifying conditions for medical cannabis are: severe chronic pain, painful peripheral neuropathy, intractable nausea/vomiting, severe anorexia/cachexia, hepatitis C infection, Crohn's disease, Post-Traumatic Stress Disorder, ALS (Lou Gehrig's disease), cancer, glaucoma, multiple sclerosis, damage to the nervous tissue of the spinal cord with intractable spasticity, epilepsy, HIV/AIDS, and hospice patients. **Possession/Cultivation:** Patients have the right to possess up to six ounces of usable cannabis, four mature plants and 12 seedlings. Usable cannabis is defined as dried leaves and flowers; it does not include seeds, stalks or roots. A primary caregiver may provide services to a maximum of four qualified patients under the Medical Cannabis Program.	**New Mexico Department of Health** 1190 St. Francis Drive P.O. Box 26110 Santa Fe, NM 87502-6110 Phone: 505-827-2321 medical.cannabis@state.nm.us NM Medical Cannabis Program **Information provided by the state on sources for medical marijuana:** "Patients can apply for a license to produce their own medical cannabis... Once a patient is approved we provide them with information about how to contact the licensed producers to receive medical cannabis." (accessed Jan. 11, 2010) **Patient Registry Fee:** $0 **Accepts other states' registry ID cards?** No **Registration:** Mandatory
18. Oregon **Ballot Measure 67** (75 KB) -- Approved by 55% of voters on Nov. 3, 1998 **Effective:** Dec. 3, 1998	**Oregon Department of Human Services** Medical Marijuana Program PO Box 14450 Portland, OR 97293-0450 Phone: 971-673-1234 Fax: 971-673-1278

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a signed recommendation from their physician stating that marijuana "may mitigate" his or her debilitating symptoms.

Approved Conditions: Cancer, glaucoma, positive status for HIV/AIDS, or treatment for these conditions; A medical condition or treatment for a medical condition that produces cachexia, severe pain, severe nausea, seizures, including seizures caused by epilepsy, or persistent muscle spasms, including spasms caused by multiple sclerosis. Other conditions are subject to approval by the Health Division of the Oregon Department of Human Resources.

Possession/Cultivation: A registry identification cardholder or the designated primary caregiver of the cardholder may possess up to six mature marijuana plants and 24 ounces of usable marijuana. A registry identification cardholder and the designated primary caregiver of the cardholder may possess a combined total of up to 18 marijuana seedlings. (per Oregon Revised Statutes ORS 475.300 -- ORS 475.346) (52 KB)

Amended: Senate Bill 1085 (52 KB)
Effective: Jan. 1, 2006

State-qualified patients who possess cannabis in amounts exceeding the new state guidelines will no longer retain the ability to argue an "affirmative defense" of medical necessity at trial. Patients who fail to register with the state, but who possess medical cannabis in amounts compliant with state law, still retain the ability to raise an "affirmative defense" at trial.

The law also redefines "mature plants" to include only those cannabis plants that are more than 12 inches in height and diameter, and establish a state-registry for those authorized to produce medical cannabis to qualified patients.

Amended: House Bill 3052
Effective: July 21, 1999

Mandates that patients (or their caregivers) may only cultivate marijuana in one location, and requires that patients must be diagnosed by their physicians at least 12 months prior to an arrest in order to present an "affirmative defense." This bill also states that law enforcement officials who seize marijuana from a patient pending trial do not have to keep those plants alive. Last year the Oregon Board of Health approved agitation due to Alzheimer's disease to the list of debilitating conditions qualifying for legal protection.

In August 2001, program administrators filed established temporary procedures further defining the relationship between physicians and patients. The new rule defines attending physician as "a physician who has established a physician/patient relationship with the patient;... is primarily responsible for the care and treatment of the patients;... has reviewed a patient's medical records at the patient's request, has conducted a thorough physical examination of the patient, has provided a treatment plan and/or follow-up care, and has documented these activities in a patient file."

OR Medical Marijuana Program (OMMP)

Information provided by the state on sources for medical marijuana:
"The OMMP is not a resource for the growing process and does not have information to give to patients." (accessed Jan. 11, 2010)

Patient Registry Fee:
[10]:$200 for new applications and renewals; $100 for application and annual renewal fee for persons receiving SNAP (food stamp) and for Oregon Health Plan cardholders; $20 for persons receiving SSI benefits

An additional $50 grow site registration fee is charged if the patient is not his or her own grower.

Accepts other states' registry ID cards?
No

Registration:
Mandatory

Amended: SB 281 (25 KB)
Signed by Gov. John Kitzhaber on June 6, 2013

Adds post-traumatic stress disorder (PTSD) to the list of approved conditions for medical marijuana use.

Amended: HB 3460 (50 KB)
Signed by Gov. John Kitzhaber on Aug. 14, 2013

Creates a dispensary program by allowing the state licensing and regulation of medical marijuana facilities to transfer marijuana to registry identification cardholders or their designated primary caregivers.

[**Editor's Note:** On Nov. 2, 2010, 55.79% of Oregon Voters rejected Measure 74 (100 KB), which would have allowed for the creation of state-regulated dispensaries.]

19. Rhode Island

Senate Bill 0710 -- Approved by state House and Senate, vetoed by the Governor. Veto was over-ridden by House and Senate.

Timeline:

1. June 24, 2005: passed the House 52 to 10
2. June 28, 2005: passed the State Senate 33 to 1
3. June 29, 2005: Gov. Carcieri vetoed the bill
4. June 30, 2005: Senate overrode the veto 28-6
5. Jan. 3, 2006: House overrode the veto 59-13 to pass the Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act (48 KB) (Public Laws 05-442 and 05-443)
6. June 21, 2007: Amended by Senate Bill 791 (30 KB)
   Effective: Jan. 3, 2006

Approved Conditions: Cancer, glaucoma, positive status for HIV/AIDS, Hepatitis C, or the treatment of these conditions; A chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome; severe, debilitating, chronic pain; severe nausea; seizures, including but not limited to, those characteristic of epilepsy; or severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis or Crohn's disease; or agitation of Alzheimer's Disease; or any other medical condition or its treatment approved by the state Department of Health.

If you have a medical marijuana registry identification card from any other state, U.S. territory, or the District of Columbia you may use it in Rhode Island. It has the same force and effect as a card issued by the Rhode Island Department of Health.

Possession/Cultivation: Limits the amount of marijuana that can be possessed and grown to up to 12 marijuana plants or 2.5 ounces of cultivated marijuana. Primary caregivers may not possess an amount of marijuana in excess of 24 marijuana plants and five ounces of usable marijuana for qualifying patients to whom he or she is connected through the Department's registration process.

Rhode Island Department of Health
Office of Health Professions Regulation, Room 104
3 Capitol Hill
Providence, RI 02908-5097
Phone: 401-222-2828

RI Medical Marijuana Program (MMP)

Information provided by the state on sources for medical marijuana:
"The MMP is not a resource for marijuana and does not have information to give to patients related to the supply of marijuana." (accessed Jan. 11, 2010)

Patient Registry Fee:
$75/$10 for applicants on Medicaid or Supplemental Security Income (SSI)

Accepts other states' registry ID cards?
Yes, but only for the conditions approved in Rhode Island

Registration:
Mandatory

Amended: H5359 (70 KB) - The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act (substituted for the original bill)

Timeline:

1. **May 20, 2009:** passed the House 63-5
2. **June 6, 2009:** passed the State Senate 31-2
3. **June 12, 2009:** Gov. Carcieri vetoed the bill (60 KB)
4. **June 16, 2009:** Senate overrode the veto 35-3
5. **June 16, 2009:** House overrode the veto 67-0

Effective June 16, 2009: Allows the creation of compassion centers, which may acquire, possess, cultivate, manufacture, deliver, transfer, transport, supply, or dispense marijuana, or related supplies and educational materials, to registered qualifying patients and their registered primary caregivers.

The first dispensary, the Thomas C. Slater Compassion Center, opened on Apr. 19, 2013.

20. Vermont

Senate Bill 76 (45 KB) -- Approved 22-7; House Bill 645 (41 KB) -- Approved 82-59
"Act Relating to Marijuana Use by Persons with Severe Illness" (Sec. 1. 18 V.S.A. chapter 86 (41 KB) passed by the General Assembly) *Gov. James Douglas (R), allowed the act to pass into law unsigned on May 26, 2004*
Effective: July 1, 2004

Amended: Senate Bill 00007 (65 KB)
Effective: May 30, 2007

Approved Conditions: Cancer, AIDS, positive status for HIV, multiple sclerosis, or the treatment of these conditions if the disease or the treatment results in severe, persistent, and intractable symptoms; or a disease, medical condition, or its treatment that is chronic, debilitating and produces severe, persistent, and one or more of the following intractable symptoms: cachexia or wasting syndrome, severe pain or nausea or seizures.

Possession/Cultivation: No more than two mature marijuana plants, seven immature plants, and two ounces of usable marijuana may be collectively possessed between the registered patient and the patient's registered caregiver. A marijuana plant shall be considered mature when male or female flower buds are readily observed on the plant by unaided visual examination. Until this sexual differentiation has taken place, a marijuana plant will be considered immature.

Amended: Senate Bill 17 (100 KB) "An Act Relating To Registering Four Nonprofit Organizations To Dispense Marijuana For Symptom Relief"
Signed by Gov. Peter Shumlin on June 2, 2011

The bill "establishes a framework for registering up to four nonprofit marijuana dispensaries in the state... A dispensary will be permitted to cultivate and possess at any one time up to 28 mature marijuana plants, 98 immature marijuana plants, and 28 ounces of usable

Marijuana Registry
Department of Public Safety
103 South Main Street
Waterbury, Vermont 05671
Phone: 802-241-5115

VT Marijuana Registry Program

Information provided by the state on sources for medical marijuana:
"The Marijuana Registry is neither a source for marijuana nor can the Registry provide information to patients on how to obtain marijuana." (accessed Jan. 11, 2010)

Patient Registry Fee:
$50

Accepts other states' registry ID cards?
No

Registration:
Mandatory

marijuana."

On Sep. 12, 2012, the State of Vermont Department of Public Safety announced conditional approval (65 KB) of two medical marijuana dispensaries. In June 2013, two dispensaries opened in Vermont.

21. Washington

Chapter 69.51A RCW (4KB) **Ballot Initiative I-692** -- Approved by 59% of voters on Nov. 3, 1998
Effective: Nov. 3, 1998

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess "valid documentation" from their physician affirming that he or she suffers from a debilitating condition and that the "potential benefits of the medical use of marijuana would likely outweigh the health risks."

Approved Conditions: Cachexia; cancer; HIV or AIDS; epilepsy; glaucoma; intractable pain (defined as pain unrelieved by standard treatment or medications); and multiple sclerosis. Other conditions are subject to approval by the Washington Board of Health.

Possession/Cultivation: Patients (or their primary caregivers) may legally possess or cultivate no more than a 60-day supply of marijuana. The law does not establish a state-run patient registry.

Amended: **Senate Bill 6032** (29 KB)
Effective: 2007 (rules being defined by Legislature with a July 1, 2008 due date)

Amended: Final Rule (123 KB) based on Significant Analysis (370 KB)
Effective: Nov. 2, 2008

Approved Conditions: Added Crohn's disease, Hepatitis C with debilitating nausea or intractable pain, diseases, including anorexia, which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, or spasticity, when those conditions are unrelieved by standard treatments or medications.

Possession/Cultivation: A qualifying patient and designated provider may possess a total of no more than twenty-four ounces of usable marijuana, and no more than fifteen plants. This quantity became the state's official "60-day supply" on Nov. 2, 2008.

[**Editor's Note:** On Jan. 21, 2010, the Supreme Court of the State of Washington ruled that Ballot Initiative "I-692 did not legalize marijuana, but rather provided an authorized user with an affirmative defense if the user shows compliance with the requirements for medical marijuana possession." *State v. Fry* (125 KB)

ProCon.org contacted the Washington Department of Health to ask whether it had received any instructions in light of this ruling. Kristi Weeks, Director of Policy and Legislation, stated the following in a Jan. 25, 2010 email response to ProCon.org:

Department of Health
PO Box 47866
Olympia, WA 98504-7866
Phone: 360-236-4700
Fax: 360-236-4768

MedicalMarijuana@doh.wa.gov

WA Medical Marijuana website

Information provided by the state on sources for medical marijuana:
"The law allows a qualifying patient or designated provider to grow medical marijuana. It is not legal to buy or sell it. The law does not allow dispensaries." (accessed Jan. 11, 2010)

Patient Registry Fee:
**No state registration program has been established

Accepts other states' registry ID cards?
No

Registration:
None

"The Department of Health has a limited role related to medical marijuana in the state of Washington. Specifically, we were directed by the Legislature to determine the amount of a 60 day supply and conduct a study of issues related to access to medical marijuana. Both of these tasks have been completed. We have maintained the medical marijuana webpage for the convenience of the public. The department has not received 'any instructions' in light of State v. Fry. That case does not change the law or affect the 60 day supply. Chapter 69.51A RCW, as confirmed in Fry, provides an affirmative defense to prosecution for possession of marijuana for qualifying patients and caregivers."] **Amended:** SB 5073 (375 KB) **Effective:** July 22, 2011 Gov. Christine Gregoire signed sections of the bill and partially vetoed others, as explained in the Apr. 29, 2011 veto notice. (50 KB) Gov. Gregoire struck down sections related to creating state-licensed medical marijuana dispensaries and a voluntary patient registry. [**Editor's Note:** On Nov. 6, 2012, Washington voters passed Initiative 502, which allows the state to "license and regulate marijuana production, distribution, and possession for persons over 21 and tax marijuana sales." The website for Washington's medical marijuana program states that the intiative "does not amend or repeal the medical marijuana laws (chapter 69.51A RCW) in any way. The laws relating to authorization of medical marijuana by healthcare providers are still valid and enforceable."]	

For a detailed list of sources used to compile this information, please see our sources page.

Read the 2012 presidential candidates' views on medical marijuana at our 2012 presidential election website.

Other sites are welcome to link to this page, but please see our reprinting policy for details on how to request permission to reprint the content from our website.

233 Wilshire Blvd., Suite 200, Santa Monica, CA 90401

Tel: 310-451-9596 Fax: 310-393-2471

Information on States with Medical Marijuana Laws

A summary listing of states with medical marijuana laws from the Marijuana Policy Project (MPP), updated August 26, 2013.

Marijuana Policy Project
236 Massachusetts Ave. NE
Suite 400
Washington, DC 20002
p: (202) 462-5747 • f: (202) 232-0442
info@mpp.org • www.mpp.org

Key Aspects of State and D.C. Medical Marijuana Laws

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Alaska	1998, initiative, revised later by the legislature.	Allowed.	Yes. Caregivers can assist only one patient, unless the caregiver is a relative of more than one patient.	One ounce of marijuana, six plants.	Not allowed.	Cancer, HIV/AIDS, glaucoma, cachexia, severe pain, severe nausea, seizures, and persistent muscle spasms.* The health department can approve additional conditions.	Yes, through the Department of Health and Social Services.	No.
Ariz.	2010, initiative.	Allowed in enclosed, locked facility if the patient does not live within 25 miles of a dispensary.	Yes. Caregivers can assist up to five patients. Caregivers cannot be paid for their services, but they may be reimbursed for actual expenses.	Two and one-half ounces of marijuana, 12 plants for those allowed to cultivate.	Yes. More than 90 Department of Health Services-regulated non-profit dispensaries received preliminary certificates. At least 64 have opened. Subject to 6.6% sales tax.	Cancer, HIV/AIDS, Hepatitis C, ALS, Crohn's disease, glaucoma, Alzheimer's, severe and chronic pain, cachexia, severe nausea, seizures, or persistent muscle spasms. The Department of Heath Services can approve additional conditions.	Yes, through the Department of Health Services.	Yes, for patients with conditions that qualify under Arizona law. Does not allow out-of-state patients to obtain marijuana from dispensaries.

Last updated: August 26, 2013

Disclaimer: This grid is not intended for or offered for legal advice. It is for informational and educational purposes only. It also does not capture nuances of the laws, many of which are a dozen or more pages. Please consult with an attorney licensed to practice in the state in question for legal advice.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Calif.	1996, initiative, added to later by the legislature.	Allowed.	Yes. Caregivers must have "consistently assumed responsibility for the housing, health, or safety of [the] patient."	At least eight ounces and six mature plants, or 12 immature plants. Counties can allow more and a defense can be raised for more.	Collectives and cooperatives are allowed. There is no state licensing, but some localities issue licenses and regulations. They pay the state sales tax and some cities have specific taxes.	"Cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief."	Yes, optional. Issued by the Department of Public Health.	No.
Colo.	2000, amendment to state constitution approved by voters, legislation enacted later.	Allowed.	Yes. A caregiver must have "significant responsibility for managing the well-being of the patient." Generally, a caregiver cannot assist more than five patients.	Two ounces of marijuana, six plants.	Yes. Over 500 "medical marijuana centers" and more than 1,000 growers and infused product makers are regulated by the department of revenue and local governments. Medical marijuana is subject to sales tax, with an exemption for indigent patients.	Cancer, HIV/AIDS, glaucoma, severe pain, cachexia, severe nausea, seizures, and persistent muscle spasms. The health department can approve additional conditions.	Yes. Issued by the Department of Public Health and Environment.	No.
Conn.	2012, legislation.	Not allowed.	Yes, a caregiver can serve one patient (or more for close family). The need for a caregiver must be evaluated by the physician and be included in a written certification.	A one-month supply, to be determined by the Department of Consumer Protection.	Yes. The department will set the number of dispensaries. Only pharmacists may file dispensary applications. Three to 10 growers are allowed. Medical marijuana will likely be subject to sales tax.	Cancer, glaucoma, HIV/AIDS, Parkinson's disease, multiple sclerosis, spinal cord damage causing intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease or PTSD. The Department of Consumer Protection can approve additional conditions.	Yes. They will be issued by the Department of Consumer Protection. Temporary registrations are currently available.	No.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Del.	2011, legislation.	Not allowed.	Yes. Caregivers can assist up to five patients.	Up to six ounces at one time.	Yes. A single compassion center is expected to open in 2014. The governor put a broader program on hold in 2012. Only revenues above $1.2 million per year are subject to gross receipts taxes.	Cancer, HIV/AIDS, ALS, decompensated cirrhosis, Alzheimer's, PTSD, debilitating pain that has not responded to other treatments or if they produced serious side effects, intractable nausea, seizures, and persistent muscle spasms. The health department can add conditions.	Yes. Issued by the Department of Health and Social Services.	Yes, for patients with conditions that qualify under Delaware law. Dispensaries can only provide marijuana to patients with a Delaware ID card.
D.C.	1998, initiative, later revised by D.C. Council. Because of intervention by Congress, the law did not go into effect until July 2010.	Not presently allowed, but a committee was supposed to recommend whether to allow it by January 1, 2012.	Yes. Caregivers can assist only one patient.	Up to two ounces in a 30-day period, obtained from a registered dispensary. The mayor can increase this to four ounces.	Yes, the District health department has approved three dispensaries and three growers. The first dispensary began serving patients in July 2013. Dispensaries must have a sliding scale of prices for low-income patients. Six percent sales tax.	Cancer, HIV/AIDS, glaucoma, severe and persistent muscle spasms, and conditions treated with chemotherapy, AZT, protease inhibitors, or radiotherapy. The mayor can approve additional conditions.	Yes. Issued by the Department of Health.	No.
Hawaii	2000, legislation.	Allowed.	Yes. Caregivers can assist only one patient.	A patient and caregiver can collectively possess three ounces, three mature plants, and four immature plants. The amounts will increase in 2015.	Not allowed.	Severe pain, cachexia, severe nausea, seizures, or severe and persistent muscle spasms. The health department can approve additional conditions.	Yes, through the state Department of Public Safety. The program will be transferred to the Department of Public Health by Jan. 1, 2015.	No.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Ill.	2013, legislation.	Not allowed.	Yes. Caregivers can assist only one patient.	2.5 ounces of marijuana, unless a waiver is granted for more.	Yes. There will be 60 dispensaries, probably beginning in late 2014, and 22 cultivation facilities. There will be a 7% excise tax at the wholesale level and a 1% sales tax.	One of 33 specific medical conditions, including HIV/AIDS, cancer, spinal cord injury or disease, MS, and residual limb pain. The health department can add conditions.	Yes, through the Department of Public Health.	No.
Maine	1999, initiative, revised later by initiative and the legislature.	Allowed in enclosed, locked location.	Yes. Caregivers can assist up to five patients at a time.	2.5 ounces. The patient, caregiver, or dispensary can grow up to six mature plants for a patient and may have plants at other states of harvesting.	Yes. Health department regulated non-profit dispensaries are allowed. So far, eight have been registered. They are subject to the state sales tax.	Cancer, HIV/AIDS, ALS, Hepatitis C, Crohn's, nail patella, glaucoma, Alzheimer's, intractable pain, cachexia, severe nausea, seizures, persistent muscle spasms, and (beginning in late Sept.) PTSD. The health department can add conditions.	Yes, optional for patients and some caregivers. Issued by the Department of Health and Human Services.	Yes.
Mass.	2012, initiative.	In some cases, such as financial hardship or if a dispensary is far away. Must grow in enclosed, locked location.	Yes. Unless an exception applies — such as for immediate family and medical professionals — caregivers may assist one patient.	A 60-day supply. The health department set a 10-ounce presumptive amount, but physicians may specify a patient needs a greater amount. No set number of plants is included.	Yes. The health department must register up to 35 non-profit dispensaries by Jan. 1, 2014. More can be approved later if they are needed. As a medicine, marijuana will not be subject to sales tax.	Cancer, glaucoma, HIV/AIDS, Hepatitis C, ALS, Crohn's disease, Parkinson's, multiple sclerosis, or another debilitating condition approved of by a patient's physician. Debilitating is defined as causing symptoms such as weakness or intractable pain and substantially limiting life activities.	Yes, through the Department of Public Health.	No.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Md. (research-focused law and a defense)	2013 legislation, also 2011 and 2003 legislation.	No.	Yes. The defense is available to caregivers in some instances. The research-oriented programs could also allow for them.	The defense applies to up to an ounce. Participating hospitals will determine the amount in the research-oriented program.	No. Teaching hospitals — if they participate — would set up a program providing marijuana from state-licensed growers or the federal government, (which is very unlikely to participate).	For the defense: Cachexia, severe or chronic pain, severe nausea, seizures, severe and persistent spasms, or any severe condition that is resistant to other medicine. The teaching hospitals would propose the conditions for their programs.	It does not appear so for the 2013 teaching hospital law. The affirmative defense and sentencing mitigation do not involve ID cards or a registry.	No.
Mich.	2008, initiative, some legislative changes in 2012.	Allowed in enclosed, locked location.	Yes. Caregivers can assist up to five patients at a time.	2.5 ounces. The patient or caregiver can grow up to 12 plants for a patient.	Not provided for in the state law, though some cities have local ordinances.	Cancer, HIV/AIDS, Hepatitis C, ALS, Crohn's disease, nail patella, glaucoma, Alzheimer's, severe and chronic pain, cachexia, severe nausea, seizures, or severe and persistent muscle spasms. The department can add conditions.	Yes, through the Department of Licensing and Regulatory Affairs.	Yes.
Mont.	2011 legislation replaced 2004 voter initiative. Parts of the new law have been blocked in court.	Allowed.	Yes. Under the revised law, caregivers can assist only three and cannot be compensated; however, this limitation has been blocked by injunction.	Four mature plants, 12 seedlings, and one ounce.	Not explicitly allowed, but caregivers could assist an unlimited number of patients until mid-2011, resulting in storefront operations. However, the three patient cap part of the new law is currently enjoined.	Cancer, HIV/AIDS, glaucoma, cachexia, intractable nausea or vomiting, seizure disorder, multiple sclerosis, Crohn's, painful peripheral neuropathy, admittance to hospice care, or in some cases, severe pain or spasms.	Yes, through the Department of Health and Human Services.	No. The state had reciprocity prior to the 2011 law.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Nev.	1998 and 2000, amendment to state constitution approved by voters, legislation followed in 2001 and 2013.	Allowed.	Yes. Caregivers must have significant responsibility for managing a patient's well-being. Marijuana cannot be delivered for compensation.	2.5 ounces every 14 days, 12plants (for those allowed to grow), and an amount of marijuana-infused products to be set by the Health Division.	Yes, a 2013 law will allow up to 66 dispensaries regulated by the Health Division, along with growers, infused product makers, and labs. Sales taxes and two 2% excise taxes will apply.	Cancer, HIV/AIDS, glaucoma, severe pain, cachexia, severe nausea, seizures, or persistent muscle spasms. The health department can approve additional conditions.	Yes, through the Department of Health and Human Services.	Yes, beginning in April 2014. Patients must have an ID card and sign an affidavit created by the Health Division. In April 2016, the process will change.
N.H.	2013, legislation.	Not allowed.	Yes. Caregivers can generally help no more than five patients.	Two ounces of marijuana.	Yes. There will be four non-profit alternative treatment centers. The first two should open in 2015.	The patient must have both a qualifying symptom and one of the following conditions: cancer, glaucoma, HIV/AIDS, Hepatitis C, ALS, muscular dystrophy, Crohn's, Alzheimer's, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, and injuries that significantly interfere with daily activities. The department may grant waivers for patients with other conditions.	Yes, through the Department of Health and Human Services.	Yes, for patients with conditions qualifying in New Hampshire. They must bring their own marijuana.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
N.J.	2010, legislation.	Not allowed.	Yes. Caregivers can assist only one patient.	No more than two ounces can be dispensed to a patient in 30 days.	Yes. In March 2011, six state-regulated "alternative treatment centers" were registered. As of July 2013, one is open and a second is expected to open in September. Medical marijuana is subject to sales tax.	ALS, multiple sclerosis, muscular dystrophy, inflammatory bowel disease, cancer, HIV/AIDS, terminal illness, seizure disorders, intractable skeletal muscular spasticity, and glaucoma.* The health department may approve additional conditions.	Yes, through the Department of Health and Senior Services.	No.
N.M.	2007, legislation.	Allowed with special permit and possible inspection.	Yes. Caregivers can assist up to four patients at a time, but they cannot cultivate.	Six ounces. Patients with cultivation licenses are also allowed to cultivate four mature plants and 12 seedlings.	Yes. As of July 2013, there are 23 "licensed producers" that can grow only 150 plants and seedlings. The state health department regulates the licensed producers. Medical marijuana sales are subject to gross receipts tax.	Severe chronic pain, peripheral neuropathy, intractable nausea/vomiting, cachexia, Hepatitis C, Crohn's, PTSD, ALS, cancer, glaucoma, multiple sclerosis, spinal cord damage with spasticity, epilepsy, and HIV/AIDS. The health department can approve additional conditions.	Yes, through the Department of Health.	No.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Ore.	1998, initiative, revised later by legislature.	Allowed at registered grow sites. No one can produce marijuana for more than four people at a time.	Yes. A caregiver must have "significant responsibility for managing the well-being" of the patient.	24 ounces of marijuana, six mature plants, and 18 immature plants.	Yes. Beginning in March 2014, state-registered and state-regulated medical marijuana facilities may receive marijuana from patients, caregivers, and persons responsible for grow sites. Until March 2014, existing facilities are exempt from criminal penalties if they follow the law.	Cancer, HIV/AIDS, glaucoma, Alzheimer's, cachexia, severe pain, severe nausea, seizures, PTSD, and persistent muscle spasms. The health department can approve additional medical conditions.	Yes, through the Department of Human Services.	No.
R.I.	2006, legislation, revised later by legislature.	Allowed in enclosed, locked facility.	Yes. Patients are allowed up to two caregivers (dispensaries are considered caregivers). Caregivers can assist up to five patients.	2.5 ounces, 12 plants, and 12 seedlings. Caregivers can possess that much per patient, with a total cap of 24 plants and five ounces. The dispensary cap is 150 plants (99 mature) and 1,500 ounces.	Yes. As of July 2013, two compassion centers are open and a third has been approved but is not yet open. Sales tax applies, along with a 4% surcharge.	Cancer, HIV/AIDS, Hepatitis C, glaucoma, Alzheimer's, severe, debilitating pain, cachexia, severe nausea, seizures, and persistent muscle spasms. The health department can add conditions.	Yes, through the state Department of Health.	Yes.

State	Year Initially Enacted	Home Cultivation	Caregivers	Possession Limits	Dispensaries	Qualifying Conditions	ID Cards?	Recognizes Out-of-State ID Cards?
Vt.	2004, legislation, revised later by legislature.	Allowed in enclosed, locked facility.	Yes. Caregivers can assist only one patient.	Two ounces of marijuana, two mature plants, and seven immature plants.	Yes. Two non-profit dispensaries opened in June 2013. Another should open later in 2013, and a fourth will be approved later. It is expected that medical marijuana will not be subject to sales tax.	Cancer, multiple sclerosis, HIV/AIDS, severe pain, cachexia, severe nausea, or seizures.*	Yes, through the Department of Public Safety.	No.
Wash.	1998, initiative, revised later by legislature**.**	Allowed.	Yes. Caregivers can only assist one patient at a time. Caregivers must wait 15 days between serving two different patients.	24 ounces of marijuana and 15 plants, with a defense for more. Patients can collectively grow, with no more than 10 patients, 72 ounces, and 45 plants.	In Nov. 2012, voters approved allowing stores to sell adults 21 and older marijuana for any purpose*.*	Cancer, HIV/AIDS, multiple sclerosis, seizure and spasm disorders, intractable pain, glaucoma, Crohn's, Hepatitis C, and diseases causing nausea, vomiting, or appetite loss.	No. Note: This law does not include protection from arrest or prosecution. It has an affirmative defense that prevents conviction. However, under Washington law, all adults 21 and older can possess up to one ounce of marijuana for any purpose.	No.

* = Some or all of this state's listed illnesses must be resistant to other treatments.

Information on States with Medical Marijuana Laws

A detailed listing of states with medical marijuana laws from the Marijuana Policy Project (MPP), updated August 26, 2013.

Marijuana Policy Project
236 Massachusetts Ave. NE
Suite 400
Washington, DC 20002
p: (202) 462-5747 • f: (202) 232-0442
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The Twenty States and One Federal District With Effective Medical Marijuana Laws

And a 21st state with a research-oriented program and a limited defense

Twenty U.S. states and the District of Columbia have enacted laws that remove criminal sanctions for the medical use of marijuana, define eligibility for such use, and allow some means of access — either through home cultivation, dispensaries, or both. In addition, Maryland has both a limited defense for qualifying patients who are charged with possessing up to an ounce of marijuana and a law allowing teaching hospitals to propose medical marijuana programs. [1]

In each of the states, a doctor's recommendation or certification is required for a patient to qualify. In all of those laws, except California and Massachusetts', a physician must certify that the patient has a specific serious medical condition or symptom that is listed in the law. The laws generally include cancer, AIDS, multiple sclerosis, severe or debilitating pain, and severe nausea. The laws also protect physicians who make the recommendations and include designated caregivers who may assist one or more patients, such as by picking up their medicine for them from a dispensary. In all of the jurisdictions except Washington state and Maryland, the patient can send an application, a fee, and the physician's certification in to a state or county department to receive an ID card. The cards typically have to be renewed each year, though some states allow them to be renewed every two years.

Most of the laws specify that they do not allow marijuana to be smoked in public or possessed in correctional facilities. The laws generally specify that employers do not have to allow on-site marijuana use or employees working while impaired, and several specify that they do not protect conduct that would be considered negligent. All but Maryland's law specify that insurance is not required to cover the costs of medical marijuana.

Fifteen of the laws allow at least some patients to cultivate a modest amount of marijuana at their homes. In one of those states, Arizona, patient cultivation is only allowed if the patient lives at least 25 miles away from a dispensary. Nevada's law only allows certain patients to cultivate, including those living 25 miles or more from a dispensary. In Massachusetts, patient cultivation is allowed only under certain circumstances, such as due to financial hardship. Other than New Mexico, each of the states that allow home cultivation allow patients to designate a caregiver to cultivate for them.

Fourteen states' and D.C.'s laws allow for state regulated dispensing, though some of the laws are so new their dispensaries are not yet up and running. The states with state-registered dispensary laws are Arizona, Delaware, Colorado, Connecticut, Illinois, Nevada, New Hampshire, New Mexico, Maine, Massachusetts, New Jersey, Oregon, Rhode Island, and Vermont. In addition, California has hundreds of dispensaries, many of which are regulated at the local level, but there is no statewide licensing or regulation of them. Finally, Washington state's law does not provide for regulated dispensaries, but it does allow marijuana stores for adults.

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[1] This document does not cover dozens of laws passed in the 1970s and 1980s that do not provide actual protection to patients. It also does not cover states where courts have ruled in favor of common law necessity defenses for medical marijuana. Information on those laws and rulings is available in MPP's State-by-State report, available at: www.mpp.org/statelaws

Last updated: August 26, 2013

This paper provides an overview of key provisions of each of the 21 effective (and one research-oriented) medical marijuana laws.

Alaska — Measure 8, a ballot initiative, passed with 58% of the vote in 1998, and was modified by S.B. 94 in 1999. The law's citation is **Alaska Stat. § 17.37.010** et seq.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition and a statement from an Alaska-licensed physician who has personally examined the patient stating that "the physician has considered other approved … treatments that might provide relief … and that the physician has concluded that the patient might benefit from the medical use of marijuana." A minor patient only qualifies with the consent of his or her parent or guardian and if the adult controls the dosage, acquisition, and frequency of use of the marijuana. The qualifying conditions in Alaska are cancer, HIV/AIDS, glaucoma, and conditions causing one or more of the following: cachexia, severe pain, severe nausea, seizures, or persistent muscle spasms, including those that are characteristic of multiple sclerosis. The health department can approve additional medical conditions.

Protections, Access, and Possession Limits: Alaska's law allows a patient with a registry identification card to possess one ounce of processed marijuana and cultivate six plants, only three of which can be mature plants. It only provides an affirmative defense, not protection from arrest. Each patient may have one primary caregiver and one alternate caregiver. Caregivers must be 21 years of age or older and can only serve one patient, unless the caregiver is a relative of more than one patient. They cannot be on parole or probation and cannot have certain drug felonies. Alaska's law does not include any protections for unregistered patients.

Arizona — Proposition 203, a ballot initiative, passed with 50.1% of the vote on November 2, 2010. It went into effect when the election results were certified on December 14, 2010. The law is codified at **Ariz. Rev. Stat. Chapter 36-28.1**. The Department of Health Services issued **rules** on March 28, 2011. In 2011, the legislature passed two laws to undermine Prop. 203 — H.B. 2585, which adds the medical marijuana registry to the prescription drug monitoring registry, and H.B. 2541, which relates to employment law. In 2012, the legislature passed another law to undermine Prop. 203 — HB 2349 — which prohibited medical marijuana on college campuses. The next year, in 2013, the legislature passed SB 1443 to clarify that federally approved medical marijuana research could still be conducted at universities.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition, must be "likely to receive therapeutic or palliative benefit" from the medical use of marijuana, and must obtain a statement from a physician with whom the patient has a bona fide relationship. A minor patient only qualifies with two physician certifications and the consent of his or her parent or guardian. Moreover, the adult must control the dosage, acquisition, and frequency of use of the marijuana. The qualifying conditions in Arizona are cancer, HIV/AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, glaucoma, agitation related to Alzheimer's disease, and conditions causing one or more of the following: severe and chronic pain, cachexia or wasting, severe nausea, seizures, or persistent muscle spasms. The department of health services can approve additional medical conditions. The department also administers the ID card program.

Patient Protections: Arizona's law allows a patient with a registry identification card to possess 2.5 ounces of processed marijuana. Registered caregivers may possess up to 2.5 ounces for each patient they assist. The law provides that registered patients and caregivers abiding by the act are "not subject to arrest, prosecution or penalty in any manner, or denial of any right or privilege, including any civil penalty or disciplinary action …" for doing so. It also prevents landlords, employers, and schools from discriminating based on a person's status as a caregiver

or patient, unless they would otherwise lose a federal monetary or licensing benefit. In 2012, Gov. Brewer signed HB 2349, which banned medical marijuana on all schools, including college campuses and vocational schools.

Employers generally cannot penalize staff for testing positive for marijuana unless they ingest marijuana at work or are impaired at work. In 2011, the legislature passed and Gov. Brewer signed a bill that undermines employment protections, allowing employers to depend on reports of impairment by a colleague who is "believed to be reliable" and seeming to allow termination based on a positive drug test. Prop. 203 also provides some protection for child custody and visitation rights and some protections for residents of nursing homes and other assisted living facilities.

Arizona honors visiting patients' out-of-state registry identification cards for up to 30 days, but they are not valid for obtaining marijuana. The law has an affirmative defense for unregistered patients with doctors' recommendations and their caregivers, but it sunset once the Department of Health Services began issuing ID cards.

Possession Limits and Access: If a patient lives more than 25 miles away from a dispensary, the patient can cultivate up to 12 plants in an enclosed, locked location, or he or she can designate a caregiver to do so. Patients can have a single caregiver and a caregiver can assist no more than five patients. Caregivers can receive reimbursement for their actual expenses, but cannot receive any compensation for their services.

Arizona's law provides for state-regulated nonprofit dispensaries. The department may charge up to $5,000 for each dispensary application and up to $1,000 for each renewal. Each dispensary employee must register with the department. The department developed rules for dispensaries' oversight, record keeping, and security. In addition, the initiative included several regulations. Dispensaries must be at least 500 feet from schools. Dispensaries may cultivate their own marijuana, either at the retail site or a second enclosed, locked cultivation location that must be registered with the department. They may also sell usable marijuana to one another, but dispensaries cannot purchase marijuana from anyone other than another dispensary. Patients and caregivers may donate marijuana to one another and to dispensaries. Dispensaries can dispense no more than 2.5 ounces of marijuana to a patient every 14 days. The total number of dispensaries cannot exceed one for every 10 pharmacies, which would total about 125 dispensaries.

The Department of Health Services issued certificates to more than 90 dispensaries in August 2012, and 64 are up and running as of August 2013.

California — Proposition 215, a ballot initiative, passed with 56% of the vote in 1996, and the legislature added protections by passing SB 420 in 2003. In 2010, the legislature passed AB 2650, adding a buffer zone between dispensaries and schools. In California, the legislature cannot amend a voter-initiative, so SB 420 and AB 2650 are only supplementary. The laws are codified at Cal. Health and Safety Code §**11362.5** and **11362.7 et seq**.

Qualifying for the Program: California's law is the only one to allow doctors to recommend medical marijuana for any condition. Medical marijuana can be recommended for "cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief." Patients may get a registry identification card from their county health departments, but cards are not mandatory and the vast majority of patients rely on a written recommendation from a physician.

Patient Protections: A patient is protected from "criminal prosecution or sanction" if he or she has a physician's recommendation for medical marijuana. To qualify as a primary caregiver in

California, one must be designated by a patient and must have "consistently assumed responsibility for the housing, health, or safety of [the] patient." The law allows primary caregivers to cultivate marijuana for any number of patients. The California Supreme Court ruled in *Ross v. Ragingwire* that the law does not provide protection from being fired for testing positive for marijuana metabolites, even if the patient is never is impaired at work.

Possession Limits and Access: California's law allows a patient with a physician's recommendation to possess at least eight ounces of processed marijuana and cultivate six mature plants or 12 immature plants, or greater amounts if the county allows a greater amount. Patients may also assert a defense in court for greater amounts that are for "personal medical purposes."

SB 420 provides that patients and caregivers "who associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions ... ." It also specifies that it does not "authorize any individual or group to cultivate or distribute marijuana for profit." Based on this collective language, dispensaries are operating in many parts of California. While then-Attorney General Jerry Brown issued guidelines on medical marijuana, state law provides no regulation or registration of collectives and cooperatives. Instead, many localities have moved to regulate them, while others have enacted bans, some of which are being challenged in court. In early 2012, the California Supreme Court granted review to several cases relating to dispensaries, including whether dispensaries can be banned and whether cities issuing licenses to dispensaries are federally preempted. Those cases are currently pending.

In 2012, AB 2650 prohibited a collective, cooperative, or dispensary with a storefront or mobile retail unit from dispensing medical marijuana within a 600-foot radius of a school for students between kindergarten and 12th grade.

Colorado — Amendment 20, a constitutional amendment ballot initiative, passed with 54% of the vote in 2000. In 2010, two bills were enacted to amend the medical marijuana law, H.B. 1284 and S.B. 109. In 2011, two more revisions, **HB 1250** and HB 1043, were signed into law. The citations of the statutes are Colo. Rev. Stat. § **12-43.3-101**, **18-18-406.3**, and **25-1.5-106** et seq. The constitutional amendment is **Article XVIII, Section 14**. Department of Health Rules on medical marijuana are available at **5 CCR 1006-2**. The Medical Marijuana Enforcement Group rules are **available online**. The rule on residency is available at **1 CCR 212-1**.

Qualifying for the Program: To qualify for an ID card, a patient must reside in Colorado and submit a fee and written documentation from a physician in good standing in Colorado certifying that the patient "might benefit from the medical use of marijuana" in connection with a specified qualifying medical condition. The physician must have a treatment or consulting relationship with the patient and must have done a physical exam and be available for follow-up care. The qualifying conditions in Colorado are cancer, HIV/AIDS, glaucoma, and conditions causing one or more of the following: severe pain, cachexia, severe nausea, seizures, or persistent muscle spasms. The health department administers the ID card program and can approve additional qualifying conditions. A minor patient only qualifies with two physicians' authorizations, parental consent, and if the adult controls the dosage, frequency of use, and if they acquire the medical marijuana.

Patient Protections: Colorado's law created an exception from the state's criminal laws for any patient or caregiver in possession of an ID card and a permissible amount of marijuana. The department is required to issue an ID card to a qualified applicant within 35 days of receiving an application. However, if the department fails to do so, 35 days after the submission of the application the patient's applications materials and proof of mailing will serve as an ID card. A patient and his or her caregiver may raise an affirmative defense for more than the specified

amount only if the patient's physician specified that that patient needs a specific greater amount. It seems the defense can also be raised whether or not a patient has a registry ID card. The law also says that "the use of medical marijuana is allowed under state law" to the extent it is carried out in accordance with the state constitution, statutes, and regulations.

Possession Limits and Access: Each patient can possess up to two ounces of marijuana and can cultivate up to six plants, three of which may be mature. Patients can designate a single caregiver or a medical marijuana center to cultivate for them. A caregiver can assist no more than five patients, unless the department of health determines exceptional circumstances exist. A caregiver must have "significant responsibility for managing the well-being of a patient."

Under a law that passed in 2010, medical marijuana centers (dispensaries) and entities that make marijuana-infused products are explicitly allowed and must be licensed by their locality and a state licensing authority under the department of revenue. Labs may also be licensed to test marijuana. There are several regulations spelled out in the law including for medical marijuana centers' security, proximity to schools, and hours of operation. On-site marijuana use is forbidden. Specific labels and packaging are required for marijuana sold in food products. Caregivers must have a waiver from the department to be allowed to pick up marijuana for homebound patients. In addition, the licensing authority — the Medical Marijuana Enforcement Division, which is part of the Department of Revenue — set fees and developed additional regulations, which went into effect on July 1, 2011. The Medical Marijuana Enforcement Division has the authority to impose penalties, including suspending and revoking licenses. The state's medical marijuana center fees range from $7,500 to $18,000. The infused products and cultivation fees are each $1,200. With the exception of new medical marijuana centers and those granted a waiver due to a catastrophic event related to inventory, medical marijuana centers must cultivate at least 70% of the marijuana they dispense, and the rest can only be purchased from other medical marijuana centers. Although there is an exception, a center generally can possess no more than six plants and two ounces per patient who designates it.

Medical marijuana is subject to sales tax, except for individual patients who the department finds are indigent. Up to $2 million per year in tax revenue will be appropriated to services related to substance abuse. The medical marijuana center licensing provisions sunset on July 1, 2015. For fiscal year 2012, the Medical Marijuana Enforcement Division reported there were 532 medical marijuana centers either licensed and operating or allowed to operate while awaiting the review of their license applications.

In addition to Colorado's medical marijuana law, voters approved Amendment 64 in November 2012, which allows any adult, 21 and older, to possess up to an ounce of marijuana and up to six plants. It will also allow the retail sales of marijuana for recreational use.

Other: The state licensing authority is directed to petition the federal DEA to reschedule marijuana.

Connecticut — The Connecticut Legislature passed and Gov. Dannel Malloy signed HB 5389 in 2012. The law is available at **Conn. Gen. Stat. § 21a-408 to 21a-408o**. The effective date for part of the law — including for patients' temporary registry ID cards — was October 1, 2012. The Department of Consumer Protection submitted proposed regulations to the Regulation Review Committee on June 21, 2013.

Qualifying for the Program: From October 1, 2012 until 30 days after the department issues permanent registrations, patients and their caregivers may obtain a temporary registry identification card from the Department of Consumer Protection. To qualify for an ID card, a patient will be required to have a qualifying condition and a physician's written certification stating that the potential benefits of the palliative use of marijuana would likely outweigh the

health risks. Patients must be 18 or older and must be Connecticut residents. The law does not protect patients with out-of-state ID cards.

The qualifying conditions in Connecticut are: cancer, glaucoma, HIV/AIDS, Parkinson's disease, multiple sclerosis, spinal cord damage causing intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, PTSD, or a condition added by the Department of Consumer Protection.

Patient Protections: Connecticut's law provides that registered patients, registered caregivers, dispensaries and their employees, producers and their employees, and physicians may not be "subject to arrest or prosecution, penalized in any manner, including, but not limited to, being subject to any civil penalty, or denied any right or privilege, including, but not limited to, being subject to any disciplinary action" by a professional licensing board for acting in accordance with the law.

The law also includes protections from discrimination by landlords, employers, and schools, with an exception for if discrimination is required to obtain federal funding or to comply with federal law. These civil protections are all based on one's status as a patient or caregiver.

Patients cannot ingest marijuana anywhere in public, in a workplace, in any moving vehicle, in the line of sight of a person under 18, or on any school or university grounds, including in dorm rooms.

Possession Limits and Access: Connecticut's law does not provide for home cultivation. It provides for dispensaries, which will be licensed by the Department of Consumer Protection. Only pharmacists can file applications for dispensaries. The draft rules would require the department to allow at least one dispensary facility and would allow it to authorize more if "additional dispensary facilities are desirable to assure access to marijuana for qualifying patients."

Dispensaries will only be allowed to obtain marijuana from licensed producers. The Department of Consumer Protection will also decide how many producers to license, and the number must be between no less than three and no more than 10. The draft rules seem to favor a lower number of producers. The non-refundable application fee for producers must be at least $25,000. The department has proposed an annual fee of $75,000 for producers. Dispensary facility application fees would be $1,000, with their annual fees being $5,000.

The Department of Consumer Protection will decide how much usable marijuana patients can possess, which will be a one-month supply. An eight member board of physicians will review and recommend protocols to decide the amount that would be reasonably necessary for a one-month supply, including for topical treatment. The board will also make recommendations on whether to add qualifying conditions.

Primary caregivers can serve a single patient, unless they are close relatives or guardians to each patient, and each patient can have only one caregiver. Caregivers cannot have convictions for selling or manufacturing drugs. The need for a caregiver must be evaluated by the physician and be included in a written certification.

Other: Connecticut's law directs the Commissioner of Consumer Protection to submit regulations to reclassify marijuana as a Schedule II substance under state law.

Delaware — Gov. Jack Markell signed SB 17 on May 13, 2011. The bill is codified at **Title 16, Chapter 49A of the Delaware Code**. Following a February 2012 letter from the U.S. attorney for Delaware, Gov. Markell placed the dispensary portion of the bill on hold. Gov. Markell

announced on August 15, 2013 that he would restart the program, allowing a single pilot dispensary, which could possess up to 150 plants and have up to 1,500 ounces of marijuana.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition and a physician's statement that the patient is "likely to receive therapeutic or palliative benefit" from the medical use of marijuana. The physician must be the patient's primary care physician or physician responsible for treating the patient's qualifying condition. Patients must be 18 or older. The qualifying conditions in Delaware are cancer, HIV/AIDS, decompensated cirrhosis, amyotrophic lateral sclerosis, agitation related to Alzheimer's disease, post-traumatic stress disorder, and conditions causing one or more of the following: severe debilitating pain that has not responded to other treatments for more than three months or for which other treatments produced serious side effects, intractable nausea, seizures, or severe and persistent muscle spasms. The department of health and social services can approve additional medical conditions. The department will also administer the ID card program.

Patient Protections: The law provides that registered patients and caregivers abiding by the act are "not subject to arrest, prosecution, or denial of any right or privilege, including but not limited to civil penalty or disciplinary action …" for doing so. It also prevents landlords, employers, and schools from discriminating based on a person's status as a caregiver or patient, unless they would otherwise lose a federal monetary or licensing benefit. Employers generally cannot penalize staff for testing positive for marijuana unless they used, possessed, or were impaired by marijuana at work or during work hours. It provides some protection for child custody and visitation rights and receiving organ donations.

Delaware honors visiting patients' out-of-state registry identification cards for up to 30 days if they have conditions that qualify in Delaware. However, patients must obtain a Delaware registry card to obtain marijuana from a Delaware compassion center. The law has an affirmative defense for unregistered patients with doctors' recommendations, but it only applies until the department begins issuing cards and between when a patient submits a valid application and when the patient receives his or her ID card.

Possession Limits and Access: Delaware's law allows a patient with a registry identification card to possess six ounces at once and to obtain up to three ounces of processed marijuana every 14 days. When patients or caregivers are out of their residences, marijuana must be stored in an approved, sealed container obtained from a compassion center, unless the marijuana is being administered or prepared for administration. Registered caregivers may possess up to six ounces for each patient they assist.

Home cultivation is not allowed in Delaware. Patients are allowed to obtain marijuana from state-registered non-profit compassion centers. The first pilot compassion center is expected to be registered in 2014. Patients can have a single caregiver, and a caregiver can assist no more than five patients. The law directed the health department to develop rules for compassion centers' oversight, record keeping, and security, and to set application and registration fees, which (along with donations) must cover the costs of administering the program. It issued final rules for the registry identification card program on June 1, 2012.

The department is also charged with selecting compassion centers, based on a scored, competitive application process. Dispensaries must be at least 500 feet from schools. They must cultivate their own marijuana, either at the retail site or at additional enclosed, locked cultivation locations that must be registered with the department. Dispensaries can dispense no more than three ounces of marijuana to a patient every 14 days. The department was supposed to register three compassion centers by January 1, 2013 and three more by January 1, 2014. Additional ones could also be approved if they are needed. However, as was mentioned, that

part of the law was put on hold. Now, a single center will be approved in 2014.

Hawaii — S.B. 862 was passed by the Hawaii Legislature in 2000. It was the first medical marijuana bill to be passed legislatively. Its citation is **Haw. Rev. Stat. § 329-121** et seq. The rules are at **HAR Chapter 23-202**.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition and a statement from a Hawaii physician that the "potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient." Although most states house their medical marijuana programs in their health departments, Hawaii's is administered by the state Department of Public Safety. The qualifying conditions in Hawaii are cancer, HIV/AIDS, glaucoma, and conditions causing one or more of the following: severe pain, cachexia or wasting, severe nausea, seizures, or severe and persistent muscle spasms. The health department can approve additional conditions. A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana.

Protections, Access, and Possession Limits: Hawaii's law allows a patient with a registry identification card and his or her caregiver to collectively possess three ounces of processed marijuana and cultivate three mature plants and four immature plants. Hawaii's law does not provide for dispensaries and a primary caregiver can only assist one patient at a time. There is also a "choice of evils" defense patients can raise.

Illinois: Gov. Patrick Quinn signed **HB 1** into law on August 1, 2013, after it was approved by the General Assembly. The new law goes into effect on January 1, 2014, and the executive branch will then have four months to craft rules.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying medical condition and a statement from an Illinois-licensed MD or DO who is caring for the patient's condition. The physician must certify that the patient "is likely to receive therapeutic or palliative benefit" from medical marijuana.

Restrictions on Who May Be a Patient: Minors cannot qualify as patients. Patients also cannot not be active police officers, firefighters, correctional officers, probation officers, or bus drivers. They cannot have a commercial driver's license or a felony drug conviction.

Qualifying Medical Conditions: The qualifying conditions in Illinois are HIV/AIDS; hepatitis C; amyotrophic lateral sclerosis (ALS); Crohn's disease; agitation of Alzheimer's disease; cachexia/wasting syndrome; muscular dystrophy; severe fibromyalgia; spinal cord disease; Tarlov cysts; hydromyelia; syringomyelia; spinal cord injury; traumatic brain injury and post-concussion syndrome; multiple sclerosis; Arnold Chiari malformation; Spinocerebellar Ataxia (SCA); Parkinson's disease; Tourette's syndrome; Myoclonus; Dystonia; Reflex Sympathetic Dystrophy (RSD); Causalgia; CRPS; Neurofibromatosis; Chronic Inflammatory Demyelinating Polyneuropathy; Sjogren's syndrome; Lupus; Interstitial Cystitis; Myasthenia Gravis; Hydrocephalus; nail patella syndrome; residual limb pain; or the treatment of these conditions. The public health department may approve additional conditions.

Caregivers: Patients may have a single caregiver who may pick up medical marijuana for them. Caregivers must be 21 or older and cannot have a disqualifying drug conviction. They may only assist a single patient.

Patient Protections: Registered patients may not be arrested or prosecuted or face criminal or other penalties, including property forfeiture for engaging in the medical use of marijuana in compliance with the law. There are also protections against patients being discriminated against

in medical care — such as organ transplants — and in reference to child custody. In addition, landlords may not refuse to rent to a person solely due to his or her status as a registered patient or caregiver unless doing so violates federal law on the part of the landlord. Landlords may prohibit smoking medical marijuana on their premises. Similarly, schools and employers are prohibited from discriminating based on patient status unless they face restrictions under federal law. However, employers may continue to enforce drug-free workplace policies, and they do not have to allow employees to possess marijuana at work or work while they are impaired.

Possession Limits and Access: Illinois' law allows a patient or caregiver with a registry ID card to possess 2.5 ounces of processed marijuana. Patients and caregivers may not grow marijuana. Instead, they will be allowed to obtain medical marijuana from one of up to 60 state-regulated medical marijuana dispensaries, which may be for-profit. Dispensaries will be subject to rules created by the Department of Financial and Professional Regulation. They will obtain medical marijuana from one of up to 22 cultivation centers. Prospective cultivation centers will have to submit detailed plans to the Department of Agriculture. All cultivation centers will have 24-hour surveillance that law enforcement can access. They will also be required to have cannabis-tracking systems and perform weekly inventories. Grow centers will be required to abide by department rules, including for labeling, safety, security, and record keeping. Centers will also have to comply with local zoning laws and must be located at least 2,500 feet from daycare centers, schools, and areas zoned for residential use.

Fees for both dispensaries and cultivation centers will be determined by the department.

Other: The law was created with a “sunset” provision, meaning that if the legislature does not renew the program or create a new law, the program will cease to operate four years from the date it goes into effect. Medical marijuana will be subject to a 7% privilege tax and a 1% sales tax.

Maine — Question 2, a ballot initiative, passed with 61% of the vote in 1999. It was modified in 2002 by S.B. 611 and in 2009 by Question 5, an initiative that passed with 59% of the vote. It was then amended by LD 1811 in 2010, by LD 1296 in 2011, and by LD 480, LD 1062, LD 1404, LD 1423, LD 1462, and LD 1531 in 2013. Its citation is **Me. Rev. Stat. Ann. tit 22 § 2421** et seq. Rules are available at **10-144 C.M.R, Chapter 122**.

Qualifying for the Program: Registry identification cards are voluntary for patients and for caregivers who are members of their patients’ families or households. They are mandatory for other caregivers. To qualify for protection from arrest, a patient must have a qualifying condition and a statement from a physician with which the patient has a bona fide relationship. The statement must be on tamper-resistant paper, is valid for no more than a year, and must state that the patient is "likely to receive therapeutic or palliative benefit" from the medical use of marijuana. A minor patient only qualifies with the consent of his or her parent or guardian, and the adult must control the dosage, acquisition, and frequency of use of the marijuana.

The qualifying conditions in Maine are cancer, HIV/AIDS, hepatitis C, amyotrophic lateral sclerosis, nail patella, glaucoma, agitation related to Alzheimer’s disease, and conditions causing one or more of the following: intractable pain, cachexia or wasting, severe nausea, seizures, or severe and persistent muscle spasms. Beginning in mid-October 2013, post-traumatic stress disorder, inflammatory bowel disease, and dyskinetic and spastic movement will also qualify. A health department-created advisory panel can approve additional medical conditions and make recommendations about what an adequate supply of marijuana would be. The department of health also administers the ID card program.

Caregivers must be 21 or older and cannot have a disqualifying drug conviction. They can also

be hospice providers or nursing facilities, but those entities cannot grow for patients. They may have a single employee.

Patient Protections: Maine's law provides that those abiding by the act may not "be denied any right or privilege or be subjected to arrest, prosecution, penalty or disciplinary action" for those medical marijuana-related actions. It also generally prevents landlords and schools from discriminating based on a person's status as a caregiver or patient, though it allows landlords to prevent cultivation and landlords and businesses to prevent smoking in their properties. It also provides some protection for child custody and visitation rights. Maine protects patients from states that allow medical marijuana if they have a written certification, the required identification, and if Maine's health department adds the other state's law to a list.

Possession Limits and Access: Maine's law allows a patient or caregiver with the required documentation or registry ID card to possess 2.5 ounces of processed marijuana per patient. A total of six mature plants may be cultivated for each patient in an enclosed, locked location. The patient can choose to cultivate and/or can designate either a caregiver or a dispensary to cultivate for the patient, as long as the total amount of plants per patient does not exceed six mature plants. Plants in other stages of harvest may also be cultivated. The law has an affirmative defense for patients needing additional amounts of marijuana. Adult patients can have a single caregiver, and a caregiver can assist no more than five patients. Caregivers can receive reasonable monetary compensation. Collective cultivation by caregivers is expressly forbidden, except that two patients or two caregivers may share an enclosed, locked facility if they live together. Caregivers may donate excess marijuana to patients, other caregivers, or to dispensaries. Beginning on October 3, 2013, they may also sell up to two pounds of marijuana to dispensaries each year.

Maine's law also provides for state-regulated not-for-profit dispensaries, of which there can be no more than eight in the first year. As of August 2013, eight non-profit dispensaries have been registered. The department charged $15,000 for each registration. In addition, each dispensary employee must register with the department. The state health department developed rules for dispensaries' oversight, record keeping, and security, in addition to several specific requirements from the law. Dispensaries must be at least 500 feet from schools, they must have on-site parking, sufficient lighting, and electronic monitoring. Dispensaries must cultivate their own marijuana, either at the retail site or a second enclosed, locked cultivation location that must be registered with the department. Dispensaries can dispense no more than 2.5 ounces of marijuana to a patient every 15 days. The department may determine the number and location of dispensaries.

Maryland (partial law) — The Maryland General Assembly enacted and Gov. Martin O'Malley signed a medical marijuana defense bill in 2010. The bill was codified at Md. Code, Crim. Law § **5–601**, **5–619**, and **Health Occ. §14–404 (c)**. In 2013, the legislature and governor expanded the defense bill and enacted a research-oriented law, which is codified at **Md. Code, Health, §13-3101, et seq**. It goes into effect on October 1, 2013.

Qualifying for the Program: Maryland has two types of possible protection for patients: 1) an affirmative defense and sentencing mitigation that can be raised in court after an arrest; and 2) a research-oriented medical marijuana program that is not yet operational.

Regarding the affirmative defense, if a patient who has been diagnosed with a defined debilitating medical condition by a physician with whom he or she has a bona-fide physician-patient relationship, he or she may raise the defense in court. The defense only applies to possession of up to an ounce of marijuana. To raise the defense, caregivers must meet a number of requirements, including that they are immediate family members of the patient. The defense is only available if the caregiver was designated by the patient prior to the arrest and the

designation is in the patient's medical record. If it is proven, the patient or caregiver will be acquitted. The qualifying conditions for the defense are cachexia or wasting syndrome, severe or chronic pain, severe nausea, seizures, severe and persistent muscle spasms, or any other condition that is severe and resistant to conventional medicine. Regardless of the condition, to qualify for the defense, a patient's condition must be severe and resistant to conventional medicine, and marijuana must be likely to provide the patient with relief.

The law also includes a "medical necessity" sentencing mitigation, which was first enacted in 2003 and allows the sentence to be reduced to $100 if proven. The list of conditions, requirement that possession be limited to one ounce or less, and the requirement that the patient's condition must be severely resistant to conventional medicine appears not to apply to the sentencing mitigation.

Patient Protections: Patients and caregivers who prove the affirmative defense will be spared a conviction, but they will still be subject to an arrest and court proceedings. Patients who are enrolled in the research-oriented program, which was enacted in 2013 and is not currently operational, would be protected from arrest.

Possession Limits and Access: Under the research-oriented law, patients may possess the amount provided by the academic medical centers — hospitals that perform federally approved research and have medical residency programs. The defense law applies to up to one ounce and does not include home cultivation or any means of access. The teaching hospital law would allow patients to possess the amount of marijuana provided for by the program.

Under the research-oriented law, teaching hospitals may apply to an independent commission to run an investigational use-type medical marijuana program. Those centers will then provide marijuana to patients. Each program application must specify which medical conditions will be treated, the treatment duration, the proper dosage, where marijuana will be obtained, sources of funding, and a plan for monitoring data and outcomes, among other things. It is not clear if any teaching hospitals will actually participate.

Academic medical centers also must specify how they would include or exclude patients and how they would evaluate patients for addiction. Programs would initially be approved for one year and could be extended. Each program must be approved by the academic medical center's institutional review board.

All marijuana provided by the academic medical centers must be obtained from either an in-state grower licensed and regulated by the commission or from the federal government (which is very unlikely to be willing to do so). An independent commission would set security and manufacturing requirements for growers. The commission will license no more than XX programs at a time and no more than five growers for each medical marijuana program it licenses.

Other: Maryland's governor could suspend the research-oriented law if there is a reasonable chance the federal government could prosecute state employees.

Massachusetts — Question 3, a ballot initiative, passed with 63% of the vote in 2012. The citation for the law is **Mass. Gen. Laws ch. 94C § 1-2 to 1-17**.

Qualifying for the Program: To qualify for protection from arrest, a patient generally must have a registry identification card issued by the health department. To obtain a card, a patient must have a qualifying condition and a statement from a physician with whom the patient has a bona fide relationship. The qualifying conditions in Massachusetts are cancer, glaucoma, HIV/AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, Parkinson's disease,

multiple sclerosis, and other debilitating conditions as determined in writing by a qualifying patient's physician. Until the department has fully implemented the law, a patient's written certification will serve as his or her ID card.

Personal caregivers must be 21 or older and must also generally be registered with the health department.

Patient Protections: Massachusetts' law provides that "Any person meeting the requirements under this law shall not be penalized under Massachusetts law in any manner, or denied any right or privilege, for such actions." Patients, caregivers, and dispensary agents who present their ID cards to law enforcement and possess a permissible amount of marijuana may not be subject to arrest, prosecution, or civil penalty.

Massachusetts' law does not provide recognition for out-of-state ID cards.

Possession Limits and Access: Massachusetts' law allows a patient or caregiver to possess a 60-day supply of marijuana. The health department's draft rules define a presumptive 60-day supply as 10 ounces, but physicians can certify that a greater amount is needed if they document the rationale.

A patient with limited access to dispensaries may cultivate if he or she receives a hardship registration allowing the patient or his or her caregiver to cultivate a 60-day supply of medical marijuana. The department will issue cultivation registrations to patients whose access to dispensaries is limited by financial hardship, the physical incapacity to access reasonable transportation, or the lack of dispensaries reasonably close to — or that will deliver to — the patient.

Patients may also obtain marijuana from state-regulated nonprofit dispensaries. Question 3 requires the department to issue registration certificates to qualified applicants wishing to operate medical marijuana treatment centers within 90 days of receiving their applications. Up to 35 centers may be registered by January 1, 2014. If the department determines 35 centers are insufficient, it may decide to increase the number in 2014. At least one center must be located in each county, and no more than five may locate in a single county. There is no clear timetable for when treatment centers will be able to open and begin serving patients.

Michigan — Proposition 1, a ballot initiative, passed with 63% of the vote in 2008. In late 2012, the Michigan Legislature made some additions and modifications to the act. Michigan's medical marijuana act is codified at **MCL § 333.26421** et seq. Rules are at **Rule 333.101** et seq.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition and a statement from a physician that the patient has a bona fide relationship with that physician and that the patient is "likely to receive therapeutic or palliative benefit" from the medical use of marijuana. The qualifying conditions in Michigan are cancer, HIV/AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's diseases, nail patella, glaucoma, agitation related to Alzheimer's disease, and conditions causing one or more of the following: severe and chronic pain, cachexia or wasting, severe nausea, seizures, or severe and persistent muscle spasms. The health department processes ID card applications and can approve additional medical conditions. A minor patient only qualifies with two physician recommendations, parental consent, and if the adult controls the dosage, frequency of use, and acquisition of marijuana.

Patient Protections: Michigan's law allows a patient or caregiver with a registry identification card to possess 2.5 ounces of processed marijuana. It provides that those abiding by the act cannot be subject to "arrest, prosecution, or penalty in any manner, or denied any right or

privilege, including but not limited to civil penalty or disciplinary action by a business or occupational or professional licensing board or bureau" for actions allowed by the law. Michigan honors visiting patients' out-of-state registry identification cards. If a patient applies for an ID card but has not received a response within 20 days, their doctor's certification and application materials function as an ID card. The law has an affirmative defense available to patients and their caregivers whose physicians believe the patients are "likely to receive therapeutic or palliative benefit" from medical marijuana if they possess "a quantity of marihuana that was not more than was reasonably necessary to ensure the uninterrupted availability" of medical marijuana.

Possession Limits and Access: A patient can choose to cultivate up to 12 plants in an enclosed, locked area, or can designate a caregiver to do so for the patient. Patients can have a single caregiver and caregivers can assist no more than five patients. Caregivers can receive reasonable compensation. While Michigan law does not provide for dispensaries, several cities have enacted ordinances recognizing, licensing, and regulating them.

Other: The legislature added a requirement that marijuana must be in a case in a trunk while it is transported, or — if the vehicle has no trunk — it must be in a case that isn't readily accessible from inside the vehicle.

Montana — I-148, a ballot initiative, passed with 62% of the vote in 2004. It was amended by SB 325 in 2009, and it was replaced with a much more restrictive law, SB 423, in 2011. Some of SB 423 went into effect on July 1, 2011 and some was enjoined in court. As of August 2013, litigation is still ongoing. The law is codified at **MCA § 50-46-301 et seq**. The original law was codified at **MCA § 50-46-101** et seq.

Qualifying for the Program: To qualify for an ID card under the revised law, a patient must submit an extensive written certification form, completed by the patient's physician that, among other things, states that the patient has a qualifying condition. The qualifying conditions are now: cachexia or wasting syndrome, intractable nausea or vomiting, epilepsy or intractable seizure disorder, multiple sclerosis, Crohn's disease, painful peripheral neuropathy, admittance to hospice, a nervous system disease causing painful spasticity or spasms, conditions whose symptoms severely adversely affect the patient's health, cancer, glaucoma, HIV/AIDS, and severe pain that significantly interferes with daily activities and for which there is objective proof and is verified by an independent second physician. Patients must be Montana residents. Patient ID cards under the original law are valid until they expire.

Under SB 423, physicians must describe all other attempts at treatment and that the treatments have been unsuccessful. Physicians also have to state that they have a "reasonable degree of certainty" that each patient would benefit from medical marijuana. A provision that is currently enjoined provides that physicians will be investigated at their own expense by the medical board if they make 25 or more recommendations in a 12-month period.

A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana. They must also have two physicians' recommendations. The health department is responsible for issuing ID cards and may approve additional medical conditions.

Protections or lack there of: Montana's law provides that those abiding by the act "may not be arrested, prosecuted, or penalized in any manner or be denied any right or privilege, including but not limited to civil penalty or disciplinary action by a professional licensing board or the department of labor and industry" for the medical use of marijuana in accordance with the act.

SB 423 lets landlords ban tenants who are patients from using medical marijuana and requires a landlord's written permission for cultivation. A provision that has been enjoined allows state and local law enforcement to make unannounced inspections of caregivers registered premises during business hours. SB 423 bans advertising of marijuana or related products, including on the internet, but that part of the law is currently enjoined.

Previously, Montana honored visiting patients' out-of-state registry identification cards and included an affirmative defense for unregistered patients or those needing larger amounts of marijuana. SB 423 eliminated both of those protections.

Possession Limits and Access: Montana's revised law allows a registered patient or his or her registered provider to possess four mature plants, 12 seedlings, and one ounce of usable marijuana per patient. If a patient cultivates, his or her provider may not. Although the initial law did not mention dispensaries, it also did not limit the number of patients a caregiver could serve. Under I-148, caregivers could receive reasonable compensation, and some cities and counties enacted regulations on dispensaries. However, under parts of SB 423 that were enjoined, providers could only assist up to three patients and could not receive any compensation.

Nevada — Question 9, a constitutional amendment ballot initiative, passed first in 1998 and then with 65% of the vote in 2000. It was implemented by AB 453 in 2001, which was revised by AB 130 in 2003, AB 519 in 2005, and AB 538 in 2009. In 2013, the legislature enacted S.B. 374, which added a dispensary program. Question 9 is codified at **Article 4, section 38** of the Nevada Constitution. The statutory provisions are codified at **Nev. Rev. Stat. 453A**. Rules are at **NAC 453A**.

Qualifying for the Program: To qualify for an ID card in Nevada, a patient must have a qualifying condition and a statement from a Nevada physician who has responsibility for caring for or treating the patient that marijuana "may mitigate the symptoms or effects" of their condition. A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana. The qualifying conditions in Nevada are cancer, HIV/AIDS, glaucoma, and conditions causing one or more of the following: severe pain, cachexia, severe nausea, seizures, or persistent muscle spasms. The department can approve additional conditions. Nevada's revised law contains reciprocity provisions, which recognize patients from other medical marijuana states as long as the other state programs are substantially similar to the requirements of Nevada law.

Nevada's registered patients may have a single caregiver. Caregivers must have significant responsibility for managing a qualifying patient's wellbeing and may serve only one patient.

Patient Protections: Registered patients are exempt from prosecution for the acts allowed under Nevada law. Patients may also not be disciplined by a professional licensing board and employers must "attempt to make reasonable accommodations for the medical needs" of employees who are registered patients.

Patients with qualifying conditions may also assert an affirmative defense if they have been advised by a physician that marijuana may mitigate their condition, even if they do not have an ID card. This defense may also be raised by people assisting patients and for greater amounts of marijuana if the amounts are "medically necessary as determined by the person's attending physician."

Possession Limits: Patients and their caregivers may collectively possess two and a half ounces of marijuana. They can obtain that amount each 14-day period. Those patients or caregivers who are allowed to grow may cultivate up to 12 plants.

Access: The voter-enacted constitutional amendment directed lawmakers to enact a medical marijuana law, including "authorization of appropriate methods for supply of the plant to patients authorized to use it." However, Nevada's law initially did not allow anyone to deliver marijuana for compensation, including to qualified patients. It allowed patients and their caregivers to cultivate, but did not allow dispensaries. In 2013, the legislature and governor modified the law to allow dispensaries. The revised law also limits which patients can cultivate marijuana. Under the revised law, patients who were already cultivating can continue to cultivate until March 31, 2016. In addition, all patients may cultivate if they do not live near a dispensary, if they cannot travel to one, or if the dispensaries near them do not have an adequate supply of marijuana or of the strain that works for the patient.

There will be a total of up to 66 licensed and regulated dispensaries in the state. Clark County may have up to 40 dispensaries. Washoe County may have 10. Carson City can have two, and each of the other 14 counties can have one. In addition to dispensaries, the Health Division will regulate cultivators, infused product manufacturers, and laboratories. All of the establishments may be for-profit. Dispensaries must have a single, secure entrance for patrons. All cultivation by cultivation centers must occur in an enclosed, locked facilitation that is registered with the department. Marijuana must be tested and labeled, including with the concentration of THC and weight. Medical marijuana businesses may not allow on-site marijuana consumption. Medical marijuana businesses must also have inventory control systems, their staff must register with the state, and they must enter information on patrons into an electronic verification system. Businesses will also have to comply with local rules and those crafted by the Health Division.

Other: Medical marijuana sales will be subject to a 2% excise tax at the wholesale level, along with a 2% excise tax at the retail level. Standard sales taxes also apply. Seventy-five percent of the tax revenue will go to education and 25% to regulatory oversight.

New Hampshire: Gov. Maggie Hassan signed HB 573 into law on July 23, 2013, after it was approved by the legislature. The new law went into effect immediately, but the health department has a year to craft rules for the patient registry and 18 months for alternative treatment center rules.

Qualifying for the Program: To qualify for an ID card, a patient must obtain a written certification from a physician or an advanced practice registered nurse and send it in to the Department of Health and Human Services. The provider must be primarily responsible for treating the patient's qualifying condition. Minors with qualifying serious medical conditions may register if the parent or guardian responsible for their health care decisions submits written certifications from two providers, one of which must be a pediatrician. The parent must also serve as the patient's caregiver and control the frequency of the patient's marijuana use. Out-of-state patients with a valid medical marijuana card from another state will be allowed to bring their cannabis into New Hampshire and use it in the state. They must also have documentation from their physicians that they have a condition that qualifies under New Hampshire law.

Qualifying Medical Conditions: The law allows patients to qualify if they have one of the listed medical conditions and one of the listed qualifying symptoms. In addition, on a case-by-case basis, the department may allow patients to register who do not have a listed medical condition if their providers certify that they have a debilitating medical condition. The qualifying conditions are cancer, glaucoma, HIV/AIDS, hepatitis C, ALS, muscular dystrophy, Crohn's disease, Alzheimer's, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, and injuries that significantly interfere with daily activities. The qualifying symptoms are severely debilitating or terminal medical conditions or their treatments that have produced elevated intraocular pressure, cachexia, chemotherapy-induced anorexia, wasting syndrome, severe pain if it has not responded to other treatments or if treatments

produced serious side effects, severe nausea, vomiting, seizures, or severe, persistent muscle spasms.

Caregivers: Patients may have a single caregiver who may pick up medical marijuana for them. Caregivers must be 21 or older and cannot have a felony conviction. Caregivers typically may assist no more than five patients.

Patient Protections: Registered patients may not be arrested or prosecuted or face criminal or other penalties for engaging in the medical use of marijuana in compliance with the law. The law also offers protections against discrimination in child custody cases and in medical care — such as organ transplants.

Possession Limits and Access: New Hampshire's law allows a patient with a registry ID card to obtain up to two ounces of processed marijuana every 10 days. Caregivers may possess that amount for each patient they assist. Patients and caregivers may not grow marijuana. Instead, they will be allowed to obtain medical marijuana from one of up to four state-regulated alternative treatment centers (ATCs). ATCs will be non-profit and may not be located within 1,000 feet of the property of a drug-free zone or school. They must provide patients with educational information on strains and dosage and must collect information patients voluntarily provide on strains' effectiveness and side effects. Staff must be at least 21, wear ATC-issued badges, and cannot have any felony convictions. The law includes numerous additional requirements, including for periodic inventories, staff training, reporting incidents, prohibiting non-organic pesticides, and requiring recordkeeping. ATCs cannot possess more than either 80 mature plants and 80 ounces total, or three mature plants and six ounces per patient. The health department — with input from an advisory council — will set additional rules, including for electrical safety, security, sanitary requirements, advertising, hours of operations, personnel, liability insurance, and labeling. Rules on security must include standards for lighting, physical security, video security, alarms, measures to prevent loitering, and on-site parking

Other: Marijuana cannot be *used* on someone else's property without the written permission of the property owner or, in the case of leased property, without the permission of the tenant. Marijuana cannot be *smoked* on leased premises if doing so would violate rental policies. Marijuana cannot be *smoked or vaporized* in a public place, including a public bus, any other public vehicle, a public park, a public beach, or a public field.

New Jersey — Gov. Jon Corzine signed S.B. 119 into law in early 2010. Its effective date was delayed by S. 2105, which was also enacted in 2010. The law is codified at N.J. Stat. Ann. **C.24:6I** et seq. Regulations are available at N.J.A.C 8:64.

Qualifying for the Program: To qualify for an ID card, a patient will be required to have a qualifying condition and a physician's certification authorizing the patient to apply to use medical marijuana. The physician must be licensed in New Jersey and must be the patient's primary care or hospice physician, or the physician responsible for treatment for the patient's debilitating medical condition. The qualifying conditions in New Jersey are: amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy, inflammatory bowel disease, terminal illness, conditions resistant to conventional treatments, seizure disorders, intractable skeletal muscular spasticity, glaucoma, HIV/AIDS, cancer, or, conditions accompanied by severe pain, severe nausea, vomiting, or cachexia. The department of health and senior services administers the ID card program and can approve additional qualifying conditions. A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana.

Patient Protections: New Jersey's law provides that patients, caregivers, and others acting in accordance with the law "shall not be subject to any civil or administrative penalty, or denied

any right or privilege, including, but not limited to, civil penalty or disciplinary action by a professional licensing board, related to the medical use of marijuana." It also provides that the medical marijuana authorization is an "exemption from criminal liability" and that it shall also be an affirmative defense.

Possession Limits and Access: New Jersey's law does not allow for home cultivation but it does provide for "alternative treatment centers" that are registered with the state to produce and dispense medical marijuana to qualified patients and their caregivers. The department of health and senior services decides how many centers to authorize. It registered the minimum number, six, in March 2011. The first alternative treatment center opened in December 2012.

At least six of the dispensaries will have to be nonprofit. The department set the fee for applications and has drafted regulations to monitor and oversee the dispensaries and to ensure security and adequate record keeping for dispensing. Every two years, the department will evaluate whether there are enough dispensaries in the state and whether the amount of marijuana allowed is sufficient.

No more than two ounces can be dispensed to a patient in 30 days. Physicians must provide written instructions, which can be for up to a 90-day supply, each time marijuana is dispensed. The dispensing must happen within a month of the written instruction. Physicians also are required to furnish information to the division of consumer affairs about their written instructions.

Primary caregivers can serve a single patient. Caregivers and dispensary employees cannot have a drug conviction unless they demonstrate rehabilitation as is provided for in the act or if the conviction is a federal conviction for medical marijuana.

New Mexico — S.B. 523 was passed by the New Mexico legislature in 2007. Its citation is **N.M. Stat. Ann. § 26-2B-1** et seq. Rules are available at **7.34.2-7.34.4 NMAC**.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition and a statement from a person licensed to prescribe drugs in New Mexico that "the practitioner believes that the potential health benefits of the medical use of cannabis would likely outweigh the health risks for the patient." The qualifying conditions in New Mexico are severe chronic pain, painful peripheral neuropathy, inflammatory autoimmune-mediated arthritis, intractable nausea/vomiting, severe anorexia/cachexia, hepatitis C receiving antiviral treatment, Crohn’s disease, amyotrophic lateral sclerosis, post-traumatic stress disorder, amyotrophic lateral sclerosis, cancer, glaucoma, multiple sclerosis, spinal cord damage with intractable spasticity, epilepsy, and HIV/AIDS. Hospice patients also qualify. "Severe chronic pain" only qualifies if the person's primary care physician and a specialist certify all standard treatments have been tried and failed to provide adequate relief.

The health department administers the ID card program and it approved adding several of the qualifying conditions. A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana. The law required the health department set up an advisory board with medical practitioners to make recommendations on whether to add qualifying conditions and to recommend how much marijuana should be allowed so that patients can possess an adequate supply.

Patient Protections: New Mexico's law provides that qualified patients "shall not be subject to arrest, prosecution, or penalty in any manner for the possession of or the medical use of cannabis if the quantity of cannabis does not exceed an adequate supply."

Possession Limits and Access: Patients may possess up to six ounces of marijuana, and

caregivers can possess this amount for each patient who has designated the caregiver. Patients may also request permission to possess a larger supply. Though the law itself was silent on home cultivation, by rule, the state health department has allowed patients to apply for a separate personal cultivation license. If granted, they can cultivate up to four mature plants and 12 seedlings. Caregivers cannot produce for patients and patients can only produce marijuana for themselves.

The law granted the health department broad discretion to develop rules to regulate licensed nonprofit producers of medical marijuana. The health department developed rules and, as of August 2013, 23 producers are licensed. It determines the number of producers based on factors that include supply of marijuana to patients statewide and the safety of the public. The department conducts an on-site visit. They also consider the applicants' plans for purity and consistency of dose as well as testing, their skills and knowledge, and the board members' experience.

To be producers, applicants must submit a great deal of information, including a $1,000 fee, security plans, the names of persons with authority over the facility's policies, and a description of packaging that will be used. Each producer's board members must include at least one physician and at least three registered patients. Producers may produce 150 total plants and seedlings and supply marijuana to their patients. Producers cannot be located within 300 feet of schools, churches, or daycare centers. Once a patient registers, the health department provides patients with information on how to contact licensed producers. Annual registration fees range from $5,000 to $30,000 for producers and vary based on how long the producers have been operational.

Oregon — Measure 67, a ballot initiative, passed with 55% of the vote in 1998, and was modified throughout the years. It is codified at **Or. Rev. Stat. § 475.300** and rules are available at **OAR 333-008-0000**. In 2013, the state legislature approved and Gov. John Kitzhaber signed HB 3640, which allows regulated dispensaries.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition and a statement from a physician who has primary responsibility for treating the patient that marijuana may mitigate their symptoms. A minor patient only qualifies with the consent of his or her parent or guardian and if the adult controls the dosage, acquisition, and frequency of use of the marijuana. The qualifying conditions in Oregon are cancer, HIV/AIDS, glaucoma, agitation related to Alzheimer's disease, and conditions causing one or more of the following: cachexia, severe pain, severe nausea, seizures, or persistent muscle spasms, including those that are characteristic of multiple sclerosis. The health department can approve additional medical conditions.

Patient Protections: Registered patients and caregivers are exempted from the state's criminal laws for acting in accordance with the medical marijuana law. Patients may also assert an affirmative defense if they have a qualifying condition and a physician has recommended medical marijuana even with if they do not have a registry identification card. In April 2010, the Oregon Supreme Court ruled in *Emerald Steel v. BOLI* that patients are not protected from being penalized by their employers.

Possession Limits and Access: Patients can have one designated caregiver, who must have "significant responsibility for managing the well-being" of the patient. Patients can reimburse caregivers for the actual cost of supplies and utilities, but not for their labor. Oregon's law allows a patient with a registry identification card or a primary caregiver to possess 24 ounces of processed marijuana and cultivate six mature plants and 18 immature plants for each patient the caregiver cultivates for. Each grow site must be registered with the health department. The law includes an advisory committee made of patients and advocates to advise the department.

In August 2013, Gov. Kitzhaber signed a bill into law to create medical marijuana facilities that will be allowed to transfer usable marijuana and immature marijuana plants to patients and their designated primary caregivers. The facilities will not grow marijuana; they will obtain it from patients, caregivers, or people responsible for grow sites. The legislation becomes operative on March 1, 2014. Until then, medical marijuana facilities that are currently operating will be exempted from certain criminal laws so long as they are operating in accordance with the law.

Medical marijuana facilities cannot be located within 1,000 feet of elementary or secondary schools and cannot be located within 1,000 feet of another facility. The Oregon Health Authority will adopt rules related to security, which must require a security system, video surveillance, an alarm system, and a safe. It will also set fees and adopt rules for testing.

Rhode Island — S. 710 was passed by the Rhode Island legislature in 2006 and amended by S. 791 in 2007, H. 5359 in 2009, S 2834 in 2010, and H 7888 in 2012. It is codified at R.I. Gen. Laws **Chapter 21-28.6**. Regulations are at **R21-28.6-MMP(5923)**.

Qualifying for the Program: To qualify for an ID card, a patient must have a qualifying condition and a statement from a prescriber who is licensed in Rhode Island or a physician licensed in Massachusetts or Connecticut that the patient has a bona fide relationship with that physician and that the "potential benefits of the medical use of marijuana would likely outweigh the health risks" for the patient. A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana. The qualifying conditions in Rhode Island are cancer, HIV/AIDS, hepatitis C, glaucoma, agitation related to Alzheimer's disease, and conditions causing one or more of the following: severe, debilitating pain, cachexia or wasting syndrome, severe nausea, seizures, or persistent muscle spasms. The health department administers the ID card program and may approve additional qualifying conditions.

Patient Protections: Rhode Island's law provides that cardholders abiding by the act "shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a business or occupational or professional licensing board or bureau, for the medical use of marijuana." It also explicitly prevents landlords, employers, and schools from discriminating based on a person's status as a caregiver or patient. The law also provides that medical marijuana shall be considered a treatment, not an illicit substance, for the purposes of medical care, such as qualification for an organ transplant. Rhode Island honors visiting patients' out-of-state registry identification cards. The law has an affirmative defense for patients with doctors' recommendations and permissible amounts of marijuana.

Possession Limits and Access: Each patient can possess up to 2.5 ounces of marijuana and can cultivate up to 12 plants and 12 seedlings in an enclosed, locked area. Patients can also designate up to two caregivers or compassion centers to cultivate for them. A caregiver can assist no more than five patients. Caregivers can possess 2.5 ounces per patient they assist and 12 plants per patient, but their total cap is 24 plants and 5 ounces. Caregivers can receive reimbursement for their costs associated with assisting a patient.

Rhode Island's law provides for up to three state-regulated not-for-profit compassion centers, and the state approved three centers in March 2011 based on a competitive application scoring process. However, Gov. Lincoln Chafee placed the compassion center program on hold after U.S. attorneys in Rhode Island and other states said large-scale, commercial growers could be prosecuted. In May 2012, Gov. Chafee and the legislature approved compromise legislation to restart the program. The legislation capped the amount of plants a compassion center can grow

at 150, with 99 mature, and the amount of usable marijuana at 1,500 ounces. In addition, the amount of marijuana can't exceed 2.5 ounces per patient. Caregivers and patients can sell compassion centers their overages under the revised law. The first two compassion centers opened in Spring 2013.

The state health department charges $5,000 annually for each registration and $250 for applications. Each compassion center employee must register with the health department. In 2010, the department developed rules for compassion centers' oversight, record keeping, and security. Compassion centers may cultivate either at the retail site or a second cultivation location that must be registered with the department. Dispensaries can dispense no more than 2.5 ounces of marijuana to a patient every 15 days.

Vermont — S. 76 was passed by the Vermont legislature in 2004. The law was expanded by S. 7 in 2007 and S. 17 in 2011. The law's citation is **Vt. Stat. Ann. tit. 18 § 4472** et seq.

Qualifying for the Program: Vermont is one of two states where the department issuing ID cards is the department of public safety. (The other state, Hawaii, will move its program to the health department by 2015.) To qualify for an ID card, a patient must have a statement from a Vermont, Massachusetts, New York, or New Hampshire-licensed physician, advance practice nurse, or physician's assistant who has treated the patient for at least six months that the patient has had a qualifying medical condition. The qualifying conditions are cancer, multiple sclerosis, or HIV/AIDS if the disease results in severe and intractable symptoms, or a chronic, debilitating condition causing one or more of the following, which can not have responded to reasonable medical efforts over a reasonable period of time: severe pain, cachexia, severe nausea, or seizures. Patients must also be Vermont residents. A minor patient only qualifies if his or her parent or guardian also signs the application.

Protections, Access, and Possession Limits: Vermont's law allows a patient to choose to cultivate up to two mature and seven immature plants or to designate either a caregiver or a dispensary to cultivate for the patient. A patient with a registry identification card and his or her caregiver may collectively possess two ounces of processed marijuana. Cultivation must occur in a locked, indoor location. Caregivers must be 21 and have no drug-related convictions. They can only assist one patient.

Pursuant to a law enacted on June 2, 2011, the department of public safety was directed to approve four nonprofit dispensaries. In the first round of applications, only two applicants met the standards, and they both opened in late Spring 2013. One more dispensary was approved, but has not yet opened. Under the law, dispensaries are chosen based on a competitive process, including factors like convenience to patients, the applicants' experience, and their ability to provide for patients. Each dispensary employee must register with the state, and they generally cannot have drug convictions or convictions for violent felonies. Dispensaries must be at least 1,000 feet from schools. Municipalities can regulate their locations and operations and may also ban them within the locality. The state's department of public safety developed rules for dispensaries' oversight, record keeping, and security. Fees will include a $2,500 application fee, a $20,000 registry fee for the first year, and a $30,000 annual fee in subsequent years.

A patient must designate the dispensary he or she wishes to utilize, though the patient can change the designation. Dispensaries cannot deliver unless the legislature affirmatively allows them to in the future, and they can only dispense by appointment. Dispensaries must cultivate their own marijuana, either at the retail site or a second enclosed, locked cultivation location that must be registered with the department. Dispensaries can dispense no more than two ounces of marijuana every 30 days to a given patient. The law also included a survey of patients and an oversight committee that will assess the effectiveness of the compassion centers and security measures.

Vermont's law does not include any protections for unregistered patients or out-of-state patients.

Washington — Measure 692, a ballot initiative, passed with 59% of the vote in 1998. It was modified by SB 6032 in 2007, SB 5798 in 2010, and SB 5073 in 2011. It is codified at **Wash. Rev. Code § 69.51A.010** et seq. An administrative rule is available at **WAC 246-75-010**.

Qualifying under the Law: Washington is the only medical marijuana state without a registry identification card program (not counting Maryland's partial law). In 2011, Gov. Christine Gregoire vetoed the sections of a bill, SB 5073, that included a patient and caregiver registry and dispensary regulation and licensing. To qualify for protection under Washington's law, a patient must have a signed statement on tamper-resistant paper from a Washington-licensed physician, physician assistant, naturopath, or advanced registered nurse practitioner who advised the patient of marijuana's risks and benefits and advised the patient that he or she "may benefit from the medical use of marijuana." Qualifying conditions include cancer, HIV, multiple sclerosis, epilepsy, seizure and spasm disorders, intractable pain, glaucoma, Crohn's disease, hepatitis C, and diseases causing nausea, vomiting, or appetite loss. Some of those conditions only qualify if they have been unrelieved by standard medical treatments. The health department's Medical Quality Assurance Commission may also add additional conditions and has done so. In Washington, the possession, acquisition, and cultivation of marijuana by a minor patient is the parent or legal guardian's responsibility.

Patient Protections: Washington's medical marijuana law does not provide protection from arrest. Instead, it provides an affirmative defense that patients and caregivers may raise in court.

In June 2011, the state Supreme Court ruled against a person who was fired for being a medical marijuana patient in *Roe v. Teletech Customer Care Management*. The law that passed in 2011, SB 5073, provides that an employer does not have to accommodate medical marijuana if it establishes a drug-free workplace and that it also does not require employers to allow the on-site medical use of marijuana. Medical marijuana cannot be the "sole disqualifying factor" for an organ transplant unless it could cause rejection or organ failure. Washington's law also restricts when parental rights and residential time can be limited due to the medical use of marijuana.

Access, and Possession Limits: Washington's law allows a patient with valid documentation and his or her designated provider to collectively possess 24 ounces of processed marijuana and 15 plants. A patient also has the ability to argue in court that more marijuana is needed. Up to 10 patients may form a collective garden, which may contain no more than 72 ounces and 45 plants. A person may only serve as a designated provider to one patient at a time and must wait 15 days between serving two different patients. Providers must be 18 or older and must be designated by a patient in writing.

SB 5073 provides that localities may regulate dispensaries, but due to the sectional veto by Gov. Gregoire, Washington law fails to provide any clear legal protections for them. However, in November 2012, voters approved I-502, allowing the regulated sales of marijuana to all adults 21 and older — including for recreational use. Under the initiative, all adults 21 and older may possess up to an ounce of marijuana.

Washington, District of Columbia — On November 3, 1998, 69% of D.C. voters approved Initiative 59. Congress blocked the implementation of the law until December 2009. The D.C. Council then put the law on hold temporarily and enacted amendments to it, B18-622. The revised law went into effect in late July 2010, and regulations were issued on April 15, 2011. A few modifications were made in 2011. The law is codified at District of Columbia Official Code

§ 7-1671.13 et seq.

Qualifying for the Program: To qualify for an ID card, a patient will have to have a qualifying condition and physician's recommendation that medical marijuana is necessary for the patient's treatment. The physician must be licensed in D.C., have a bona fide relationship with the patient, and have responsibility for ongoing treatment of the patient. The physician must review other approved treatments before making the recommendations. The board of medicine may audit physician recommendations and must audit recommendations for any physician who provides more than 250 recommendations in a 12-month period. A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana.

The qualifying conditions in D.C. are cancer, HIV/AIDS, glaucoma, and conditions with severe and persistent muscle spasms, such as multiple sclerosis. In addition, conditions treated with chemotherapy, azidothymidine or protease inhibitors, and radiotherapy qualify. The health department administers the ID card program and can approve additional qualifying conditions for which marijuana would be beneficial if the conditions are chronic or long lasting, debilitating, and either cannot be treated by ordinary measures or marijuana would be significantly less addictive than the ordinary treatment. It can also approve medical marijuana for treatments whose side effects require medical marijuana treatment. A minor patient only qualifies with parental consent and if the adult controls the dosage, frequency of use, and acquisition of marijuana.

Patient Protections: Registered qualifying patients may possess and administer medical marijuana, and caregivers can do so for the purpose of assisting a patient. The marijuana and paraphernalia must be obtained from a registered dispensary. Medical marijuana can only be administered in a patient's residence or a medical facility that permits its administration. Marijuana cannot be used where its exposure would negatively affect a minor. Marijuana can only be transported in a container or sealed package that has a label received from a dispensary.

The ordinance also provides an affirmative defense for an adult who assists a patient in administering medical marijuana in their home or a permitted medical facility where the caregiver was not reasonably available to assist.

Possession Limits and Access: A patient or caregiver can possess no more than two ounces in a 30-day period, which must be obtained from a dispensary. However, the mayor may increase the amount to up to four ounces. The law provides for regulated cultivation facilities and dispensaries. The facilities and their staff are required to register with the mayor. Cultivation facilities will be allowed to produce up to 95 marijuana plants and to sell them to dispensaries. The ordinance allows for between five and eight dispensaries. The mayor set the number of dispensaries at five and cultivation centers at 10.

On March 30, 2012, the District granted preliminary licenses to six cultivation centers, after having developed standards for deciding who would be licensed. When selecting centers, it was required to consider the security plan, staffing plan, product safety and labeling plan, the suitability of the proposed facility, and input from neighborhood commissions. On April 12 2012, the District announced that four dispensaries had met minimum requirements to move forward to the next stage. The first dispensary began serving patients in July 2013.

No employee with access to marijuana at a cultivation facility or dispensary can have a misdemeanor for a drug-related offense or any felony conviction. Dispensaries and cultivation centers cannot locate in residential districts or within 300 feet of schools or recreation centers. The ordinance requires records to be kept on each transaction, the quantity of medical marijuana stored, and how marijuana is disposed of. Police must be notified immediately of

loss, theft, or destruction. Dispensaries may not operate between 9:00 p.m. and 7:00 a.m. Rules also include requirements for signage, labeling, and security — which includes security cameras. Rules include provisions to revoke or suspend a license if the law is violated and for inspections. The dispensary selection criteria include the location's convenience, the suitability of the building, the staffing plan and knowledge, the security plan, the product safety and labeling plan.

D.C.'s law also establishes an advisory committee to monitor other states' best practices, scientific research, and the effectiveness of D.C.'s medical marijuana program. It also provides for the committee to make recommendations to the Council, including whether home cultivation should be allowed and, if so, how to implement it.

Other: The D.C. rules specify that the department will make an educational program on medical marijuana and side effects for physicians and medical institutions. They also provide to allow people or entities to apply to be a "medical marijuana certification provider," which would conduct education and training, including on medical marijuana's effects, procedures for handling and dispensing, the medical marijuana law, advertising, and security.

Information on States with Medical Marijuana Laws

A review of medical marijuana program finances for selected states, prepared by the Marijuana Policy Project (MPP). The full report that was issued in 2011 is available at: http://www.mpp.org/assets/pdfs/library/State-by-State-Laws-Report-2011.pdf

Appendix U: State Medical Marijuana Program Finances

With many states around the country facing serious budget shortfalls, one concern frequently raised when debating the need for medical marijuana laws is the cost to state governments of implementing and administering such laws. However, data collected from states with functioning medical marijuana programs show that such concerns are unfounded. Most states require the administering agency to set fees for registry ID cards and dispensary registrations high enough to offset administration costs, and in states where patients can obtain marijuana from dispensaries, transactions are often subject to sales or excise taxes. Consequently, no state medical marijuana program is currently facing significant budget deficits. In fact, most are operating at a surplus, with some generating millions in badly needed revenue.

As of late 2011, eight states – Arizona, Colorado, Delaware, Maine, New Jersey, New Mexico, Rhode Island, and Vermont – and the District of Columbia have laws that recognize dispensaries or other entities where patients can purchase medical marijuana. Of these, only Colorado, Maine, and New Mexico have fully-implemented systems with open dispensaries. A fourth state, California, does not have a statewide regulatory structure but does have several dispensaries licensed at the local level.

Of these, only California, Colorado, and New Mexico have readily available information on revenue generated through taxes. In California, the non-partisan state Board of Equalization estimates that dispensaries generate $58-$105 million in annual sales tax revenue.[1] In Colorado, for the fiscal year ending in June 2010, medical marijuana sales taxes brought in $2.2 million to state coffers,[2] and between Boulder, Colorado Springs, Denver, and Fort Collins, an estimated $3.84 million in local sales taxes has already been collected in 2011.[3] In New Mexico, sales by non-profit producers in the second quarter of 2011 (April – June) totaled $744,079, generating $55,938 in gross receipts tax revenue for state and local governments.[4] This projects to over $223,000 per year in gross receipts tax revenue.

These states also bring in added revenue by assessing dispensaries application and registration fees. Dispensaries are licensed at the local level in both Colorado and California. In California, Oakland, which has licensed four medical marijuana dispensaries, provides a typical example. The fee structure is graduating depending on how many patients the dispensaries serve and ranges from $5,000 (for under 500 patients) to $20,000 (for over 1,500 patients).[5] In Colorado, the Department of Revenue collected at least $8.9 million in fees from July 2010 through March 2011 from medical cannabis businesses.[6] The state application fees for medical marijuana centers are $7,500 for 300 or fewer patients, $12,500 for 301

[1] "Berkeley cannabis collectives slapped with huge tax bills," *Berkeleyside*, February 3, 2011. <http://www.berkeleyside.com/2011/02/03/berkeley-cannabis-collectives-slapped-with-huge-tax-bills>

[2] "City reaps $209k in medical marijuana tax," Coloradan.com, Nov. 6, 2010. <http://www.coloradoan.com/article/20101106/NEWS01/11060341/1002/CUSTOMERSERVICE02>

[3] "State Medical Marijuana Programs' Financial Information, Marijuana Policy Project, available at http://www.mpp.org/issues/medical-marijuana/.

[4] Email communications with Dominick Zurlo, September 28, 2011.

[5] "Oakland approves plan to license medical marijuana farms," *Oakland Tribune*, July 21, 2010. <http://www.mercurynews.com/alameda-county/ci_15566683?nclick_check=1>

[6] "Oversight Office for Medical Pot is Well Off," *Denver Post*, March 18, 2011. < http://www.denverpost.com/news/marijuana/ci_17640484>

to 500 patients, and $18,000 for those serving 501 or more patients. A cultivation license is $1,250, and an infused products manufacturer license is $1,250.[7] New Mexico has a similar graduated fee schedule, though the variance is based on how long the non-profit producer has operated. The fee is $5,000 for those who have been licensed less than a year, $10,000 for those licensed for more than one year, $20,000 for more than two years, and $30,000 for more than three years. In Maine, the Department of Human Services' Licensing and Regulatory Services requires all dispensary applicants to pay a $15,000 application fee, $14,000 of which is refunded if they are not awarded a registration,[8] and the annual renewal fee is $15,000.

Other states that are in the process of implementing dispensary systems will also charge registration fees to dispensaries and similar entities. Application fees range from $20,000 in New Jersey ($2,000 of which is non-refundable) to a $2,500 non-refundable fee in Vermont. Registrations are similar to those in Colorado and New Mexico. For example, the District of Columbia will charge dispensaries $10,000 annually for a registration, and cultivation centers would pay $5,000 annually, while Vermont will charge $20,000 for the first year and $30,000 for subsequent years.

These states also collect revenue through fees for registry ID cards for patients, caregivers, and dispensary employees. Fees are generally around $100 for cards, with some states – including Michigan, Oregon, Maine, and the District of Columbia – reducing the fee for low-income patients. Through the first half of fiscal year 2011 (October-March 2011), these fees have already generated $4,860,783 in revenue in Michigan, while the program required only $687,634 to operate during the same time frame.[9]

Expenses are generally minimal. Programs have reported expenses for database-related software, for machines to make registry cards, and for staffing. Some programs — especially ones with a few thousand patients or fewer — have been able to use software included with Microsoft Office for their databases, and at least one program shares the card-making machines with other health department programs. New Mexico's program purchased a machine to make holographic cards, which cost about $6,000-$8,000.

Most states employ only a handful of staffers. For example, New Mexico has two full-time employees and one manager who also oversees three other programs, while Alaska and Vermont's programs each require less than one full-time employee's time. Oregon and Michigan's programs, which are each operating in the black, employ 25 employees each. Some programs do not even need dedicated staffers. In Rhode Island, for example, staffers are not designated for the medical marijuana program, and instead work on all 35 licensure programs the health department oversees.

For more information on state medical marijuana programs' financial impact, download our full report at **http://www.mpp.org/reports/state-medical-marijuana.html**.

7 <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251643794376&ssbinary=true>

8 <http://www.maine.gov/dhhs/dlrs/rulemaking/adopted.shtml>

9 Report on the Amount Collected and Cost of Administering the Medical Marihuana Program, April 1, 2011. Submitted by Michigan Department of Community Health to Michigan House and Senate Appropriations Committees.

Tab 4

Congressional Research Service Report

Congressional Research Service Report

A review of federal and state policies related to medical marijuana for states with medical marijuana laws, released April 2, 2010.

Medical Marijuana: Review and Analysis of Federal and State Policies

Mark Eddy
Specialist in Social Policy

April 2, 2010

Congressional Research Service
7-5700
www.crs.gov
RL33211

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

The issue before Congress is whether to continue the federal prosecution of medical marijuana patients and their providers, in accordance with the federal Controlled Substances Act (CSA), or whether to relax federal marijuana prohibition enough to permit the medicinal use of botanical cannabis products when recommended by a physician, especially where permitted under state law.

Fourteen states, mostly in the West, have enacted laws allowing the use of marijuana for medical purposes, and many thousands of patients are seeking relief from a variety of serious illnesses by smoking marijuana or using other herbal cannabis preparations.

Two bills relating to the therapeutic use of cannabis have been introduced in the 111th Congress. The Medical Marijuana Patient Protection Act (H.R. 2835), which would allow the medical use of marijuana in states that permit its use with a doctor's recommendation, was introduced on June 11, 2009, by Representative Barney Frank. The bill would move marijuana from Schedule I to Schedule II of the CSA and exempt from federal prosecution authorized patients and medical marijuana providers who are acting in accordance with state laws. Also, the Truth in Trials Act (H.R. 3939), a bill that would make it possible for defendants in federal court to reveal to juries that their marijuana activity was medically related and legal under state law, was introduced on October 27, 2009, by Representative Sam Farr.

For the first time since District of Columbia residents approved a medical marijuana ballot initiative in 1998, a rider blocking implementation of the initiative was not attached to the D.C. appropriations act for FY2010 (P.L. 111-117), clearing the way for the creation of a medical marijuana program for seriously ill patients in the nation's capital.

The Obama Administration Department of Justice, in October 2009, announced an end to federal raids by the Drug Enforcement Administration of medical marijuana dispensaries that are operating in "clear and unambiguous compliance with existing state laws." This move fulfills a pledge to end such raids that was made by candidate Obama during the presidential campaign.

Claims and counterclaims about medical marijuana—much debated by journalists and academics, policymakers at all levels of government, and interested citizens—include the following: Marijuana is harmful and has no medical value; marijuana effectively treats the symptoms of certain diseases; smoking is an improper route of drug administration; marijuana should be rescheduled to permit medical use; state medical marijuana laws send the wrong message and lead to increased illicit drug use; the medical marijuana movement undermines the war on drugs; patients should not be arrested for using medical marijuana; the federal government should allow the states to experiment and should not interfere with state medical marijuana programs; medical marijuana laws harm the federal drug approval process; the medical cannabis movement is a cynical ploy to legalize marijuana and other drugs. With strong opinions being expressed on all sides of this complex issue, the debate over medical marijuana does not appear to be approaching resolution.

This report will be updated as legislative activity and other developments occur.

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Introduction: The Issue Before Congress

The issue before Congress is whether to continue the federal prosecution of medical marijuana[1] patients and their providers, in accordance with marijuana's status as a Schedule I drug under the Controlled Substances Act, or whether to relax federal marijuana prohibition enough to permit the medicinal use of botanical cannabis[2] products when recommended by a physician, especially in those states that have created medical marijuana programs under state law.

Two bills, versions of which have been introduced in prior Congresses, have been proposed again in the 111th Congress. The Medical Marijuana Patient Protection Act (H.R. 2835), which would allow the medical use of marijuana in states that permit its use with a doctor's recommendation, was introduced on June 11, 2009, by Representative Barney Frank. The bill would also move marijuana from Schedule I to Schedule II of the CSA and exempt from federal prosecution authorized patients and medical marijuana providers who are acting in accordance with state laws. The second bill, the Truth in Trials Act (H.R. 3939), introduced by Representative Sam Farr on October 27, 2009, would make it possible for medical marijuana users and providers who are being tried in federal court to reveal to juries that their marijuana activity was medically related and legal under state law.

Background: Medical Marijuana Prior to 1937

The Cannabis sativa plant has been used for healing purposes throughout history. According to written records from China and India, the use of marijuana to treat a wide range of ailments goes back more than 2,000 years. Ancient texts from Africa, the Middle East, classical Greece, and the Roman Empire also describe the use of cannabis to treat disease.

For most of American history, growing and using marijuana was legal under both federal law and the laws of the individual states. By the 1840s, marijuana's therapeutic potential began to be recognized by some U.S. physicians. From 1850 to 1941 cannabis was included in the *United States Pharmacopoeia* as a recognized medicinal.[3] By the end of 1936, however, all 48 states had enacted laws to regulate marijuana.[4] Its decline in medicine was hastened by the development of aspirin, morphine, and then other opium-derived drugs, all of which helped to replace marijuana in the treatment of pain and other medical conditions in Western medicine.[5]

[1] The terms *medical marijuana* and *medical cannabis* are used interchangeably in this report to refer to marijuana (scientific name: Cannabis sativa) and to marijuana use that qualifies for a medical use exception under the laws of certain states and under the federal Investigational New Drug Compassionate Access Program.

[2] The terms *botanical cannabis*, *herbal cannabis*, *botanical marijuana*, and *crude marijuana*, used interchangeably in this report, signify the whole or parts of the natural marijuana plant and therapeutic products derived therefrom, as opposed to drugs produced synthetically in the laboratory that replicate molecules found in the marijuana plant.

[3] Gregg A. Bliz, "The Medical Use of Marijuana: The Politics of Medicine," *Hamline Journal of Public Law and Policy*, vol. 13, spring 1992, p. 118.

[4] Oakley Ray and Charles Ksir, *Drugs, Society, and Human Behavior*, 10th ed. (New York: McGraw-Hill, 2004), p. 456.

[5] Bill Zimmerman, *Is Marijuana the Right Medicine for You? A Factual Guide to Medical Uses of Marijuana* (New Canaan, CT: Keats Publishing, 1998), p. 19.

Federal Medical Marijuana Policy

All three branches of the federal government play an important role in formulating federal policy on medical marijuana. Significant actions of each branch are highlighted here, beginning with the legislative branch.

Congressional Actions

The Marihuana Tax Act of 1937[6]

Spurred by spectacular accounts of marijuana's harmful effects on its users, by the drug's alleged connection to violent crime, and by a perception that state and local efforts to bring use of the drug under control were not working, Congress enacted the Marihuana Tax Act of 1937.[7] Promoted by Harry Anslinger, Commissioner of the recently established Federal Bureau of Narcotics, the act imposed registration and reporting requirements and a tax on the growers, sellers, and buyers of marijuana. Although the act did not prohibit marijuana outright, its effect was the same. (Because marijuana was not included in the Harrison Narcotics Act in 1914,[8] the Marihuana Tax Act was the federal government's first attempt to regulate marijuana.)

Dr. William C. Woodward, legislative counsel of the American Medical Association (AMA), opposed the measure. In oral testimony before the House Ways and Means Committee, he stated that "there are evidently potentialities in the drug that should not be shut off by adverse legislation. The medical profession and pharmacologists should be left to develop the use of this drug as they see fit."[9] Two months later, in a letter to the Senate Finance Committee, he again argued against the act:

> There is no evidence, however, that the medicinal use of these drugs ["cannabis and its preparations and derivatives"] has caused or is causing cannabis addiction. As remedial agents they are used to an inconsiderable extent, and the obvious purpose and effect of this bill is to impose so many restrictions on their medicinal use as to prevent such use altogether. Since the medicinal use of cannabis has not caused and is not causing addiction, the prevention of the use of the drug for medicinal purposes can accomplish no good end whatsoever. How far it may serve to deprive the public of the benefits of a drug that on further research may prove to be of substantial value, it is impossible to foresee.[10]

Despite the AMA's opposition, the Marihuana Tax Act was approved, causing all medicinal products containing marijuana to be withdrawn from the market and leading to marijuana's

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[6] In Spanish, the letter "j" carries the sound of "h" in English. This alternative spelling of marijuana (with an "h") was formerly used by the federal government and is still used by some writers today.

[7] P.L. 75-238, 50 Stat. 551, August 2, 1937. In *Leary* v. *United States* (395 U.S. 6 (1968)), the Supreme Court ruled the Marihuana Tax Act unconstitutional because it compelled self-incrimination, in violation of the Fifth Amendment.

[8] P.L. 63-223, December 17, 1914, 38 Stat. 785. This law was passed to implement the Hague Convention of 1912 and created a federal tax on opium and coca leaves and their derivatives.

[9] U.S. Congress, House Committee on Ways and Means, *Taxation of Marihuana*, hearings on H.R. 6385, 75th Cong., 1st sess., May 4, 1937 (Washington: GPO, 1937), p. 114.

[10] U.S. Congress, Senate Committee on Finance, Taxation of Marihuana, hearing on H.R. 6906, 75th Cong., 1st sess., July 12, 1937 (Washington: GPO, 1937), p. 33.

removal, in 1941, from *The National Formulary* and the *United States Pharmacopoeia*, in which it had been listed for almost a century.

Controlled Substances Act (1970)

With increasing use of marijuana and other street drugs during the 1960s, notably by college and high school students, federal drug-control laws came under scrutiny. In July 1969, President Nixon asked Congress to enact legislation to combat rising levels of drug use.[11] Hearings were held, different proposals were considered, and House and Senate conferees filed a conference report in October 1970.[12] The report was quickly adopted by voice vote in both chambers and was signed into law as the Comprehensive Drug Abuse Prevention and Control Act of 1970 (P.L. 91-513).

Included in the new law was the Controlled Substances Act (CSA),[13] which placed marijuana and its derivatives in Schedule I, the most restrictive of five categories. Schedule I substances have "a high potential for abuse," "no currently accepted medical use in treatment in the United States," and "a lack of accepted safety [standards] for use of the drug ... under medical supervision."[14] Other drugs used recreationally at the time also became Schedule I substances. These included heroin, LSD, mescaline, peyote, and psilocybin. Drugs of abuse with recognized medical uses—such as opium, cocaine, and amphetamine—were assigned to Schedules II through V, depending on their potential for abuse.[15] Despite its placement in Schedule I, marijuana use increased, as did the number of health-care professionals and their patients who believed in the plant's therapeutic value.

The CSA does not distinguish between the medical and recreational use of marijuana. Under federal statute, simple possession of marijuana for personal use, a misdemeanor, can bring up to one year in federal prison and up to a $100,000 fine for a first offense.[16] Growing marijuana is considered *manufacturing* a controlled substance, a felony.[17] A single plant can bring an individual up to five years in federal prison and up to a $250,000 fine for a first offense.[18]

The CSA is not preempted by state medical marijuana laws, under the federal system of government, nor are state medical marijuana laws preempted by the CSA. States can statutorily create a medical use exception for botanical cannabis and its derivatives under their own, state-level controlled substance laws. At the same time, federal agents can investigate, arrest, and prosecute medical marijuana patients, caregivers, and providers in accordance with the federal

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[11] U.S. President, 1969-1974 (Nixon), "Special Message to the Congress on Control of Narcotics and Dangerous Drugs," July 14, 1969, *Public Papers of the Presidents of the United States 1969* (Washington: GPO, 1971), pp. 513-518.

[12] U.S. Congress, Conference Committees, *Comprehensive Drug Abuse Prevention and Control Act of 1970*, conference report to accompany H.R. 18583, 91st Cong., 2nd sess., H.Rept. 91-1603 (Washington: GPO, 1970).

[13] Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, P.L. 91-513, October 27, 1970, 84 Stat. 1242, 21 U.S.C. §801, *et seq*.

[14] Ibid., Sec. 202(b)(1), 84 Stat. 1247, 21 U.S.C. §812(b)(1).

[15] Ibid., Sec. 202(c), 84 Stat. 1248.

[16] Ibid., Sec. 404 (21 U.S.C. §844) and 18 U.S.C. §3571. Sec. 404 also calls for a minimum fine of $1,000, and Sec. 405 (21 U.S.C. §844a) permits a civil penalty of up to $10,000.

[17] Sec. 102(15), (22) of the CSA (21 U.S.C. §802(15), (22)).

[18] Sec. 401(b)(1)(D) of the CSA (21 U.S.C. §841(b)(1)(D)).

Controlled Substances Act, even in those states where medical marijuana programs operate in accordance with state law.

Anti-Medical Marijuana Legislation in the 105th Congress (1998)

In September 1998, the House debated and passed a resolution (H.J.Res. 117) declaring that Congress supports the existing federal drug approval process for determining whether any drug, including marijuana, is safe and effective and opposes efforts to circumvent this process by legalizing marijuana, or any other Schedule I drug, for medicinal use without valid scientific evidence and without approval of the Food and Drug Administration (FDA). With the Senate not acting on the resolution and adjournment approaching, this language was incorporated into the FY1999 omnibus appropriations act under the heading "Not Legalizing Marijuana for Medicinal Use."[19]

In a separate amendment to the same act, Congress prevented the District of Columbia government from counting ballots of a 1998 voter-approved initiative that would have allowed the medical use of marijuana by persons suffering from serious diseases, including cancer and HIV infection.[20] The amendment was challenged and overturned in District Court, the ballots were counted, and the measure passed 69% to 31%. Nevertheless, despite further court challenges, Congress continued to prohibit implementation of the initiative until the rider known as the Barr Amendment[21] was dropped from the FY2010 D.C. appropriations act (H.R. 3288) in the 111th Congress.

The Hinchey-Rohrabacher Amendment (2003-2007) [22]

In the first session of the 108th Congress, in response to federal Drug Enforcement Administration (DEA) raids on medical cannabis users and providers in California and other states that had approved the medical use of marijuana if recommended by a physician, Representatives Hinchey and Rohrabacher offered a bipartisan amendment to the FY2004 Commerce, Justice, State appropriations bill (H.R. 2799). The amendment would have prevented the Justice Department from using appropriated funds to interfere with the implementation of medical cannabis laws in the nine states that had approved such use. The amendment was debated on the floor of the House

[19] Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999, P.L. 105-277, October 21, 1998, 112 Stat. 2681-760.

[20] Ibid., District of Columbia Appropriations Act, 1999, Sec. 171, 112 Stat. 2681-150.

[21] "The Legalization of Marijuana for Medical Treatment Initiative of 1998, also known as Initiative 59, approved by the electors of the District of Columbia on November 3, 1998, shall not take effect." (District of Columbia Appropriations Act, 2006 (Division B of P.L. 109-115, Sec. 128 (b); 119 Stat. 2521.) This recurring provision of D.C. appropriations acts is known as the Barr Amendment because it was originally offered by Rep. Bob Barr. Since leaving Congress in 2003, Barr changed his position and worked for a period of time in support of medical marijuana as a lobbyist for the Marijuana Policy Project. See his website http://www.bobbarr.org.

[22] When last considered in July 2007, the amendment stated: "None of the funds made available in this Act to the Department of Justice may be used, with respect to the States of Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington, to prevent such States from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana." The wording of previous versions of the amendment was similar.

on July 22, 2003. When brought to a vote on the following day, it was defeated 152 to 273 (61 votes short of passage).[23]

The amendment was offered again in the second session of the 108th Congress. It was debated on the House floor on July 7, 2004, during consideration of H.R. 4754, the Commerce, Justice, State appropriations bill for FY2005. This time it would have applied to 10 states, with the recent addition of Vermont to the list of states that had approved the use of medical cannabis. It was again defeated by a similar margin, 148 to 268 (61 votes short of passage).[24]

The amendment was voted on again in the first session of the 109th Congress and was again defeated, 161-264 (52 votes short of passage), on June 15, 2005. During floor debate on H.R. 2862, the FY2006 Science, State, Justice, Commerce appropriations bill, a Member stated in support of the amendment that her now-deceased mother had used marijuana to treat her glaucoma. Opponents of the amendment argued, among other things, that its passage would undermine efforts to convince young people that marijuana is a dangerous drug.[25]

Despite an extensive pre-vote lobbying effort by supporters, the amendment gained only two votes in its favor over the previous year when it was debated and defeated, 163 to 259 (49 votes short of passage), on June 28, 2006.[26] The bill under consideration this time was H.R. 5672, the FY2007 Science, State, Justice, Commerce appropriations bill.

In the first session of the 110th Congress, on July 25, 2007, the amendment was proposed to H.R. 3093, the Commerce, Justice, Science appropriations bill for FY2008. It was debated on the House floor for the fifth time in as many years and was again rejected, 165 to 262 (49 votes short of passage). The amendment's supporters framed it as a states' rights issue:

> A vote "yes" on Hinchey-Rohrabacher is a vote to respect the intent of our Founding Fathers and respect the rights of our people at the State level to make the criminal law under which they and their families will live. It reinforces rules surrounding the patient-doctor relationship, and it is in contrast to emotional posturing and Federal power grabs and bureaucratic arrogance, which is really at the heart of the opposition.[27]

Opponents argued that smoked marijuana is not a safe and effective medicine and that its approval would send the wrong message to young people.

Legislative Activity in the 110th Congress

The first action on medical marijuana in the 110th Congress occurred during consideration of legislation to reauthorize existing FDA programs and expand the agency's authority to ensure the safety of prescription drugs, medical devices, and biologics. On April 18, 2007, at markup of the

[23] "Amendment No. 1 offered by Mr. Hinchey," *Congressional Record*, daily edition, vol. 149 (July 22, 2003), pp. H 7302-H7311 and vol. 149 (July 23, 2003), pp. H7354-H7355.

[24] "Amendment No. 6 Offered by Mr. Farr," *Congressional Record*, daily edition, vol. 150 (July 7, 2004), pp. H5300-H 5306, H5320.

[25] "Amendment Offered by Mr. Hinchey," *Congressional Record*, daily edition, vol. 151 (July 15, 2005), pp. H4519-H 4524, H4529.

[26] "Amendment Offered by Mr. Hinchey," *Congressional Record*, daily edition, vol. 152 (June 28, 2006), pp. H4735-H 4739.

[27] "Amendment Offered by Mr. Hinchey," *Congressional Record*, daily edition, vol. 153 (July 25, 2007), p. H8484.

Prescription Drug User Fee Act (S. 1082), the Senate Committee on Health, Education, Labor, and Pensions adopted, in an 11-9 vote, an amendment offered by Senator Coburn designed to shut down state medical marijuana programs. The amendment stated:

> The Secretary of Health and Human Services shall require that State-legalized medical marijuana be subject to the full regulatory requirements of the Food and Drug Administration, including a risk evaluation and mitigation strategy and all other requirements of the Federal Food, Drug, and Cosmetic Act regarding safe and effective reviews, approval, sale, marketing, and use of pharmaceuticals.

Herbal cannabis products are not, in fact, being marketed in the United States as pharmaceuticals, nor are they being developed as investigational new drugs due largely to federal restrictions on marijuana research. Because of this and other possibly complicating factors, the validity and actual effect of this amendment, if it had been signed into law, would have been unclear and would have been subject to legal interpretation and judicial review.[28] The bill, as amended, cleared the Senate and was sent to the House on May 9. The Coburn Amendment, however, was not included in the version of the FDA amendments act (H.R. 2900) that was approved by Congress and enacted into law (P.L. 110-85) on September 27, 2007.

In another action on medical marijuana, the House Judiciary Subcommittee on Crime, Terrorism, and Homeland Security held an oversight hearing on DEA's regulation of medicine on July 12, 2007. A DEA official testified that his agency would "continue to enforce the law as it stands and to investigate, indict, and arrest those who use the color of state law to possess and sell marijuana." A California medicinal cannabis patient and provider stated, "The well-being of thousands of seriously ill Americans backed by the opinion of the vast majority of their countrymen demands that medical marijuana be freed from federal interference." In his introduction of the patient, the subcommittee chairman observed, "Even if the law technically gives DEA the authority to investigate medical marijuana users, it is worth questioning whether targeting gravely ill people is the best use of federal resources."

Two weeks later, on July 25, the whole House decided to continue to use federal resources against medical marijuana users when it rejected the Hinchey-Rohrabacher amendment, 165-262, as described above.

In the second session of the 110th Congress, on April 17, 2008, Representative Frank introduced H.R. 5842, the Medical Marijuana Patient Protection Act, to provide for the medical use of marijuana in accordance with the laws of the various states. Introduced with four original co-sponsors—Representatives Farr, Hinchey, Paul, and Rohrabacher—the bill would have moved marijuana from schedule I to schedule II of the CSA and would have, within states with medical marijuana programs, permitted

- a physician to prescribe or recommend marijuana for medical use;
- an authorized patient to obtain, possess, transport, manufacture, or use marijuana;
- an authorized individual to obtain, possess, transport, or manufacture marijuana for an authorized patient; and

[28] For a legal analysis of the amendment, see CRS Congressional Distribution Memorandum, "Possible Legal Effects of the Medical Marijuana Amendment to S. 1082," by Vanessa Burrows and Brian Yeh.

- a pharmacy or other authorized entity to distribute medical marijuana to authorized patients.

No provision of the Controlled Substances Act or the Federal Food, Drug, and Cosmetic Act would have been allowed to prohibit or otherwise restrict these activities in states that have adopted medical marijuana programs. Also, the bill would not have affected any federal, state, or local law regulating or prohibiting smoking in public. In his introductory statement, Representative Frank said, "When doctors recommend the use of marijuana for their patients and states are willing to permit it, I think it's wrong for the federal government to subject either the doctors or the patients to criminal prosecution."[29] Although differently worded, H.R. 5842 had the same intent as the States' Rights to Medical Marijuana Act, versions of which had been introduced in every Congress since the 105th in 1997. The bill was referred to the House Committee on Energy and Commerce and saw no further action.

Medical Marijuana Measures in the 111th Congress

Bills have been introduced in recent Congresses to allow patients who appear to benefit from medical cannabis to use it in accordance with the various regulatory schemes that have been approved, since 1996, by the voters or legislatures of 14 states. This legislative activity continues in the 111th Congress with the reintroduction of two bills that would serve to relax somewhat the federal prohibition against the medical use of marijuana.

The Medical Marijuana Patient Protection Act (H.R. 2835), which would allow the medical use of marijuana in states that permit its use with a doctor's recommendation, was introduced on June 11, 2009, by Representative Barney Frank with 13 original cosponsors. The bill would move marijuana from Schedule I to Schedule II of the CSA and exempt from federal prosecution authorized patients and medical marijuana providers who are acting in accordance with state laws. Its wording is identical to H.R. 5842 as introduced in the 110th Congress, and its provisions are described more fully above. H.R. 2835 was referred to the House Committee on Energy and Commerce, where it awaits further action. (Versions of this bill have been introduced in every Congress since 1997 but have not seen action beyond the committee referral process.)

The second bill, the Truth in Trials Act (H.R. 3939), was introduced by Representative Sam Farr on October 27, 2009. It would make it possible for medical marijuana users and providers who are being tried in federal court to reveal to juries that their marijuana activity was medically related and legal under state law. After the 2001 Supreme Court decision *U.S.* v. *Oakland Buyers' Cooperative* (discussed below), it was no longer permissible for medical marijuana defendants in federal court to introduce evidence showing that their marijuana-related activities were undertaken for a valid medical purpose under state law.[30] H.R. 3939 would amend the Controlled Substances Act to make an affirmative defense possible for persons who provide or use marijuana in accordance with state medical marijuana laws. The bill also would limit the authority of federal agents to seize marijuana authorized for medical use under state law and would provide for the

[29] "Frank Introduces Legislation to Remove Federal Penalties on Personal Marijuana Use," press release from the office of Rep. Barney Frank, April 17, 2008.

[30] When it was first introduced in the 108th Congress, the bill was called the Steve McWilliams Truth in Trials Act. It was named after a Californian who took his own life while awaiting federal sentencing for marijuana trafficking. At his trial, it was impermissible to inform the jury that he was actually providing marijuana to seriously ill patients in San Diego in compliance with state law.

retention and return of seized plants pending resolution of a case involving medical marijuana. Introduced with nine original co-sponsors, the bill was referred to the Committee on the Judiciary and also to the Committee on Energy and Commerce.

For the first time since District of Columbia residents approved a medical marijuana ballot initiative in 1998, a rider blocking implementation of the initiative was not attached to the D.C. appropriations act for FY2010 (H.R. 3288), signed into law on December 16, 2009 (P.L. 111-117), clearing the way for the creation of a medical marijuana program for seriously ill patients in the nation's capital.

Executive Branch Actions and Policies

IND Compassionate Access Program (1978)

In 1975, a Washington, DC, resident was arrested for growing marijuana to treat his glaucoma. He won his case by using the medical necessity defense,[31] forcing the government to find a way to provide him with his medicine. In 1978, FDA created the Investigational New Drug (IND) Compassionate Access Program,[32] allowing patients whose serious medical conditions could be relieved only by marijuana to apply for and receive marijuana from the federal government. Over the next 14 years, other patients, less than 100 in total, were admitted to the program for conditions including chemotherapy-induced nausea and vomiting (emesis), glaucoma, spasticity, and weight loss. Then, in 1992, in response to a large number of applications from AIDS patients who sought to use medical cannabis to increase appetite and reverse wasting disease, the George H.W. Bush Administration closed the program to all new applicants. Several previously approved patients remain in the program today and continue to receive their monthly supply of government-grown medical marijuana.

Approval of Marinol (1985)

Made by Unimed, Marinol is the trade name for dronabinol, a synthetic form of delta-9-tetrahydrocannabinol (THC), one of the principal psychoactive components of botanical marijuana. It was approved in May 1985 for nausea and vomiting associated with cancer chemotherapy in patients who fail to respond to conventional antiemetic treatments. In December 1992, it was approved by FDA for the treatment of anorexia associated with weight loss in patients with AIDS. Marketed as a capsule, Marinol was originally placed in Schedule II.[33] In July 1999, in response to a rescheduling petition from Unimed, it was moved administratively by DEA to Schedule III to make it more widely available to patients.[34] The rescheduling was granted

[31] The Common Law *Doctrine of Necessity* argues that the illegal act committed (in this case, growing marijuana) was necessary to avert a greater harm (blindness).

[32] Despite the program's name, it was not a clinical trial to test the drug for eventual approval, but a means for the government to provide medical marijuana to patients demonstrating necessity. Some have criticized the government for its failure to study the safety and efficacy of the medical-grade marijuana it grew and distributed to this patient population.

[33] U.S. Dept. of Justice, Drug Enforcement Administration, "Schedules of Controlled Substances: Rescheduling of Synthetic Dronobinol in Sesame Oil and Encapsulation in Soft Gelatin Capsules From Schedule I to Schedule II; Statement of Policy," 51 *Federal Register* 17476, May 13, 1986.

[34] Ibid., "Schedules of Controlled Substances: Rescheduling of the Food and Drug Administration Approved Product Containing Synthetic Dronabinol [(-)-delta nine-(trans)-Tetrahydrocannabinol] in Sesame Oil and Encapsulated in Soft (continued...)

after a review by DEA and the Department of Health and Human Services found little evidence of illicit abuse of the drug. In Schedule III, Marinol is now subject to fewer regulatory controls and lesser criminal sanctions for illicit use.

Administrative Law Judge Ruling to Reschedule Marijuana (1988)

Congressional passage of the Controlled Substances Act in 1970 and its placement of marijuana in Schedule I provoked controversy at the time because it strengthened the federal policy of marijuana prohibition and forced medical marijuana users to buy marijuana of uncertain quality on the black market at inflated prices, subjecting them to fines, arrest, court costs, property forfeiture, incarceration, probation, and criminal records. The new bureaucratic controls on Schedule I substances were also criticized because they would impede research on marijuana's therapeutic potential, thereby making its evaluation and rescheduling through the normal drug approval process unlikely.

These concerns prompted a citizens' petition to the Bureau of Narcotics and Dangerous Drugs (BNDD) in 1972 to reschedule marijuana and make it available by prescription. The petition was summarily rejected.[35] This led to a long succession of appeals, hearing requests, and various court proceedings. Finally, in 1988, after extensive public hearings on marijuana's medicinal value, Francis L. Young, the chief administrative law judge of the Drug Enforcement Administration (the BNDD's successor agency), ruled on the petition, stating that "Marijuana, in its natural form, is one of the safest therapeutically active substances known to man."[36] Judge Young also wrote:

> The evidence in this record clearly shows that marijuana has been accepted as capable of relieving the distress of great numbers of very ill people, and doing so with safety under medical supervision. It would be unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence in this record.

Judge Young found that "the provisions of the [Controlled Substances] Act permit and require the transfer of marijuana from schedule I to schedule II," which would recognize its medicinal value and permit doctors to prescribe it. The judge's nonbinding findings and recommendation were soon rejected by the DEA Administrator because "marijuana has not been demonstrated as suitable for use as a medicine."[37] Subsequent rescheduling petitions also have been rejected, and marijuana remains a Schedule I substance.

(...continued)

Gelatin Capsules From Schedule II to Schedule III," 64 *Federal Register* 35928, July 2, 1999.

[35] Ibid., Bureau of Narcotics and Dangerous Drugs, "Schedule of Controlled Substances: Petition to Remove Marijuana or in the Alternative to Control Marijuana in Schedule V of the Controlled Substances Act," 37 *Federal Register* 18097, September 7, 1972.

[36] Ibid., Drug Enforcement Administration, "In the Matter of Marijuana Rescheduling Petition, Docket No. 86-22, Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law and Decision of Administrative Law Judge," Francis L. Young, Administrative Law Judge, September 6, 1988. This quote and the following two quotes are at pp. 58-59, 68, and 67, respectively. This opinion is online at http://www.druglibrary.net/olsen/MEDICAL/YOUNG/young.html.

[37] Ibid., "Marijuana Scheduling Petition; Denial of Petition," 54 *Federal Register* 53767 at 53768, December 29, 1989. The petition denial was appealed, eventually resulting in yet another DEA denial to reschedule. See Ibid., "Marijuana Scheduling Petition; Denial of Petition; Remand," 57 *Federal Register* 10499, March 26, 1992.

NIH-Sponsored Workshop (1997)

NIH convened a scientific panel on medical marijuana composed of eight nonfederal experts in fields such as cancer treatment, infectious diseases, neurology, and ophthalmology. Over a two-day period in February, they analyzed available scientific information on the medical uses of marijuana and concluded that "in order to evaluate various hypotheses concerning the potential utility of marijuana in various therapeutic areas, more and better studies would be needed." Research would be justified, according to the panel, into certain conditions or diseases such as pain, neurological and movement disorders, nausea of patients undergoing chemotherapy for cancer, loss of appetite and weight related to AIDS, and glaucoma.[38]

Institute of Medicine Report (1999)

In January 1997, shortly after passage of the California and Arizona medical marijuana initiatives, the Director of the Office of National Drug Control Policy (the federal drug czar) commissioned the Institute of Medicine (IOM) of the National Academy of Sciences to review the scientific evidence on the potential health benefits and risks of marijuana and its constituent cannabinoids. Begun in August 1997, IOM's 257-page report, *Marijuana and Medicine: Assessing the Science Base*, was released in March 1999.[39] A review of all existing studies of the therapeutic value of cannabis, the IOM Report was also based on public hearings and consultations held around the country with biomedical and social scientists and concerned citizens.

For the most part, the IOM Report straddled the fence and provided sound bites for both sides of the medical marijuana debate. For example, "Until a nonsmoked rapid-onset cannabinoid drug delivery system becomes available, we acknowledge that there is no clear alternative for people suffering from *chronic* conditions that might be relieved by smoking marijuana, such as pain or AIDS-wasting" (p. 179) and "Smoked marijuana is unlikely to be a safe medication for any chronic medical condition" (p. 126). For another example, "There is no conclusive evidence that marijuana causes cancer in humans, including cancers usually related to tobacco use" (p. 119) and "Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory disease" (p. 127).

The IOM Report did find more potential promise in synthetic cannabinoid drugs than in smoked marijuana (p. 177):

> The accumulated data suggest a variety of indications, particularly for pain relief, antiemesis, and appetite stimulation. For patients such as those with AIDS or who are undergoing chemotherapy, and who suffer simultaneously from severe pain, nausea, and appetite loss, cannabinoid drugs might offer broad-spectrum relief not found in any other single medication.

In general, the report emphasized the need for well-formulated, scientific research into the therapeutic effects of marijuana and its cannabinoid components on patients with specific disease

[38] National Institutes of Health. The Ad Hoc Group of Experts. *Workshop on the Medical Utility of Marijuana: Report to the Director,* August 1997. (Hereafter cited as NIH Workshop.)

[39] Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr., eds., *Marijuana and Medicine: Assessing the Science Base* (Washington: National Academy Press, 1999). (Hereafter cited as the IOM Report.) http://www.nap.edu/books/0309071550/html/

conditions. To this end, the report recommended that clinical trials be conducted with the goal of developing safe delivery systems.

Denial of Petition to Reschedule Marijuana (2001)

In response to a citizen's petition to reschedule marijuana submitted to the DEA in 1995, DEA asked the Department of Health and Human Services (HHS) for a scientific and medical evaluation of the abuse potential of marijuana and a scheduling recommendation. HHS concluded that marijuana has a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision. HHS therefore recommended that marijuana remain in Schedule I. In a letter to the petitioner dated March 20, 2001, DEA denied the petition.[40]

FDA Statement That Smoked Marijuana Is Not Medicine (2006)

On April 20, 2006, the FDA issued an interagency advisory restating the federal government's position that "smoked marijuana is harmful" and has not been approved "for any condition or disease indication." The one-page announcement did not refer to new research findings. Instead, it was based on a "past evaluation" by several agencies within HHS that "concluded that no sound scientific studies supported medical use of marijuana for treatment in the United States, and no animal or human data supported the safety or efficacy of marijuana for general medical use."[41]

Media reaction to this pronouncement was largely negative, asserting that the FDA position on medical marijuana was motivated by politics, not science, and ignored the findings of the 1999 Institute of Medicine Report.[42] In Congress, 24 House Members, led by Representative Hinchey, sent a letter to the FDA acting commissioner requesting the scientific evidence behind the agency's evaluation of the medical efficacy of marijuana and citing the FDA's IND Compassionate Access Program as "an example of how the FDA could allow for the legal use of a drug, such as medical marijuana, without going through the 'well-controlled' series of steps that other drugs have to go through if there is a compassionate need."[43]

Administrative Law Judge Ruling to Grow Research Marijuana (2007-2009)

Since 1968, the only source of marijuana available for scientific research in the United States has been tightly controlled by the federal government. Grown at the University of Mississippi under a contract administered by the National Institute on Drug Abuse, the marijuana is difficult to obtain even by scientists whose research protocols have been approved by the FDA. Not only is the

[40] U.S. Dept. of Justice, Drug Enforcement Administration, "Notice of Denial of Petition," 65 *Federal Register* 20038, April 18, 2001.

[41] U.S. Food and Drug Administration, "Inter-Agency Advisory Regarding Claims That Smoked Marijuana Is a Medicine," press release, April 20, 2006, p. 1. Although not cited in the press release, the "past evaluation" referred to is apparently the 2001 denial of the petition to reschedule marijuana discussed above.

[42] See, for example, "The Politics of Pot," editorial, *New York Times*, April 22, 2006, p. A26, which calls the FDA statement "disingenuous" and concludes: "It's obviously easier and safer to issue a brief, dismissive statement than to back research that might undermine the administration's inflexible opposition to the medical use of marijuana."

[43] "Hinchey Leads Bipartisan House Coalition In Calling For FDA To Explain Baseless Anti-Medical Marijuana Policy," press release, April 27, 2006. (The press release, which includes the full text of the letter, is available on Rep. Hinchey's website at http://www.house.gov/hinchey/newsroom/press_2006/042706medmarijuanafdaletter.html.)

federal supply of marijuana largely inaccessible, but researchers also complain that it does not meet the needs of research due to its inferior quality and lack of multiple strains.[44] Other Schedule I substances—such as LSD, heroin, and MDMA (Ecstasy)—can be provided legally by private U.S. laboratories or imported from abroad for research purposes, with federal permission. Only marijuana is limited to a single, federally-controlled provider.

In response to this situation, Dr. Lyle Craker, a professor of plant biology and director of the medicinal plant program at the University of Massachusetts at Amherst, applied in 2001 for a DEA license to cultivate research-grade marijuana. The application was filed in association with the Multidisciplinary Association for Psychedelic Studies (MAPS), a nonprofit drug research organization headed by Dr. Rick Doblin, whose stated goal is

> to break the government's monopoly on the supply of marijuana that can be used in FDA-approved research, thereby creating the proper conditions for a $5 million, 5 year drug development effort designed to transform smoked and/or vaporized marijuana into an FDA-approved prescription medicine.[45]

After being sued for "unreasonable delay" in the DC Circuit Court of Appeals, the DEA rejected the Craker/MAPS application in December 2004 as not consistent with the public interest. Upon appeal, nine days of hearings were held over a five-month period in 2005, at which researchers testified that their requests for marijuana had been rejected, making it impossible to conduct their FDA-approved research. On February 12, 2007, DEA's Administrative Law Judge Mary Ellen Bittner found that "an inadequate supply" of marijuana is available for research and ruled that it "would be in the public interest" to allow Dr. Craker to create the proposed marijuana production facility.[46]

Rulings by administrative law judges, however, are nonbinding and may be rejected by agency heads, which happened in this case. In the closing days of the Bush Administration, on January 7, 2009, the DEA Deputy Administrator signed an order denying Dr. Craker's application for a DEA certificate of registration as a manufacturer of marijuana.[47] In response, Dr. Craker submitted to DEA a Motion to Reconsider, which, if rejected, would trigger an appeal that has been docketed by the U.S. Court of Appeals for the First Circuit in Boston.[48]

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[44] Jessica Winter, "Weed Control: Research on the Medicinal Benefits of Marijuana May Depend on Good Gardening—and Some Say Uncle Sam, the Country's Only Legal Grower of the Cannabis Plant, Isn't Much of a Green Thumb," *Boston Globe*, May 28, 2006.

[45] "The UMass Amherst MMJ Production Facility Project," on the MAPS website at http://www.maps.org/mmj/mmjfacility.html. See the entry for February 8, 2005. (Numerous documents related to the Craker/MAPS application are linked here.)

[46] U.S. Dept. of Justice, Drug Enforcement Administration, "In the Matter Lyle E. Craker, Ph.D., Docket No. 05-16, Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law, and Decision of Administrative Law Judge," Mary Ellen Bittner, Administrative Law Judge, February 12, 2007, p. 87. This opinion is online at http://www.maps.org/mmj/DEAlawsuit.html.

[47] Department of Justice, "Lyle E. Craker; Denial of Application," 74 *Federal Register* 2101-2133, January 14, 2009.

[48] The documents in this case, including the ones cited here, can be found at http://www.maps.org/mmj/DEAlawsuit.html.

DEA Enforcement Actions Against Medical Marijuana Providers

Most arrests in the United States for marijuana possession are made by state and local police, not the DEA. This means that patients and their caregivers in the states that permit medical marijuana mostly go unprosecuted, because their own state's marijuana prohibition laws do not apply to them and because federal law is not usually enforced against them.

Federal agents have, however, moved against medical cannabis growers and distributors in states with medical marijuana programs. In recent years, especially during the George W. Bush Administration, DEA agents conducted many raids of medical marijuana dispensaries, especially in California, where the law states that marijuana providers can receive "reasonable compensation" on a nonprofit basis. The DEA does not provide statistics on its moves against medical marijuana outlets because the agency does not distinguish between criminal, non-medical marijuana trafficking organizations and locally licensed storefront dispensaries that are legal under state law. They are all felony criminal operations under the federal Controlled Substances Act. As a practical matter, however, the DEA reportedly was targeting larger, for-profit medical marijuana providers who were engaged in "nothing more than high-stakes drug dealing, complete with the same high-rolling lifestyles."[49] A few high-profile medical marijuana patients were also being prosecuted under federal law.[50]

In July 2007, DEA's Los Angeles Field Division Office introduced a new enforcement tactic against medical marijuana dispensaries in the city when it sent letters to the owners and managers of buildings in which medical marijuana facilities were operating. The letters threatened the property owners and managers with up to 20 years in federal prison for violating the so-called "crack house statute," a provision of the CSA enacted in 1986 that made it a federal offense to "knowingly and intentionally rent, lease, or make available for use, with or without compensation, [a] building, room, or enclosure for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance."[51] The DEA letters also threatened the landlords with seizure of their property under the CSA's asset forfeiture provisions.[52]

In response, L.A. City Council members wrote a letter to DEA Administrator Karen Tandy in Washington urging her to abandon this tactic and allow them to continue work on an ordinance to regulate medical cannabis facilities "without federal interference." They also unanimously approved a resolution endorsing the Hinchey-Rohrabacher amendment, which would prohibit

[49] Rone Tempest, "DEA Targets Larger Marijuana Providers," *Los Angeles Times*, January 1, 2007.

[50] These include medical marijuana activist and author Ed Rosenthal, whose first federal jury, in 2003, renounced its guilty verdict when it learned after the trial that he was legally helping patients under state law. He was retried and reconvicted in 2007 but not re-sentenced because he had already served his sentence of one day. See "'Guru of Ganja' Convicted on Marijuana Charges," *Associated Press*, May 30, 2007.

[51] Sec. 416 of the Controlled Substances Act (21 U.S.C. § 856) as amended by P.L. 99-570, Title I, sec. 1841(a), October 27, 1986; 100 Stat. 3207-52. Actually, the crack house statute was amended in 2003 by the "rave act" (§ 608 of P.L. 108-21, May 1, 2003; 117 Stat. 691), which broadened the language of the crack house statute to include outdoor venues and other possible places where raves could be held by striking the words "building, room, or enclosure" (which appear in the DEA letter) and replacing them with "place." This and other subtle but significant changes in the language of the law were designed to penalize rave promoters and the owners and managers of the venues where raves (all-night music festivals) occur at which Ecstasy (MDMA) and other club drugs might be used. The July 2007 DEA letter cites the language of the pre-2003 version of the crack house statute rather than the provision of law currently in force. This section of the CSA has also been used by the DEA against fund-raising events put on by drug law reform organizations.

[52] 21 U.S.C. § 881(a)(7).

such DEA actions and which was about to be debated in the House, as discussed above. An editorial in the *Los Angeles Times* called the DEA threats to landlords a "deplorable new bullying tactic."[53]

In subsequent months, DEA expanded this enforcement mechanism to other parts of California, including the Bay Area. In one lawsuit challenging the right of landlords to evict marijuana dispensaries, a Los Angeles County Superior Court judge ruled, in April 2008, that federal law preempts California's Compassionate Use Act. If the ruling is affirmed on appeal, it would threaten the future of medical marijuana in California and elsewhere.

DEA's actions against medical marijuana growing and distribution operations have provoked other lawsuits. In April 2003, for example, the city and county of Santa Cruz, CA, along with seven medical marijuana patients, filed a lawsuit in San Jose federal district court in response to DEA's earlier raid on the Wo/Men's Alliance for Medical Marijuana (WAMM). The court granted the plaintiffs' motion for a preliminary injunction, thereby allowing WAMM to resume growing and producing marijuana medications for its approximately 250 member-patients with serious illnesses, pending the final outcome of the case.[54] The suit is said to be the first court challenge brought by a local government against the federal war on drugs.

The Obama Administration and Medical Marijuana

During the presidential campaign, candidate Barack Obama stated several times his position that moving against medical marijuana dispensaries that were operating in compliance with state laws would not be a priority of his administration. Nevertheless, the continuation of such raids during the early days of the Obama Administration created confusion regarding the medical marijuana policies of the new government.[55] In mid-March, Attorney General Eric H. Holder, Jr., stated that such raids would cease.[56]

The new policy was finally formalized in a Justice Department memorandum to U.S. Attorneys dated October 19, 2009.[57] Noting that "Congress has determined that marijuana is a dangerous drug, and the illegal distribution and sale of marijuana is a serious crime," the memo directs the U.S. Attorneys in states with medical marijuana programs not to focus their investigative and prosecutorial resources "on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana." The memo does not free medical marijuana providers from federal scrutiny, especially in cases where "state law is being invoked as a pretext for the production or distribution of marijuana for purposes not authorized by state law." The memo specifically states that "prosecution of commercial enterprises that unlawfully market and sell marijuana for profit continues to be an enforcement priority of the Department." The new directive, however, can be expected to result in fewer federal operations against medical marijuana providers than were conducted by the previous administration.

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[53] "New Challenges for Medical Marijuana," *Los Angeles Times* editorial, July 19, 2007.

[54] *County of Santa Cruz* v. *Ashcroft*, 314 F.Supp.2d 1000 (N.D.Cal. 2004); the decision, however, rests on the 9th Circuit's ruling in *Raich*, subsequently reversed by the Supreme Court, as described below.

[55] Stephen Dinan and Ben Conery, "DEA Continues Pot Raids Obama Opposes," *Washington Times*, February 5, 2009.

[56] David Johnston and Neil A. Lewis, "Obama Administration to Stop Raids on Medical Marijuana Dispensers," *New York Times*, March 19, 2009.

[57] The memorandum is available at http://blogs.usdoj.gov/blog/archives/192.

Medical Cannabis in the Courts: Major Cases

Because Congress and the executive branch have not acted to permit seriously ill Americans to use botanical marijuana medicinally, the issue has been considered by the judicial branch, with mixed results. Three significant cases have been decided so far, and other court challenges are moving through the judicial pipeline.[58]

U.S. v. *Oakland Cannabis Buyers' Cooperative* (2001)

The U.S. Department of Justice filed a civil suit in January 1998 to close six medical marijuana distribution centers in northern California. A U.S. district court judge issued a temporary injunction to close the centers, pending the outcome of the case. The Oakland Cannabis Buyers' Cooperative fought the injunction but was eventually forced to cease operations and appealed to the Ninth Circuit Court of Appeals. At issue was whether a medical marijuana distributor can use a medical necessity defense against federal marijuana distribution charges.[59]

The Ninth Circuit's decision in September 1999 found, 3-0, that medical necessity is a valid defense against federal marijuana trafficking charges if a trial court finds that the patients to whom the marijuana was distributed are seriously ill, face imminent harm without marijuana, and have no effective legal alternatives.[60] The Justice Department appealed to the Supreme Court.

The Supreme Court held, 8-0, that "a medical necessity exception for marijuana is at odds with the terms of the Controlled Substances Act" because "its provisions leave no doubt that the defense is unavailable."[61] This decision had no effect on state medical marijuana laws, which continued to protect patients and primary caregivers from arrest by state and local law enforcement agents in the states with medical marijuana programs.

Conant v. *Walters* (2002)

After the 1996 passage of California's medical marijuana initiative, the Clinton Administration threatened to investigate doctors and revoke their licenses to prescribe controlled substances and participate in Medicaid and Medicare if they recommended medical marijuana to patients under the new state law. A group of California physicians and patients filed suit in federal court, early in 1997, claiming a constitutional free-speech right, in the context of the doctor-patient relationship, to discuss the potential risks and benefits of the medical use of cannabis. A preliminary injunction, issued in April 1997, prohibited federal officials from threatening or punishing physicians for recommending marijuana to patients suffering from HIV/AIDS, cancer, glaucoma, or seizures or muscle spasms associated with a chronic, debilitating condition.[62] The court subsequently made the injunction permanent in an unpublished opinion.

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[58] For a legal analysis of the three Supreme Court cases mentioned here, see CRS Report RL31100, *Marijuana for Medical Purposes: The Supreme Court's Decision in United States v. Oakland Cannabis Buyers' Cooperative and Related Legal Issues*, by Charles Doyle.

[59] The necessity defense argues that the illegal act committed (distribution of marijuana in this instance) was necessary to avert a greater harm (withholding a helpful drug from seriously ill patients).

[60] 190 F.3d 1109.

[61] 532 U.S. 483 (2001) at 494 n. 7.

[62] *Conant* v. *McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997).

On appeal, the Ninth Circuit affirmed, in a 3-0 decision, the district court's order entering a permanent injunction. The federal government, the opinion states, "may not initiate an investigation of a physician solely on the basis of a recommendation of marijuana within a bona fide doctor-patient relationship, unless the government in good faith believes that it has substantial evidence of criminal conduct."[63] The Bush Administration appealed, but the Supreme Court refused to take the case.

Gonzales v. *Raich* (2005)

In response to DEA agents' destruction of their medical marijuana plants, two patients and two caregivers in California brought suit. They argued that applying the Controlled Substances Act to a situation in which medical marijuana was being grown and consumed locally for no remuneration in accordance with state law exceeded Congress's constitutional authority under the Commerce Clause, which allows the federal government to regulate interstate commerce. In December 2003, the Ninth Circuit Court of Appeals in San Francisco agreed, ruling 2-1 that states are free to adopt medical marijuana laws so long as the marijuana is not sold, transported across state lines, or used for nonmedical purposes.[64] Federal appeal sent the case to the Supreme Court.

The issue before the Supreme Court was whether the Controlled Substances Act, when applied to the *intra*state cultivation and possession of marijuana for personal use under state law, exceeds Congress's power under the Commerce Clause. The Supreme Court, in June 2005, reversed the Ninth Circuit's decision and held, in a 6-3 decision, that Congress's power to regulate commerce extends to purely local activities that are "part of an economic class of activities that have a substantial effect on interstate commerce."[65]

Raich does not invalidate state medical marijuana laws. The decision does mean, however, that DEA may continue to enforce the CSA against medical marijuana patients and their caregivers, even in states with medical marijuana programs.

Although *Raich* was not about the efficacy of medical marijuana or its listing in Schedule I, the majority opinion stated in a footnote: "We acknowledge that evidence proffered by respondents in this case regarding the effective medical uses for marijuana, if found credible after trial, would cast serious doubt on the accuracy of the findings that require marijuana to be listed in Schedule I."[66] The majority opinion, in closing, notes that in the absence of judicial relief for medical marijuana users there remains "the democratic process, in which the voices of voters allied with these respondents may one day be heard in the halls of Congress."[67]

Thus, the Supreme Court reminds that Congress has the power to reschedule marijuana, thereby recognizing that it has accepted medical use in treatment in the United States. Congress, however, does not appear likely to do so. Neither does the executive branch, which could reschedule marijuana through regulatory procedures authorized by the Controlled Substances Act. In the

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[63] *Conant* v. *Walters*, 309 F.3d 629, 636 (9th Cir. 2002); the parties agreed that "a doctor who actually prescribes or dispenses marijuana violates federal law," ibid. at 634.

[64] *Raich* v. *Ashcroft*, 352 F.3d 1222 (9th Cir. 2003).

[65] *Gonzales* v. *Raich*, 125 S.Ct. 2195, 2205 (2005).

[66] Ibid. at 2211 n. 37. For a legal analysis of this case, see CRS Report RS22167, *Gonzales v. Raich: Congress's Power Under the Commerce Clause to Regulate Medical Marijuana*, by Todd B. Tatelman.

[67] Ibid. at 2215.

meantime, actions taken by state and local governments continue to raise the issue, as discussed below.

Americans for Safe Access (ASA) Lawsuit Against HHS

The federal Data Quality Act of 2001 (DQA) requires the issuance of guidelines "for ensuring and maximizing the quality, objectivity, utility, and integrity of information (including statistical information) disseminated by Federal agencies" and allows "affected persons to seek and obtain correction of information maintained and disseminated by the agency that does not comply with the guidelines."[68]

In October 2004, Americans for Safe Access (ASA), a California-based patient advocacy group, formally petitioned HHS, under the DQA, to correct four erroneous statements about medical marijuana made by HHS in its 2001 denial of the marijuana rescheduling petition discussed above. Specifically, ASA requested that "there have been no studies that have scientifically assessed the efficacy of marijuana for any medical condition" be replaced with "[a]dequate and well-recognized studies show the efficacy of marijuana in the treatment of nausea, loss of appetite, pain and spasticity"; that "it is clear that there is not a consensus of medical opinion concerning medical applications of marijuana" be replaced with "[t]here is substantial consensus among experts in the relevant disciplines that marijuana is effective in treating nausea, loss of appetite, pain and spasticity. It is accepted as medicine by qualified experts"; that "complete scientific analysis of all the chemical components found in marijuana has not been conducted" be replaced with "[t]he chemistry of marijuana is known and reproducible"; and that "marijuana has no currently accepted medical use in treatment in the United States" be replaced with "[m]arijuana has a currently accepted use in treatment in the United States." The petition claimed that "HHS's statements about the lack of medical usefulness of marijuana harms these individuals [ill persons across the United States] in that it contributes to denying them access to medicine which will alleviate their suffering."[69]

Were HHS to accept the ASA petition, the revised statements would set the preconditions for placing marijuana in a schedule other than I. HHS denied the petition in 2005 and rejected ASA's subsequent appeal in 2006 on just those grounds: that HHS is already in the process of reviewing a rescheduling petition submitted to DEA in October 2002 and will be evaluating all of the publicly available peer-reviewed literature on the medicinal efficacy of marijuana in that context. In response, in February 2007, ASA filed suit in U.S. District Court for the Northern District of California to force HHS to change the four statements, which the organization believes are not science-based. The case is pending.

State and Local Referenda and Legislation

In the face of federal intransigence on the issue, advocates of medical marijuana have turned to the states in a largely successful effort, wherever it has been attempted, to enact laws that enable

[68] P.L. 106-554, 114 Stat. 2763A-153, 44 U.S.C. § 3516 note. For background on the DQA see CRS Report RL32532, *The Information Quality Act: OMB's Guidance and Initial Implementation*, by Curtis W. Copeland.

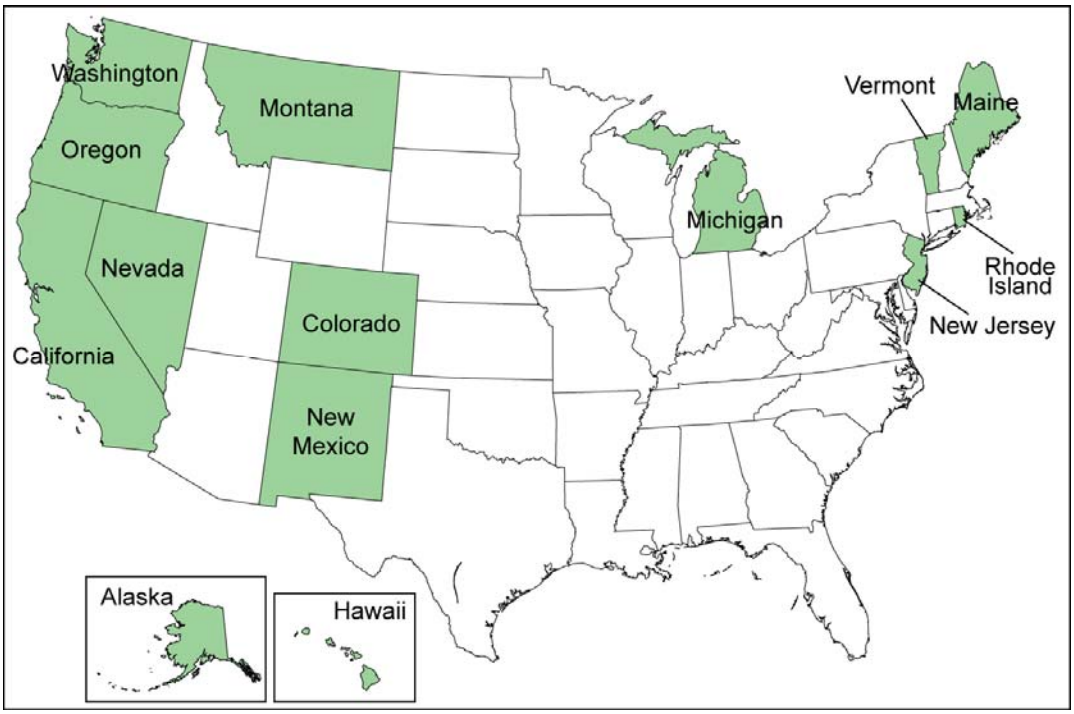
[69] The original petition and all subsequent documents relating to the case can be found at http://www.safeaccessnow.org/article.php?id=4401. See also Carolyn Marshall, "U.S. Is Sued Over Position on Marijuana," *New York Times*, February 22, 2007.

patients to obtain and use botanical marijuana therapeutically in a legal and regulated manner, even though such activity remains illegal under federal law.

States Allowing Use of Medical Marijuana[70]

Fourteen states, covering about 27% of the U.S. population, have enacted laws to allow the use of cannabis for medical purposes.[71] These states have removed state-level criminal penalties for the cultivation, possession, and use of medical marijuana, if such use has been recommended by a medical doctor. All of these states have in place, or are developing, programs to regulate the use of medical marijuana by approved patients. Physicians in these states are immune from liability and prosecution for discussing or recommending medical cannabis to their patients in accordance with state law. Patients in state programs (except for New Mexico and New Jersey) may be assisted by caregivers—persons who are authorized to help patients grow, acquire, and use the drug.

Figure 1. States With Medical Marijuana Programs



Source: Map Resources. Adapted by CRS.

[70] The information in this and the following section is drawn largely from *State-By-State Medical Marijuana Laws: How to Remove the Threat of Arrest*, Marijuana Policy Project, 2008, available at http://www.mpp.org/legislation/state-by-state-medical-marijuana-laws.html. More recent information is from press reports.

[71] Alaska (Stat. §11.71.090); California (Cal.Health & Safety Code Ann. §11362.5 and §§11362.7 to 11362.83); Colorado (Colo.Const. Art. XVIII §14); Hawaii (Rev.Stat. §§329-121 to 329-128); Maine (Me.Rev.Stat.Ann. tit.22 §1102 or 2382-B(5)); Michigan (MCL §§333.26421 to 26430); Montana (Mont.Code Ann. §§50-46-101 to 50-46-210); Nevada (Nev.Rev.Stat.Ann. §§453A.010 to 453A.400); New Jersey (N.J. Stat. §24:6I); New Mexico (N.M. Stat. Ann. §26-2B-1); Oregon (Ore.Rev.Stat. §§475.300 to 475.346); Rhode Island (RI ST §§21 to 28.6-1); Vermont (Vt.Stat.Ann. tit. 18, §§4472 to 4474d); Washington (Wash.Rev.Code Ann. §§69.51A.005 to 69.51A.902).

Nine of the 14 states that have legalized medical marijuana are in the West: Alaska, California, Colorado, Hawaii, Montana, Nevada, New Mexico, Oregon, and Washington. Of the 37 states outside the West, Michigan plus four other states, all in the Northeast—Maine, New Jersey, Rhode Island, and Vermont—have adopted medical cannabis statutes. Hawaii, New Jersey, New Mexico, Rhode Island, and Vermont have the only programs created by acts of their state legislatures. The medical marijuana programs in the other nine states were approved by the voters in statewide referenda or ballot initiatives, beginning in 1996 with California. Since then, voters have approved medical marijuana initiatives in every state where they have appeared on the ballot with the exception of South Dakota, where a medical marijuana initiative was defeated in 2006 by 52% of the voters. Bills to create medical marijuana programs have been introduced in the legislatures of additional states—Alabama, Arizona, Connecticut, Illinois, Maryland, Minnesota, and New Hampshire, among others—and have received varying levels of consideration but have so far not been enacted.

Effective state medical marijuana laws do not attempt to overturn or otherwise violate federal laws that prohibit doctors from writing prescriptions for marijuana and pharmacies from distributing it. In the 14 states with medical marijuana programs, doctors do not actually prescribe marijuana, and the marijuana products used by patients are not distributed through pharmacies. Rather, doctors *recommend* marijuana to their patients, and the cannabis products are grown by patients or their caregivers, or they are obtained from cooperatives or other alternative dispensaries. The state medical marijuana programs do, however, contravene the federal prohibition of marijuana. Medical marijuana patients, their caregivers, and other marijuana providers can, therefore, be arrested by federal law enforcement agents, and they can be prosecuted under federal law.

Statistics on Medical Marijuana Users

Determining exactly how many patients use medical marijuana with state approval is difficult, but the limited data available suggest the number is rising rapidly. According to a 2002 study published in the *Journal of Cannabis Therapeutics*, an estimated 30,000 California patients and another 5,000 patients in eight other states possessed a physician's recommendations to use cannabis medically.[72] The *New England Journal of Medicine* reported in August 2005 that an estimated 115,000 people had obtained marijuana recommendations from doctors in the states with programs.[73]

Although 115,000 people might have been approved medical marijuana users in 2005, the number of patients who had actually registered was much lower. A July 2005 CRS telephone survey of the state programs revealed a total of 14,758 registered medical marijuana users in eight states.[74] (Maine and Washington do not maintain state registries, and Rhode Island, New Mexico, Michigan, and New Jersey had not yet passed their laws.) This number vastly understated the actual number of medical marijuana users, however, because California's state registry was in pilot status, with only 70 patients so far registered.

[72] Dale Gieringer, "The Acceptance of Medical Marijuana in the U.S.," *Journal of Cannabis Therapeutics*, vol. 3, no. 1 (2003), pp. 53-67. The author later estimated that there were more than 100,000 medical marijuana patients in California alone (personal communication dated April 30, 2004).

[73] Susan Okie, "Medical Marijuana and the Supreme Court," *New England Journal of Medicine*, vol. 353, no. 7 (August 18, 2005), p. 649.

[74] The telephone survey was conducted for this report by CRS summer intern Broocks Andrew Meade.

More recently, an estimate published by *Newsweek* early in 2010 found a total of 369,634 users in the 13 states with established programs, with California's estimated patient population of 253,800 alone accounting for 69% of the total.[75] (It remains necessary to estimate California's number because registration is voluntary at both the state and county levels, and only a small fraction of patients choose to register. There were fewer than 33,000 registered patients as of March 2010, according to the state's medical marijuana program website.[76])

A brief description of each state's medical marijuana program follows. The programs are discussed in the order in which they were approved by voters or became law by actions of the state legislatures.

California (1996)

Proposition 215, approved by 56% of the voters in November, removed the state's criminal penalties for medical marijuana use, possession, and cultivation by patients with the "written or oral recommendation or approval of a physician" who has determined that the patient's "health would benefit from medical marijuana." Called the Compassionate Use Act, it legalized cannabis for "the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief." The law permits possession of an amount sufficient for the patient's "personal medical purposes." A second statute (Senate bill 420), passed in 2003, allows "reasonable compensation" for medical marijuana caregivers and states that the drug should be distributed on a nonprofit basis.

Oregon (1998)

Voters in November removed the state's criminal penalties for use, possession, and cultivation of marijuana by patients whose physicians advise that marijuana "may mitigate the symptoms or effects" of a debilitating condition. The law, approved by 55% of Oregon voters, does not provide for distribution of cannabis but allows up to seven plants per patient (changed to 24 plants by act of the state legislature in 2005). The state registry program is supported by patient fees. (In the November 2004 election, 58% of Oregon voters rejected a measure that would have expanded the state's existing program.)

Alaska (1998)

Voters in November approved a ballot measure to remove state-level criminal penalties for patients diagnosed by a physician as having a debilitating medical condition for which other approved medications were considered. The measure was approved by 58% of the voters. In 1999, the state legislature created a mandatory state registry for medical cannabis users and limited the amount a patient can legally possess to 1 ounce and six plants.

[75] Ian Yarett, "Back Story: How High Are You?," *Newsweek*, February 15, 2010, p. 56.

[76] The California Department of Public Health Medical Marijuana Program homepage is available on the Web at http://www.cdph.ca.gov/programs/MMP.

Washington (1998)

Approved in November by 59% of the voters, the ballot initiative exempts from prosecution patients who meet all qualifying criteria, possess no more marijuana than is necessary for their own personal medical use (but no more than a 60-day supply), and present valid documentation to investigating law enforcement officers. The state does not issue identification cards to patients.

Maine (1999)

Maine's ballot initiative, passed in November by 61% of the voters, puts the burden on the state to prove that a patient's medical use or possession is not authorized by statute. Patients with a qualifying condition, authenticated by a physician, who have been "advised" by the physician that they "might benefit" from medical cannabis, are permitted 1¼ ounces and six plants. There is no state registry of patients.

Hawaii (2000)

In June, the Hawaii legislature approved a bill removing state-level criminal penalties for medical cannabis use, possession, and cultivation of up to seven plants. A physician must certify that the patient has a debilitating condition for which "the potential benefits of the medical use of marijuana would likely outweigh the health risks." This was the first state law permitting medical cannabis use that was enacted by a legislature instead of by ballot initiative.

Colorado (2000)

A ballot initiative to amend the state constitution was approved by 54% of the voters in November. The amendment provides that lawful medical cannabis users must be diagnosed by a physician as having a debilitating condition and be "advised" by the physician that the patient "might benefit" from using the drug. A patient and the patient's caregiver may possess 2 usable ounces and six plants.

Nevada (2000)

To amend the state constitution by ballot initiative, a proposed amendment must be approved by the voters in two separate elections. In November, 65% of Nevada voters passed for the second time an amendment to exempt medical cannabis users from prosecution. Patients who have "written documentation" from their physicians that marijuana may alleviate their health condition may register with the state Department of Agriculture and receive an identification card that exempts them from state prosecution for using medical marijuana.

Vermont (2004)

In May, Vermont became the second state to legalize medical cannabis by legislative action instead of ballot initiative. Vermont patients are allowed to grow up to three marijuana plants in a locked room and to possess 2 ounces of manicured marijuana under the supervision of the Department of Public Safety, which maintains a patient registry. The law went into effect without the signature of the governor, who declined to sign it but also refused to veto it, despite pressure

from Washington. A 2007 legislative act expanded eligibility for the program and increased to nine the number of plants participants may grow.

Montana (2004)

In November, 62% of state voters passed Initiative 148, allowing qualifying patients to use marijuana under medical supervision. Eligible medical conditions include cancer, glaucoma, HIV/AIDS, wasting syndrome, seizures, and severe or chronic pain. A doctor must certify that the patient has a debilitating medical condition and that the benefits of using marijuana would likely outweigh the risks. The patient may grow up to six plants and possess 1 ounce of dried marijuana. The state public health department registers patients and caregivers.

Rhode Island (2006)

In January, the state legislature overrode the governor's veto of a medical marijuana bill, allowing patients to possess up to 12 plants or 2½ ounces to treat cancer, HIV/AIDS, and other chronic ailments. The law included a sunset provision and was set to expire on July 1, 2007, unless renewed by the legislature. The law was made permanent on June 21, 2007, after legislators voted again to override the governor's veto by a wide margin.

New Mexico (2007)

Passed by the legislature and signed into law by the governor in April, the Lynn and Erin Compassionate Use Medical Marijuana Act went into effect on July 1, 2007. It requires the state's Department of Health to set rules governing the distribution of medical cannabis to state-authorized patients. Unlike most other state programs, patients and their caregivers cannot grow their own marijuana; rather, it will be provided by state-licensed "cannabis production facilities."

Michigan (2008)

Approved by 63% of Michigan voters in the November 2008 presidential election, Proposal 1 permits physicians to approve marijuana use by registered patients with debilitating medical conditions, including cancer, HIV/AIDS, hepatitis C, multiple sclerosis, glaucoma, and other conditions approved by the state's Department of Community Health. Up to 12 plants can be cultivated in an indoor, locked facility by the patient or a designated caregiver.

New Jersey (2010)

A bill passed by the legislature and signed by the governor allows for the regulated distribution of marijuana by state-monitored dispensaries. Doctors may recommend up to 2 ounces monthly to registered patients, who are not allowed to grow their own. Considered the most restrictive of the state programs approved to date, the law restricts usage to a specific set of diseases including cancer, AIDS, glaucoma, muscular dystrophy, multiple sclerosis, and other diseases involving severe and chronic pain, severe nausea, seizures, or severe and persistent muscle spasms.

Other State and Local Medical Marijuana Laws

Arizona (1996)

Arizona's law,[77] approved by 65% of the voters in November, permits marijuana prescriptions, but there is no active program in the state because federal law prohibits doctors from *prescribing* marijuana. Patients cannot, therefore, obtain a valid prescription. (Other states' laws allow doctors to "recommend" rather than "prescribe.")

Maryland (2003)

Maryland's General Assembly became the second state legislature, after Hawaii, to protect medical cannabis patients from the threat of jail when it approved a bill, later signed by the governor, providing that patients using marijuana preparations to treat the symptoms of illnesses such as cancer, AIDS, and Crohn's disease would be subject to no more than a $100 fine.[78] The law falls short of full legalization and does not create a medical marijuana program, but it allows for a medical necessity defense for people who use marijuana on their own for medical purposes. If patients arrested for possession in Maryland can prove in court that they use cannabis for legitimate medical needs, they escape the maximum penalty of one year in jail and a $1,000 fine.

Other State Laws

Laws favorable to medical marijuana have been enacted in 36 states since 1978.[79] Except for the state laws mentioned above, however, these laws do not currently protect medical marijuana users from state prosecution. Some laws, for example, allow patients to acquire and use cannabis through therapeutic research programs, although none of these programs has been operational since 1985, due in large part to federal opposition. Other state laws allow doctors to prescribe marijuana or allow patients to possess marijuana if it has been obtained through a prescription, but the federal Controlled Substances Act prevents these laws from being implemented. Several states have placed marijuana in a controlled drug schedule that recognizes its medical value. State legislatures continue to consider medical marijuana bills, some favorable to its use by patients, others not. In Michigan, a medical marijuana initiative will be presented to the voters on the November 2008 ballot.

District of Columbia (1998)

In the nation's capital, 69% of voters approved a medical cannabis initiative to allow patients a "sufficient quantity" of marijuana to treat illness and to permit nonprofit marijuana suppliers. In every year since then, however, Congress attached a rider to the D.C. appropriations act blocking the Initiative 59 from taking effect, until Congress eliminated the ban in the FY2010 DC appropriations act (H.R. 3288, which was signed into law in December 2009 (P.L. 111-117). More than 11 years after DC voters approved the medical marijuana measure, city officials were free to

[77] Ariz.Rev.Stat.Ann. §13-3412.01(A).

[78] Md. Crim.Code Ann. §5-601.

[79] *State-By-State Medical Marijuana Laws: How to Remove the Threat of Arrest*, Marijuana Policy Project, 2008, p. 2 and Appendix A. The laws in some of these states have expired or been repealed.

begin drafting legislation to create a medical marijuana program in the nation's capital.[80] Any law passed by the DC Council and signed into law by the mayor would be subject to congressional approval.

Local Measures

Medical cannabis measures have been adopted in several localities throughout the country. San Diego is the country's largest city to do so. One day after the Supreme Court's anti-marijuana ruling in *Gonzales* v. *Raich* was issued, Alameda County in California approved an ordinance to regulate medical marijuana dispensaries, becoming the 17th locality in the state to do so. Localities in nonmedical marijuana states have also acted. In November 2004, for example, voters in Columbia, MO, and Ann Arbor, MI, approved medical cannabis measures. Since then, four other Michigan cities, including Detroit, have done the same. Although largely symbolic, such local laws can influence the priorities of local law enforcement officers and prosecutors.

Public Opinion on Medical Marijuana

Majorities of voters in nine states have now approved medical marijuana initiatives to protect patients from arrest under state law. More broadly, national public opinion polls have consistently favored access to medical marijuana by seriously ill patients. ProCon.org, a nonprofit and nonpartisan public education foundation, has identified 23 national public opinion polls that asked questions about medical marijuana from 1995 to the present. Respondents in every poll were in favor of medical marijuana by substantial margins, ranging from 60% to 85%.[81]

Among recent opinion surveys, a January 2010 ABC News/Washington Post poll found that more than 8 in 10 Americans (81%) supported efforts to make marijuana legal for medical use, up from 69% in 1997. Given three choices as to who should be allowed to use it where it is legal, 56% of respondents chose the most lenient position of prescribing it "for any patient the doctor thinks it could help." Its use would be restricted to "patients who have serious but not fatal illnesses" by 21%, and another 21% would limit the drug "to patients who are terminally ill and near death." According to the pollsters' analysis,

> Medical marijuana … receives majority support across the political and ideological spectrum, from 68 percent of conservatives and 72 percent of Republicans as well as 85 percent of Democrats and independents and about nine in 10 liberals and moderates. Support slips to 69 percent among seniors, vs. 83 percent among all adults under age 65.[82]

The *Journal of the American Medical Association* analyzed public opinion on the War on Drugs in a 1998 article. The authors' observations concerning public attitudes toward medical marijuana remain true today:

> While opposing the use or legalization of marijuana for recreational purposes, the public apparently does not want to deny very ill patients access to a potentially helpful drug therapy

[80] Tim Craig, "D.C. Council Proposes Legalization of Medical Marijuana," *Washington Post*, January 20, 2010, p. B1.

[81] The questions asked and the results obtained can be viewed at http://medicalmarijuana.procon.org/view.additional-resource.php?resourceID=151.

[82] Gary Langer, "High Support for Medical Marijuana," ABC News/Washington Post Poll, January 18, 2010.

> if prescribed by their physicians. The public's support of marijuana for medical purposes is conditioned by their belief that marijuana would be used only in the treatment of serious medical conditions.[83]

In public opinion polls, then, the majority of Americans appear to hold that seriously ill or terminal patients should be able to use marijuana if recommended by their doctors. Fourteen state governments have created medical marijuana programs, either through ballot initiatives or the legislative process. Many other state governments, however, along with the federal government, remain opposed to the national majority in favor of medical marijuana.

Analysis of Arguments For and Against Medical Marijuana

In the ongoing debate over cannabis as medicine, certain arguments are frequently made on both sides of the issue. These arguments are briefly stated below and are analyzed in turn. CRS takes no position on the claims or counterclaims in this debate.

What follows is an attempt to analyze objectively the claims frequently made about the role that herbal cannabis might or might not play in the treatment of certain diseases and about the possible societal consequences should its role in the practice of modern medicine be expanded beyond the places where it is now permitted under state laws.

For those interested in learning more about medical marijuana research findings, the Internet offers two useful websites. The International Association for Cannabis as Medicine (IACM), based in Germany, provides abundant information on the results of controlled clinical trials at http://www.cannabis-med.org. Information on peer-reviewed, double-blind studies on both animals and human subjects conducted since 1990 has been compiled by ProCon.org and is available at http://www.medicalmarijuanaprocon.org.

Marijuana Is Harmful and Has No Medical Value

> *Suitable and superior medicines are currently available for treatment of all symptoms alleged to be treatable by crude marijuana.*
> —Brief of the Drug Free America Foundation, et al., 2004[84]

The federal government—along with many state governments and private antidrug organizations—staunchly maintains that botanical marijuana is a dangerous drug without any legitimate medical use. Marijuana intoxication can impair a person's coordination and decision-making skills and alter behavior. Chronic marijuana smoking can adversely affect the lungs, the cardiovascular system, and possibly the immune and reproductive systems.[85]

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[83] Robert J. Blend on and John T. Young, "The Public and the War on Illicit Drugs," *Journal of the American Medical Association*, vol. 279, no. 11 (March 18, 1998), p. 831.

[84] Brief for the Drug Free America Foundation, Inc. et al. as Amici Curiae Supporting Petitioners at 13, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454). The amici curiae briefs filed in *Raich* contain a wealth of information and arguments on both sides of the medical marijuana debate. They are available online at http://www.angeljustice.org.

[85] See, for example, "Exposing the Myth of Medical Marijuana," on the DEA website at http://www.usdoj.gov/dea/ (continued...)

Of course, FDA's 1985 approval of Marinol proves that the principal psychoactive ingredient of marijuana—THC—has therapeutic value. But that is not the issue in the medical marijuana debate. Botanical marijuana remains a plant substance, an herb, and its opponents say it cannot substitute for legitimate pharmaceuticals. Just because certain molecules found in marijuana might have become approved medicines, they argue, does not make the unpollinated bud of the female Cannabis sativa plant a safe and effective medicine. The Drug Free America Foundation calls the medical use of crude marijuana "a step backward to the times of potions and herbal remedies."[86]

The federal government's argument that marijuana has no medical value is straightforward. A drug, in order to meet the standard of the Controlled Substances Act as having a "currently accepted medical use in treatment in the United States," must meet a five-part test:

> (1) The drug's chemistry must be known and reproducible,
> (2) there must be adequate safety studies,
> (3) there must be adequate and well-controlled studies proving efficacy,
> (4) the drug must be accepted by qualified experts, and
> (5) the scientific evidence must be widely available.[87]

According to the DEA, botanical marijuana meets none of these requirements. First, marijuana's chemistry is neither fully known nor reproducible. Second, adequate safety studies have not been done. Third, there are no adequate, well-controlled scientific studies proving marijuana is effective for any medical condition. Fourth, marijuana is not accepted by even a significant minority of experts qualified to evaluate drugs. Fifth, published scientific evidence concluding that marijuana is safe and effective for use in humans does not exist.[88]

The same DEA Final Order that set forth the five requirements for currently accepted medical use also outlined scientific evidence that would be considered irrelevant by the DEA in establishing currently accepted medical use. These include individual case reports, clinical data collected by practitioners, studies conducted by persons not qualified by scientific training and experience to evaluate the safety and effectiveness of the substance at issue, and studies or reports so lacking in detail as to preclude responsible scientific evaluation. Such information is inadequate for experts to conclude responsibly and fairly that marijuana is safe and effective for use as medicine.[89] The DEA and other federal drug control agencies can thereby disregard medical literature and opinion that claim to show the therapeutic value of marijuana because they do not meet the government's standards of proof.

The official view of medical marijuana is complicated by the wider War on Drugs. It is difficult to disentangle the medical use of locally grown marijuana for personal use from the overall policy of marijuana prohibition, as the Supreme Court made clear in *Raich*. To make an exemption for medical marijuana, the Court decided, "would undermine the orderly enforcement of the entire

(...continued)

ongoing/marijuanap.html.

[86] Ibid., at 25.

[87] This test was first formulated by the DEA in 1992 in response to a marijuana rescheduling petition. See U.S. Department of Justice, Drug Enforcement Administration, "Marijuana Scheduling Petition; Denial of Petition; Remand," 57 *Federal Register* 10499, March 26, 1992, at 10506.

[88] Ibid., p. 10507.

[89] Ibid., pp. 10506-10507.

regulatory scheme ... The notion that California law has surgically excised a discrete activity that is hermetically sealed off from the larger interstate marijuana market is a dubious proposition.... „[90]

It remains the position of the federal government, then, that the Schedule I substance marijuana is harmful—not beneficial—to human health. Its use for any reason, including medicinal, should continue to be prohibited and punished. Despite signs of a more tolerant public attitude toward medical marijuana, its therapeutic benefits, if any, will continue to be officially unacknowledged and largely unrealized in the United States so long as this position prevails at the federal level.

Marijuana Effectively Treats the Symptoms of Some Diseases

> *[I]t cannot seriously be contested that there exists a small but significant class of individuals who suffer from painful chronic, degenerative, and terminal conditions, for whom marijuana provides uniquely effective relief.*
> —Brief of the Leukemia & Lymphoma Society, et al., 2004[91]

Proponents of medical marijuana point to a large body of studies from around the world that support the therapeutic value of marijuana in treating a variety of disease-related problems, including

- relieving nausea,
- increasing appetite,
- reducing muscle spasms and spasticity,
- relieving chronic pain,
- reducing intraocular pressure, and
- relieving anxiety.[92]

Given these properties, marijuana has been used successfully to treat the debilitating symptoms of cancer and cancer chemotherapy,[93] AIDS, multiple sclerosis, epilepsy, glaucoma, anxiety, and other serious illnesses.[94] As opponents of medical marijuana assert, existing FDA-approved pharmaceuticals for these conditions are generally more effective than marijuana. Nevertheless, as the IOM Report acknowledged, the approved medicines do not work for everyone.[95] Many medical marijuana users report trying cannabis only reluctantly and as a last resort after

[90] *Gonzales* v. *Raich*, 125 S.Ct. 2195, at 2212 and 2213 (2005).

[91] Brief for the Leukemia & Lymphoma Society, et al. as Amici Curiae Supporting Respondents at 4, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[92] Ibid., at 1-2.

[93] A 1990 survey of oncologists found that 54% of those with an opinion on medical marijuana favored the controlled medical availability of marijuana and 44% had already broken the law by suggesting at least once that a patient obtain marijuana illegally. R. Doblin and M. Kleiman, "Marijuana as Antiemetic Medicine," *Journal of Clinical Oncology*, vol. 9 (1991), pp. 1314-1319.

[94] There is evidence that marijuana might also be useful in treating arthritis, migraine, menstrual cramps, alcohol and opiate addiction, and depression and other mood disorders.

[95] IOM Report, pp. 3-4: "The effects of cannabinoids on the symptoms studied are generally modest, and in most cases there are more effective medications. However, people vary in their responses to medications, and there will likely always be a subpopulation of patients who do not respond well to other medications."

exhausting all other treatment modalities. A distinct subpopulation of patients now relies on whole cannabis for a degree of relief that FDA-approved synthetic drugs do not provide.

Medical cannabis proponents claim that single-cannabinoid, synthetic pharmaceuticals like Marinol are poor substitutes for the whole marijuana plant, which contains more than 400 known chemical compounds, including about 60 active cannabinoids in addition to THC. They say that scientists are a long way from knowing for sure which ones, singly or in combination, provide which therapeutic effects. Many patients have found that they benefit more from the whole plant than from any synthetically produced chemical derivative.[96] Furthermore, the natural plant can be grown easily and inexpensively, whereas Marinol and any other cannabis-based pharmaceuticals that might be developed in the future will likely be expensive—prohibitively so for some patients.[97]

In recognition of the therapeutic benefits of botanical marijuana products, various associations of health professionals have passed resolutions in support of medical cannabis. These include the American Public Health Association, the American Nurses Association, and the California Pharmacists Association. The *New England Journal of Medicine* has editorialized in favor of patient access to marijuana.[98] Other groups, such as the American Medical Association, are more cautious. Their position is that not enough is known about botanical marijuana and that more research is needed.

The recent discovery of cannabinoid receptors in the human brain and immune system provides a biological explanation for the claimed effectiveness of marijuana in relieving multiple disease symptoms. The human body produces its own cannabis-like compounds, called endocannabinoids, that react with the body's cannabinoid receptors. Like the better known opiate receptors, the cannabinoid receptors in the brain stem and spinal cord play a role in pain control. Cannabinoid receptors, which are abundant in various parts of the human brain, also play a role in controlling the vomiting reflex, appetite, emotional responses, motor skills, and memory formation. It is the presence of these natural, endogenous cannabinoids in the human nervous and immune systems that provides the basis for the therapeutic value of marijuana and that holds the key, some scientists believe, to many promising drugs of the future.[99]

The federal government's own IND Compassionate Access Program, which has provided government-grown medical marijuana to a select group of patients since 1978, provides important evidence that marijuana has medicinal value and can be used safely. A scientist and organizer of the California medical marijuana initiative, along with two medical-doctor colleagues, has written:

> Nothing reveals the contradictions in federal policy toward marijuana more clearly than the fact that there are still eight patients in the United States who receive a tin of marijuana 'joints' (cigarettes) every month from the federal government.... These eight people can

[96] Brief for the Leukemia & Lymphoma Society et al. as Amici Curiae Supporting Respondents at 18, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[97] Marinol currently sells at retail for about $17 per pill.

[98] "Federal Foolishness and Marijuana," *New England Journal of Medicine*, vol. 336, no. 5 (January 30, 1997), pp. 366-367.

[99] For a summary of the growing body of research on endocannabinoids, see Roger A. Nicoll and Bradley N. Alger, "The Brain's Own Marijuana," Scientific American, December 2004, pp. 68-75, and Jean Marx, "Drugs Inspired by a Drug," Science, January 20, 2006, pp. 322-325.

> legally possess and use marijuana, at government expense and with government permission. Yet hundreds of thousands of other patients can be fined and jailed under federal law for doing exactly the same thing.[100]

Smoking Is an Improper Route of Drug Administration

> *Can you think of any other untested, home-made, mind-altering medicine that you self-dose, and that uses a burning carcinogen as a delivery vehicle?*
> —General Barry McCaffrey, U.S. Drug Czar, 1996-2000[101]

That medical marijuana is smoked is probably the biggest obstacle preventing its wider acceptance. Opponents of medical marijuana argue that smoking is a poor way to take a drug, that inhaling smoke is an unprecedented drug delivery system, even though many approved medications are marketed as inhalants. DEA Administrator Karen Tandy writes:

> The scientific and medical communities have determined that smoked marijuana is a health danger, not a cure. There is no medical evidence that smoking marijuana helps patients. In fact, the Food and Drug Administration (FDA) has approved no medications that are smoked, primarily because smoking is a poor way to deliver medicine. Morphine, for example has proven to be a medically valuable drug, but the FDA does not endorse smoking opium or heroin.[102]

Medical marijuana opponents argue that chronic marijuana smoking is harmful to the lungs, the cardiovascular system, and possibly the immune and reproductive systems. These claims may be overstated to help preserve marijuana prohibition. For example, neither epidemiological nor aggregate clinical data show higher rates of lung cancer in people who smoke marijuana.[103] The other alleged harms also remain unproven. Even if smoking marijuana is proven harmful, however, the immediate benefits of smoked marijuana could still outweigh the potential long-term harms—especially for terminally ill patients.[104]

The therapeutic value of *smoked* marijuana is supported by existing research and experience. For example, the following statements appeared in the American Medical Association's "Council on Scientific Affairs Report 10—Medicinal Marijuana,"[105] adopted by the AMA House of delegates on December 9, 1997:

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[100] Bill Zimmerman, *Is Marijuana the Right Medicine For You? A Factual Guide to Medical Uses of Marijuana* (Keats Publishing, New Canaan, CT: 1998), p. 25.

[101] Barry R. McCaffrey, "We're on a Perilous Path," *Newsweek*, February 3, 1997, p. 27.

[102] Karen Tandy, "Marijuana: The Myths Are Killing Us," *Police Chief Magazine*, March 2005, available at http://www.usdoj.gov/dea/pubs/pressrel/pr042605p.html.

[103] Lynn Zimmer and John P. Morgan, *Marijuana Myths Marijuana Facts* (New York: Lindesmith Center, 1997), p. 115.

[104] Medicines do not have to be completely safe to be approved. In fact, no medicine is completely safe; every drug has toxicity concerns. All pharmaceuticals have potentially harmful side effects, and it would be startling, indeed, if botanical marijuana were found to be an exception. The IOM Report states that "except for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications." (p. 5)

[105] American Medical Association, Council on Scientific Affairs Report: *Medical Marijuana (A-01)*, June 2001. An unpaginated version of this document can be found on the Web at http://www.mfiles.org/Marijuana/medicinal_use/b2_ama_csa_report.html.

- "Smoked marijuana was comparable to or more effective than oral THC [Marinol], and considerably more effective than prochlorperazine or other previous antiemetics in reducing nausea and emesis." (p. 10)
- "Anecdotal, survey, and clinical data support the view that smoked marijuana and oral THC provide symptomatic relief in some patients with spasticity associated with multiple sclerosis (MS) or trauma." (p. 13)
- "Smoked marijuana may benefit individual patients suffering from intermittent or chronic pain." (p. 15)

The IOM Report expressed concerns about smoking (p. 126): "Smoked marijuana is unlikely to be a safe medication for any chronic medical condition." Despite this concern, the IOM Report's authors were willing to recommend smoked marijuana under certain limited circumstances. For example, the report states (p. 154):

> Until the development of rapid-onset antiemetic drug delivery systems, there will likely remain a subpopulation of patients for whom standard antiemetic therapy is ineffective and who suffer from debilitating emesis. It is possible that the harmful effects of smoking marijuana for a limited period of time might be outweighed by the antiemetic benefits of marijuana, at least for patients for whom standard antiemetic therapy is ineffective and who suffer from debilitating emesis. Such patients should be evaluated on a case-by-case basis and treated under close medical supervision.

The IOM Report makes another exception for terminal cancer patients (p. 159):

> Terminal cancer patients pose different issues. For those patients the medical harm associated with smoking is of little consequence. For terminal patients suffering debilitating pain or nausea and for whom all indicated medications have failed to provide relief, the medical benefits of smoked marijuana might outweigh the harm.

Smoking can actually be a preferred drug delivery system for patients whose nausea prevents them from taking anything orally. Such patients *need* to inhale their antiemitic drug. Other patients *prefer* inhaling because the drug is absorbed much more quickly through the lungs, so that the beneficial effects of the drug are felt almost at once. This rapid onset also gives patients more control over dosage. For a certain patient subpopulation, then, these advantages of inhalation may prevail over both edible marijuana preparations and pharmaceutical drugs in pill form, such as Marinol.

Moreover, medical marijuana advocates argue that there are ways to lessen the risks of smoking. Any potential problems associated with smoking, they argue, can be reduced by using higher potency marijuana, which means that less has to be inhaled to achieve the desired therapeutic effect. Furthermore, marijuana does not have to be smoked to be used as medicine. It can be cooked in various ways and eaten.[106] Like Marinol, however, taking marijuana orally can be difficult for patients suffering from nausea. Many patients are turning to vaporizers, which offer the benefits of smoking—rapid action, ease of dose titration—without having to inhale smoke. Vaporizers are devices that take advantage of the fact that cannabinoids vaporize at a lower temperature than that required for marijuana to burn. Vaporizers heat the plant matter enough for the cannabinoids to be released as vapor without having to burn the marijuana preparation.

[106] Cannabis preparations are also used topically as oils and balms to soothe muscles, tendons, and joints.

Patients can thereby inhale the beneficial cannabinoids without also having to inhale the potentially harmful by-products of marijuana combustion.[107]

Marijuana Should Be Rescheduled To Permit Medical Use

> *[T]he administrative law judge concludes that the provisions of the [Controlled Substances] Act permit and require the transfer of marijuana from Schedule I to Schedule II. The Judge realizes that strong emotions are aroused on both sides of any discussion concerning the use of marijuana. Nonetheless it is essential for this Agency [DEA], and its Administrator, calmly and dispassionately to review the evidence of record, correctly apply the law, and act accordingly.*
> —Francis L. Young, DEA Administrative Law Judge, 1988[108]

Proponents of medical marijuana believe its placement in Schedule I of the CSA was an error from the beginning. Cannabis is one of the safest therapeutically active substances known.[109] No one has ever died of an overdose.[110] Petitions to reschedule marijuana have been received by the federal government, and rejected, ever since the original passage of the Controlled Substances Act in 1970.

Rescheduling can be accomplished administratively or it can be done by an act of Congress. Administratively, the federal Department of Health and Human Services (HHS) could find that marijuana meets sufficient standards of safety and efficacy to warrant rescheduling. Even though THC, the most prevalent cannabinoid in marijuana, was administratively moved to Schedule III in 1999, no signs exist that botanical marijuana will similarly be rescheduled by federal agency ruling anytime soon.

An act of Congress to reschedule marijuana is only slightly less likely, although such legislation has been introduced in recent Congresses including the 111th.[111] The Medical Marijuana Patient Protection Act (H.R. 2835/Frank), which would move marijuana from Schedule I to Schedule II of the Controlled Substances Act, has seen no action beyond committee referral.[112]

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[107] Several companies offer vaporizers for sale in the United States, but their marketing is complicated by marijuana prohibition and by laws prohibiting drug paraphernalia. The advantages of the vaporizer were brought to the attention of the IOM panel. The IOM Report, however, devoted only one sentence to such devices, despite its recommendation for research into safe delivery systems. The IOM Report said, "Vaporization devices that permit inhalation of plant cannabinoids without the carcinogenic combustion products found in smoke are under development by several groups; such devices would also require regulatory review by the FDA." (p. 216)

[108] U.S. Dept. of Justice, Drug Enforcement Administration, "In the Matter of Marijuana Rescheduling Petition, Docket No. 86-22, Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law and Decision of Administrative Law Judge," Francis L. Young, Administrative Law Judge, September 6, 1988, p. 67. This opinion is online at http://www.druglibrary.net/olsen/MEDICAL/YOUNG/young.html.

[109] Ibid., pp. 58-59.

[110] Ibid., p. 56.

[111] When Congress directly schedules a drug, as it did marijuana in 1970, it is not bound by the criteria in section 202(b) of the CSA (21 U.S.C. 812(b)).

[112] Congress could also follow the lead of some states that have a dual scheduling scheme for botanical marijuana whereby its recreational use is prohibited (Schedule I) but it is permitted when used for medicinal purposes (Schedules II or III). Congress could achieve the same effect by leaving marijuana in Schedule I but removing criminal penalties for the medical use of marijuana, commonly called *decriminalization*. Congress could also opt for *legalization* by removing marijuana from the CSA entirely and subjecting it to federal and state controls based on the tobacco or alcohol regulatory models or by devising a regulatory scheme unique to marijuana. None of these options seem likely (continued...)

Schedule II substances have a high potential for abuse and may lead to severe psychological or physical dependence but have a currently accepted medical use in treatment in the United States. Cocaine, methamphetamine, morphine, and methadone are classified as Schedule II substances. Many drug policy experts and laypersons alike believe that marijuana should also reside in Schedule II.

Others think marijuana should be properly classified as a Schedule III substance, along with THC and its synthetic version, Marinol. Substances in Schedule III have less potential for abuse than the drugs in Schedules I and II, their abuse may lead to moderate or low physical dependence or high psychological dependence, and they have a currently accepted medical use in treatment in the United States.

Rescheduling seems to be supported by public opinion. A nationwide Gallup Poll conducted in March 1999 found that 73% of American adults favored "making marijuana legally available for doctors to prescribe in order to reduce pain and suffering." An AARP poll of American adults age 45 and older conducted in mid-November 2004 found that 72% agreed that adults should be allowed to legally use marijuana for medical purposes if recommended by a physician. A January 2010 ABC News/Washington Post poll found that more than 8 in 10 Americans (81%) supported efforts to make marijuana legal for medical use.[113]

Few Members of Congress, however, publicly support the rescheduling option. The Medical Marijuana Patient Protection Act (H.R. 2835), which would move marijuana from Schedule I to Schedule II of the Controlled Substances Act, as mentioned above, currently has 30 cosponsors.

State Medical Marijuana Laws Increase Illicit Drug Use

> *The natural extension of this myth [that marijuana is good medicine] is that, if marijuana is medicine, it must also be safe for recreational use.*
> —Karen P. Tandy, DEA Administrator, 2005[114]

It is the position of the federal government that to permit the use of medical marijuana affords the drug a degree of legitimacy it does not deserve. America's youth are especially vulnerable, it is said, and state medical marijuana programs send the wrong message to our youth, many of whom do not recognize the very real dangers of marijuana.

Studies show that the use of an illicit drug is inversely proportional to the perceived harm of that drug. That is, the more harmful a drug is perceived to be, the fewer the number of people who will try it.[115] Opponents of medical marijuana argue that "surveys show that perception of harm

(...continued)

given the current political climate in which both political parties support continued marijuana prohibition.

[113] These and other poll results can be consulted at http://medicalmarijuana.procon.org/view.resource.php?resourceID=000148. This website states: "Because the majority (98% or more) of the voter initiatives and polls we located were favorable towards the medical use of marijuana, we contacted several organizations decidedly 'con' to medical marijuana—two of which were federal government agencies—and none knew of any voter initiatives or polls that were 'con' to medical marijuana."

[114] Karen Tandy, "Marijuana: The Myths Are Killing Us," *Police Chief Magazine*, March 2005, available at http://www.usdoj.gov/dea/pubs/pressrel/pr042605p.html.

[115] See, for example, J.G. Bachman et al., "Explaining Recent Increases in Students' Marijuana Use: Impacts of Perceived Risks and Disapproval, 1976 through 1996," *American Journal of Public Health*, vol. 88 (1998), pp. 887-
(continued...)

with respect to marijuana has been dropping off annually since the renewal of the drive to legalize marijuana as medicine, which began in the early 1990s when legalization advocates first gained a significant increase in funding and began planning the state ballot initiative drive to legalize crude marijuana as medicine."[116] They point to the 1999 National Household Survey on Drug Abuse (NHSDA), which "reveals that those states which have passed medical marijuana laws have among the highest levels of past-month marijuana use, of past-month other drug use, of drug addiction, and of drug and alcohol addiction."[117]

Indeed, all 11 states that have passed medical marijuana laws ranked above the national average in the percentage of persons 12 or older reporting past-month use of marijuana in 1999, as shown in **Table 2**. It is at least possible, however, that this analysis confuses cause with effect. It is logical to assume that the states with the highest prevalence of marijuana usage would be more likely to approve medical marijuana programs, because the populations of those states would be more knowledgeable of marijuana's effects and more tolerant of its use.

It is also the case that California, the state with the largest and longest-running medical marijuana program, ranked 34th in the percentage of persons age 12-17 reporting marijuana use in the past month during the period 2002-2003, as shown in **Table 1**. In fact, between 1999 and 2002-2003, of the 10 states with active medical marijuana programs, five states (AK, HI, ME, MT, VT) rose in the state rankings of past-month marijuana use by 12- to 17-year-olds and five states fell (CA, CO, NV, OR, WA).[118] Of the five states that had approved medical marijuana laws before 1999 (AK, AZ, CA, OR, WA), only Alaska's ranking rose between 1999 and 2002-2003, from 7th to 4th, with 11.08% of youth reporting past-month marijuana use in 2002-2003 compared with 10.4% in 1999. No clear patterns are apparent in the state-level data. Clearly, more important factors are at work in determining a state's prevalence of recreational marijuana use than whether the state has a medical marijuana program.

The IOM Report found no evidence for the supposition that state medical marijuana programs lead to increased use of marijuana or other drugs (pp. 6-7):

> Finally, there is a broad social concern that sanctioning the medical use of marijuana might increase its use among the general population. At this point there are no convincing data to support this concern. The existing data are consistent with the idea that this would not be a problem if the medical use of marijuana were as closely regulated as other medications with abuse potential.... [T]his question is beyond the issues normally considered for medical uses of drugs and should not be a factor in evaluating the therapeutic potential of marijuana or cannabinoids.

(...continued)

892.

[116] Brief for the Drug Free America Foundation, Inc. et al. as Amici Curiae Supporting Petitioners at 26, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[117] Ibid., at 27. The 1999 NHSDA was the first to include state-level estimates for various measures of drug use. Unfortunately, comprehensive state-level data prior to 1999 are not available from other sources.

[118] Care should be taken in comparing NHSDA data for 1999 with NSDUH data for 2002 and after, due to changes in survey methodology made in 2002. The trend observations drawn here from these data should therefore be considered suggestive rather than definitive.

Table 1. States Ranked by Percentage of Youth Age 12-17 Reporting Past-Month Marijuana Use, 1999 and 2002-2003

1999			2002-2003		
Rank	**State**	**%**	**Rank**	**State**	**%**
1	Delaware	13.9	1	**Vermont**	13.32
2	Massachusetts	11.9	2	**Montana**	12.07
3	**Nevada**	11.6	3	New Hampshire	11.79
4	**Montana**	11.4	4	**Alaska**	11.08
5	Rhode Island	10.8	5	Rhode Island	10.86
6	New Hampshire	10.7	6	**Maine**	10.56
7	**Alaska**	10.4	7	Massachusetts	10.53
8	**Colorado**	10.3	8	New Mexico	10.35
9	Minnesota	9.9	9	**Hawaii**	10.23
9	**Washington**	9.9	10	**Colorado**	9.82
11	**Oregon**	9.6	11	**Nevada**	9.58
	District of Columbia	9.6	12	South Dakota	9.57
12	Illinois	9.2	13	Delaware	9.41
12	New Mexico	9.2	14	**Oregon**	9.31
14	Maryland	8.8	15	Michigan	9.23
15	Indiana	8.7	16	Connecticut	9.22
16	Connecticut	8.6	17	Nebraska	9.13
17	**Vermont**	8.4	18	**Washington**	9.11
18	**Hawaii**	8.3	19	Minnesota	8.92
18	Wisconsin	8.3	20	New York	8.76
20	Michigan	7.8	21	Ohio	8.74
20	Wyoming	7.8	22	West Virginia	8.62
22	**California**	7.7	23	Florida	8.52
23	North Dakota	7.6	24	North Carolina	8.44
	National	7.4	25	Virginia	8.43
24	South Carolina	7.4	26	Pennsylvania	8.18
27	**Arizona**	7.3	27	Kentucky	8.16
27	Arkansas	7.3	28	Oklahoma	8.13
27	New Jersey	7.3		*National*	8.03
28	**Maine**	7.2	29	Arkansas	7.97
29	West Virginia	7.1	30	Idaho	7.92
31	Ohio	6.9	31	Maryland	7.87
31	South Dakota	6.9	32	**Arizona**	7.74
33	New York	6.8	33	Wisconsin	7.71
33	North Carolina	6.8	34	**California**	7.66
34	Mississippi	6.7	35	Illinois	7.61
37	Kansas	6.6	36	North Dakota	7.58
37	Louisiana	6.6	37	Missouri	7.43
37	Missouri	6.6		District of Columbia	7.43
38	Georgia	6.4	38	Kansas	7.39
40	Oklahoma	6.3	39	Indiana	7.37
40	Pennsylvania	6.3	40	New Jersey	7.33
41	Florida	6.2	41	South Carolina	7.25

1999			2002-2003		
Rank	**State**	**%**	**Rank**	**State**	**%**
43	Nebraska	6.1	42	Wyoming	7.14
43	Utah	6.1	43	Iowa	7.10
45	Idaho	5.9	44	Louisiana	6.92
45	Virginia	5.9	45	Georgia	6.87
46	Texas	5.7	46	Texas	6.38
47	Alabama	5.6	47	Alabama	6.37
48	Kentucky	5.3	47	Tennessee	6.37
50	Iowa	5.2	49	Mississippi	6.04
50	Tennessee	5.2	50	Utah	5.30

Sources: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse, 1999, Table 3B, at http://www.oas.samhsa.gov/ NHSDA/99StateTabs/tables2.htm. Rankings calculated by CRS. SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003, Table B.3, at http://www.oas.samhsa.gov/2k3State/appB.htm#tabB.3. Rankings calculated by CRS.

Table 2. States Ranked by Percentage of Persons 12 or Older Reporting Past-Month Marijuana Use, 1999 and 2003-2004

1999			2003-2004		
Rank	**State**	**%**	**Rank**	**State**	**%**
1	Maryland	7.9	1	New Hampshire	10.23
2	**Colorado**	7.7	2	**Alaska**	9.78
3	Massachusetts	7.5	3	**Vermont**	9.77
4	Rhode Island	7.4		District of Columbia	9.60
5	**Alaska**	7.1	4	Rhode Island	9.56
	District of Columbia	7.1	5	**Montana**	9.17
6	**Washington**	6.8	6	**Oregon**	8.88
7	**Oregon**	6.6	7	**Colorado**	8.49
8	Delaware	6.5	8	**Maine**	7.95
8	New Mexico	6.5	9	Massachusetts	7.80
10	**California**	6.0	10	**Nevada**	7.62
11	**Montana**	5.9	11	**Washington**	7.41
11	New Hampshire	5.9	12	New Mexico	7.37
13	**Hawaii**	5.8	13	New York	7.34
13	**Maine**	5.8	14	Michigan	7.20
15	**Nevada**	5.6	15	**Hawaii**	6.95
15	Wyoming	5.6	16	Connecticut	9.94
17	**Vermont**	5.4	17	Delaware	6.89
18	Michigan	5.3	18	Missouri	6.76
18	Minnesota	5.3	19	Florida	6.58
20	**Arizona**	5.2	20	**California**	6.50
21	Wisconsin	5.1	21	Ohio	6.49
22	Connecticut	5.0	22	Minnesota	6.37
22	Florida	5.0		*National*	6.18
22	New Jersey	5.0	23	Indiana	6.12
25	New York	4.9	24	Nebraska	5.97

1999			2003-2004		
Rank	**State**	**%**	**Rank**	**State**	**%**
25	Utah	4.9	25	Virginia	5.96
	National	4.9	26	North Carolina	5.89
27	Illinois	4.8	27	Louisiana	5.77
29	Missouri	4.7	28	Maryland	5.73
29	North Carolina	4.7	29	**Arizona**	5.68
30	Indiana	4.6	30	South Carolina	5.65
31	Pennsylvania	4.5	31	Pennsylvania	5.64
32	Ohio	4.3	32	Arkansas	5.63
34	Georgia	4.2	33	Kentucky	5.62
34	Idaho	4.2	34	Illinois	5.60
35	South Dakota	4.1	35	Oklahoma	5.58
36	Virginia	4.0	36	Wyoming	5.45
38	Nebraska	3.9	37	Wisconsin	5.40
38	North Dakota	3.9	38	North Dakota	5.35
39	South Carolina	3.8	39	South Dakota	5.24
40	Kansas	3.7	40	West Virginia	5.12
43	Kentucky	3.6	41	Idaho	5.09
43	Tennessee	3.6	42	New Jersey	5.05
43	West Virginia	3.6	43	Georgia	4.93
47	Arkansas	3.5	44	Kansas	4.91
47	Louisiana	3.5	45	Iowa	4.90
47	Oklahoma	3.5	46	Texas	4.79
47	Texas	3.5	47	Mississippi	4.64
50	Alabama	3.3	48	Tennessee	4.59
50	Iowa	3.3	49	Alabama	4.32
50	Mississippi	3.3	50	Utah	4.00

Sources: SAMHSA, Office of Applied Studies, National Household Survey on Drug Abuse, 1999, Table 3B, at http://www.oas.samhsa.gov/NHSDA/99StateTabs/tables2.htm. Rankings calculated by CRS. SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002 and 2003, Table B.3, at http://www.oas.samhsa.gov/2k3State/appB.htm#tabB.3. Rankings calculated by CRS.

The IOM Report further states (p. 126):

> Even if there were evidence that the medical use of marijuana would decrease the perception that it can be a harmful substance, this is beyond the scope of laws regulating the approval of therapeutic drugs. Those laws concern scientific data related to the safety and efficacy of drugs for individual use; they do not address perceptions or beliefs of the general population.

The IOM Report also found (p. 102): "No evidence suggests that the use of opiates or cocaine for medical purposes has increased the perception that their illicit use is safe or acceptable." Doctors can prescribe cocaine, morphine, amphetamine, and methamphetamine, but this is not seen as weakening the War on Drugs. Why would doctors recommending medical marijuana to their patients be any different?

The so-called "Gateway Theory" of marijuana use is also cited to explain how medical marijuana could increase illicit drug use. With respect to the rationale behind the argument that marijuana serves as a "gateway" drug, the IOM Report offered the following (p. 6):

> In the sense that marijuana use typically precedes rather than follows initiation of other illicit drug use, it is indeed a "gateway" drug. But because underage smoking and alcohol use typically precede marijuana use, marijuana is not the most common, and is rarely the first, "gateway" to illicit drug use. There is no conclusive evidence that the drug effects of marijuana are causally linked to the subsequent abuse of other illicit drugs.

A statistical analysis of marijuana use by emergency room patients and arrestees in four states with medical marijuana programs—California, Colorado, Oregon, and Washington—found no statistically significant increase in recreational marijuana use among these two population subgroups after medical marijuana was approved for use.[119] Another study looked at adolescent marijuana use and found decreases in youth usage in every state with a medical marijuana law. Declines exceeding 50% were found in some age groups.[120]

These studies are consistent with the findings of a 2002 report by the Government Accountability Office that concluded that state medical marijuana laws were operating as voters and legislators intended and did not encourage drug use among the wider population.[121] Concerns that medical cannabis laws send the wrong message to vulnerable groups such as adolescents seem to be unfounded.

Medical Marijuana Undermines the War on Drugs

> *The DEA and its local and state counterparts routinely report that large-scale drug traffickers hide behind and invoke Proposition 215, even when there is no evidence of any medical claim. In fact, many large-scale marijuana cultivators and traffickers escape state prosecution because of bogus medical marijuana claims. Prosecutors are reluctant to charge these individuals because of the state of confusion that exists in California. Therefore, high-level traffickers posing as 'care-givers' are able to sell illegal drugs with impunity.*
> —"California Medical Marijuana Information," DEA Web page[122]

It is argued by many that state medical marijuana laws weaken the fight against drug abuse by making the work of police officers more difficult. This undermining of law enforcement can occur in at least three ways: by diverting medical marijuana into the recreational drug market, by causing state and local law enforcement priorities to diverge from federal priorities, and by complicating the job of law enforcement by forcing officers to distinguish medical users from recreational users.

Diversion

Marijuana grown for medical purposes, according to DEA and other federal drug control agencies, can be diverted into the larger, illegal marijuana market, thereby undermining law

[119] Dennis M. Gorman and J. Charles Huber, Jr., "Do Medical Cannabis Laws Encourage Cannabis Use?" *International Journal of Drug Policy*, vol. 18, no. 3 (May 2007), pp. 160-167.

[120] Karen O'Keefe, et al., "Marijuana Use by Young People: The Impact of State Medical Marijuana Laws," updated June 2008, available at http://www.mpp.org/research/teen-use-report.html. (New Mexico was excluded from the study because it passed its law too recently.)

[121] U.S. General Accounting Office, *Marijuana: Early Experiences with Four States' Laws That Allow Use for Medical Purposes*, GAO-03-189, November 2002.

[122] Available at http://www.usdoj.gov/dea/ongoing/calimarijuanap.html.

enforcement efforts to eliminate the marijuana market altogether. This point was emphasized by the Department of Justice (DOJ) in its prepublication review of a report by the Government Accountability Office (GAO) on medical marijuana. DOJ criticized the GAO draft report on the grounds that the "report did not mention that state medical marijuana laws are routinely abused to facilitate traditional illegal trafficking."[123]

GAO responded that in their interviews with federal officials regarding the impact of state medical marijuana laws on their law enforcement efforts, "none of the federal officials we spoke with provided information that abuse of medical marijuana laws was routinely occurring in any of the states, including California."[124] The government also failed to establish this in the *Raich* case. (It is of course possible that significant diversion is taking place yet remains undetected.)

Just as with many pharmaceuticals, some diversion is inevitable. Some would view this as an acceptable cost of implementing a medical marijuana program. Every public policy has its costs and benefits. Depriving seriously ill patients of their medical marijuana is seen by some as a small price to pay if doing so will help to protect America's youth from marijuana. Others balance the harms and benefits of medical marijuana in the opposite direction. Legal analyst Stuart Taylor Jr. recently wrote, "As a matter of policy, Congress as well as the states should legalize medical marijuana, with strict regulatory controls. The proven benefits to some suffering patients outweigh the potential costs of marijuana being diverted to illicit uses."[125]

Changed State and Local Law Enforcement Priorities

Following the passage of the California and Arizona medical marijuana initiatives in 1996, federal officials expressed concern that the measures would seriously affect the federal government's drug enforcement effort because federal drug policies rely heavily on the state's enforcement of their own drug laws to achieve federal objectives. For instance, in hearings before the Senate Judiciary Committee, the head of the Drug Enforcement Administration stated:

> I have always felt ... that the federalization of crime is very difficult to carry out; that crime, just in essence, is for the most part a local problem and addressed very well locally, in my experience. We now have a situation where local law enforcement is unsure.... The numbers of investigations that you would talk about that might be presently being conducted by the [Arizona state police] at the gram level would be beyond our capacity to conduct those types of individual investigations without abandoning the major organized crime investigations.[126]

State medical marijuana laws arguably feed into the deprioritization movement, by which drug reform advocates seek to influence state and local law enforcement to give a low priority to the enforcement of marijuana laws. This movement to make simple marijuana possession the lowest law enforcement priority has made inroads in such cities as San Francisco, Seattle, and Oakland, but it extends beyond the medical marijuana states to college towns such as Ann Arbor, MI,

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[123] U.S. General Accounting Office, *Marijuana: Early Experiences with Four States' Laws That Allow Use for Medical Purposes*, GAO-03-189, November 2002, p. 36.

[124] Ibid., p. 37.

[125] Stuart Taylor, Jr., "Liberal Drug Warriors! Conservative Pot-Coddlers!," *National Journal*, June 11, 2005, p. 1738.

[126] Testimony of Thomas A. Constantine in U.S. Congress, Senate Committee on the Judiciary, *Prescription for Addiction? The Arizona and California Medical Drug Use Initiatives*, hearing, 104th Cong., 2nd sess., December 2, 1996 (Washington: GPO, 1997), pp. 42-43, 45.

Madison, WI, Columbia, MO, and Lawrence, KS.[127] Federal officials fear that jurisdictions that "opt out" of marijuana enforcement "will quickly become a haven for drug traffickers."[128]

Distinguishing Between Legal and Illegal Providers and Users

Police officers in medical marijuana states have complained about the difficulty of distinguishing between legitimate patients and recreational marijuana smokers. According to the DEA:

> Local and state law enforcement counterparts cannot distinguish between illegal marijuana grows and grows that qualify as medical exemptions. Many self-designated medical marijuana growers are, in fact, growing marijuana for illegal, "recreational" use.[129]

This reasoning is echoed in the *Raich* amici brief of Community Rights Counsel (p. 12):

> Creating an exception for medical use [of marijuana] could undermine enforcement efforts by imposing an often difficult burden on prosecutors of establishing the violator's subjective motivation and intent beyond a reasonable doubt. Given that marijuana used in response to medical ailments is not readily distinguishable from marijuana used for other reasons, Congress rationally concluded that the control of all use is necessary to address the national market for controlled substances.

Patients and caregivers, on the other hand, have complained that their marijuana that is lawful under state statute has been seized by police and not returned. In some cases, patients and caregivers have been unexpectedly arrested by state or local police officers. A November 2002 GAO report on medical marijuana stated that "Several law enforcement officials in California and Oregon cited the inconsistency between federal and state law as a significant problem, particularly regarding how seized marijuana is handled."[130]

The failure of state and local law enforcement officers to observe state medical marijuana laws has especially been a problem in California. The California Highway Patrol (CHP) has, on numerous occasions, arrested patients or confiscated their medical marijuana during routine traffic stops. "Although voters legalized medical marijuana in California nearly nine years ago," reports the *Los Angeles Times*, "police statewide have wrangled with activists over how to enforce the law."[131]

As a result of a lawsuit brought against the CHP by a patient advocacy group, CHP officers will no longer seize patients' marijuana as long as they possess no more than 8 ounces and can show a certified-user identification card or their physician's written recommendation. The CHP's new

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[127] "Marijuana: Lawrence, Kansas, Ponders City Marijuana Ordinance—Impact of HEA Cited," available at http://stopthedrugwar.org/chronicle/401/lawrence.shtml.

[128] Brief for U.S. Representative Mark E. Souder et al. as Amici Curiae Supporting Petitioners at 20, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[129] "California Medical Marijuana Information," available on DEA's website at http://www.usdoj.gov/dea/ongoing/calimarijuanap.html.

[130] U.S. General Accounting Office, *Marijuana: Early Experiences with Four States' Laws That Allow Use for Medical Purposes*, GAO-03-189, November 2002, p. 64. GAO interviewed 37 law enforcement agencies and found that the majority indicated that "medical-marijuana laws had not greatly affected their law enforcement activities." (p. 4)

[131] Eric Bailey, "CHP Revises Policy on Pot Seizures," *Los Angeles Times* (national edition), August 28, 2005, p. A12.

policy, announced in August 2005, will likely influence the behavior of other California law enforcement agencies.

The Committee on Drugs and the Law of the Bar of the City of New York concluded its 1997 report "Marijuana Should be Medically Available" with this statement: "The government can effectively differentiate medical marijuana and recreational marijuana, as it has done with cocaine. The image of the Federal authorities suppressing a valuable medicine to maintain the rationale of the war on drugs only serves to discredit the government's effort."[132]

Patients Should Not Be Arrested for Using Medical Marijuana

> *Centuries of Anglo-American law stand against the imposition of criminal liability on individuals for pursuing their own lifesaving pain relief and treatment.... Because the experience of pain can be so subversive of dignity—and even of the will to live—ethics and legal tradition recognize that individuals pursuing pain relief have special claims to non-interference.*
> —Brief of the Leukemia & Lymphoma Society, et al., 2004[133]

Medical marijuana advocates believe that seriously ill people should not be punished for acting in accordance with the opinion of their physicians in a bona fide attempt to relieve their suffering, especially when acting in accordance with state law. Even if marijuana were proven to be more harmful than now appears, prison for severely ill patients is believed to be a worse alternative. Patients have enough problems without having to fear the emotional and financial cost of arrest, legal fees, prosecution, and a possible prison sentence.

The American public appears to agree. The Institute of Medicine found that "public support for patient access to marijuana for medical use appears substantial; public opinion polls taken during 1997 and 1998 generally reported 60-70 percent of respondents in favor of allowing medical uses of marijuana."[134]

The federal penalty for possessing one marijuana cigarette—even for medical use—is up to one year in prison and up to a $100,000 fine,[135] and the penalty for growing a cannabis plant is up to five years and up to a $250,000 fine.[136] That patients are willing to risk these severe penalties to obtain the relief that marijuana provides appears to present strong evidence for the substance's therapeutic effectiveness.

Although the Supreme Court ruled differently in *Raich*, the argument persists that medical marijuana providers and patients are engaging in a class of activity totally different from those persons trafficking in marijuana for recreational use and that patients should not be arrested for using medical marijuana in accordance with the laws of the states in which they reside.

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[132] Committee on Drugs and the Law, "Marijuana Should be Medically Available," *Record of the Association of the Bar of the City of New York*, vol. 52, no. 2 (March 1997), p. 238.

[133] Brief for the Leukemia & Lymphoma Society et al. as Amici Curiae Supporting Respondents at 1,2, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[134] IOM Report, p. 18.

[135] 21 U.S.C. §844 and 18 U.S.C. §3571. 21 U.S.C. §844 also calls for a minimum fine of $1,000, and 21 U.S.C. §844a permits a civil penalty of up to $10,000.

[136] 21 U.S.C. §841(b)(1)(D).

With its position affirmed by *Raich*, however, DEA continues to investigate—and sometimes raid and shut down—medical marijuana distribution operations in California and other medical marijuana states. DEA's position is that:

> [F]ederal law does not distinguish between crimes involving marijuana for claimed "medical" purposes and crimes involving marijuana for any other purpose. DEA likewise does not so distinguish in carrying out its duty to enforce the CSA and investigate possible violations of the Act. Rather, consistent with the agency's mandate, DEA focuses on large-scale trafficking organizations and other criminal enterprises that warrant federal scrutiny. If investigating CSA violations in this manner leads the agency to encounter persons engaged in criminal activities involving marijuana, DEA does not alter its approach if such persons claim at some point their crimes are "medically" justified. To do so would be to give legal effect to an excuse considered by the text of federal law and the United States Supreme Court to be of no moment.[137]

Because nearly all arrests and prosecutions for marijuana possession are handled by state and local law enforcement officers, patients and caregivers in the medical marijuana states can, as a practical matter, possess medical marijuana without fear of arrest and imprisonment. DEA enforcement actions against medical marijuana dispensaries—as occurred in San Francisco shortly after the *Raich* decision was announced[138]—can, however, make it more difficult for patients to obtain the drug. The situation that Grinspoon and Bakalar described in 1995 in the *Journal of the American Medical Association* persists a decade later: "At present, the greatest danger in medical use of marihuana is its illegality, which imposes much anxiety and expense on suffering people, forces them to bargain with illicit drug dealers, and exposes them to the threat of criminal prosecution."[139]

The States Should Be Allowed to Experiment

> *Doctors, not the federal government, know what's best for their patients. If a state decides to allow doctors to recommend proven treatments for their patients, then the federal government has no rightful place in the doctor's office.*
> —Attorney Randy Barnett, 2004[140]

Three States—California, Maryland, and Washington—filed an amici curiae brief supporting the right of states to institute medical marijuana programs. Their brief argued, "In our federal system States often serve as democracy's laboratories, trying out new, or innovative solutions to society's ills."[141]

The *Raich* case shows that the federal government has zero tolerance for state medical marijuana programs. The Bush Administration appealed the decision of the Ninth Circuit Court of Appeals

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[137] Communication from DEA Congressional Affairs to author dated September 27, 2005.

[138] Stacy Finz, "19 Named in Medicinal Pot Indictment, More than 9,300 Plants Were Seized in Raids," *San Francisco Chronicle*, June 24, 2005, p. B4.

[139] Lester Grinspoon and James B. Bakalar, "Marihuana as Medicine: A Plea for Reconsideration," *Journal of the American Medical Association*, vol. 273, no. 23 (June 21, 1995), p. 1876.

[140] Angel Wings Patient OutReach press release, November 29, 2004. Barnett represented Raich et al. in Supreme Court oral argument on this date.

[141] Brief for the States of California, Maryland, and Washington et al. as Amici Curiae Supporting Respondents at 3, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

to the Supreme Court, which reversed the Ninth Circuit and upheld the federal position against the states. Framed as a Commerce Clause issue, the case became a battle for states' rights against the federal government.

The *Raich* case created unusual political alliances. Three southern states that are strongly opposed to any marijuana use, medical or otherwise—Alabama, Louisiana, and Mississippi—filed an amici curiae brief supporting California's medical marijuana users on the grounds of states' rights. Their brief argued

> As Justice Brandeis famously remarked, "[i]t is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."[142] Whether California and the other compassionate-use States are "courageous—or instead profoundly misguided—is not the point. The point is that, as a sovereign member of the federal union, California is entitled to make for itself the tough policy choices that affect its citizens.[143]

States' rights advocates argue that authority to define criminal law and the power to make and enforce laws protecting the health, safety, welfare, and morals reside at the state level and that a state has the right to set these policies free of congressional interference.

For Justice O'Connor, the *Raich* case exemplified "the role of States as laboratories."[144] She wrote in her dissenting opinion:

> If I were a California citizen, I would not have voted for the medical marijuana ballot initiative; if I were a California legislator I would not have supported the Compassionate Use Act. But whatever the wisdom of California's experiment with medical marijuana, the federalism principles that have driven our Commerce Clause cases require that room for experiment be protected in this case.[145]

Medical Marijuana Laws Harm the Drug Approval Process

> *The current efforts to gain legal status of marijuana through ballot initiatives seriously threaten the Food and Drug Administration statutorily authorized process of proving safety and efficacy.*
> —Brief of the Drug Free America Foundation, et al., 2004[146]

Although the individual states regulate the practice of medicine, the federal government has taken primary responsibility for the regulation of medical products, especially those containing controlled substances. Pharmaceutical drugs must be approved for use in the United States by the Food and Drug Administration, an agency of the Department of Health and Human Services. The Federal Food, Drug, and Cosmetics Act gives HHS and FDA the responsibility for determining

[142] *New State Ice Co.* v. *Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

[143] Brief for the States of Alabama, Louisiana, and Mississippi et al. as Amici Curiae Supporting Respondents at 3, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[144] *Gonzales* v. *Raich*, 125 S.Ct. 2195, 2220 (2005) (O'Connor, J., dissenting).

[145] Ibid. at 2229.

[146] Brief for the Drug Free America Foundation, Inc. et al. as Amici Curiae Supporting Petitioners at 12, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

that drugs are safe and effective, a requirement that all medicines must meet before they can enter interstate commerce and be made available for general medical use.[147] Clinical evaluation is required regardless of whether the drug is synthetically produced or originates from a natural botanical or animal source.

Opponents of medical marijuana say that the FDA's drug approval process should not be circumvented. To permit states to decide which medical products can be made available for therapeutic use, they say, would undercut this regulatory system. State medical marijuana initiatives are seen as inconsistent with the federal government's responsibility to protect the public from unsafe, ineffective drugs.

The Bush Administration argued in its brief in the *Raich* case that "excepting drug activity for personal use or free distribution from the sweep of [federal drug laws] would discourage the consumption of lawful controlled substances and would undermine Congress's intent to regulate the drug market comprehensively to protect public health and safety."[148]

Three prominent drug abuse experts argued in their amici brief:

> This action by the state of California did not create a "novel social and economic experiment," but rather chaos in the scientific and medical communities. Furthermore, under Court of Appeals ruling, such informal State systems could be replicated, and even expanded, in a manner that puts at risk the critical protections so carefully crafted under the national food and drug legislation of the 20th century.[149]

The Food and Drug Administration itself has stated that

> FDA is the sole Federal agency that approves drug products as safe and effective for intended indications.... FDA's drug approval process requires well-controlled clinical trials that provide the necessary scientific data upon which FDA makes its approval and labeling decisions.... Efforts that seek to bypass the FDA drug approval process would not serve the interests of public health because they might expose patients to unsafe and ineffective drug products. FDA has not approved smoked marijuana for any condition or disease indication.[150]

The Drug Free America *Raich* brief elaborates further (pp. 12-13):

> The ballot initiative-led laws create an atmosphere of medicine by popular vote, rather than the rigorous scientific and medical process that all medicines must undergo. Before the development of modern pharmaceutical science, the field of medicine was fraught with potions and herbal remedies. Many of those were absolutely useless, or conversely were harmful to unsuspecting subjects. Thus evolved our current Food and Drug Administration and drug scheduling processes, which Congress has authorized in order to create a uniform and reliable system of drug approval and regulation. This system is being intentionally undermined by the legalization proponents through use of medical marijuana initiatives.

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[147] 21 U.S.C. §351-360

[148] Brief for Petitioners at 11, Gonzales v. Raich, 125 S.Ct. 2195 (2002) (No. 03-1454).

[149] Brief for Robert L. DuPont, M.D. et al. as Amici Curiae Supporting Petitioners at 19, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[150] U.S. Food and Drug Administration, "Inter-Agency Advisory Regarding Claims That Smoked Marijuana Is a Medicine," press release, April 20, 2006, p. 1.

The organizers of the medical marijuana state initiatives deny that it was their intent to undermine the federal drug approval process. Rather, in their view, it became necessary for them to *bypass* the FDA and go to the states because of the federal government's resistance to marijuana research requests and rescheduling petitions.

As for the charge that politics should not play a role in the drug approval and controlled substance scheduling processes, medical marijuana supporters point out that marijuana's original listing as a Schedule I substance in 1970 was itself a political act on the part of Congress.

Scientists on both sides of the issue say more research needs to be done, yet some researchers charge that the federal government has all but shut down marijuana clinical trials for reasons based on politics and ideology rather than science.[151]

In any case, as the IOM Report pointed out, "although a drug is normally approved for medical use only on proof of its 'safety and efficacy,' patients with life-threatening conditions are sometimes (under protocols for 'compassionate use') allowed access to unapproved drugs whose benefits and risks are uncertain."[152] This was the case with the FDA's IND Compassionate Access Program under which a limited number of patients are provided government-grown medical marijuana to treat their serious medical conditions.

Some observers believe the pharmaceutical industry and some politicians oppose medical marijuana to protect pharmaceutical industry profits. Because the whole marijuana plant cannot be patented, research efforts must be focused on the development of *synthetic* cannabinoids such as Marinol. But even if additional cannabinoid drugs are developed and marketed, some believe that doctors and patients should still not be criminalized for recommending and using the natural substance.

The *New England Journal of Medicine* has editorialized that

> [A] federal policy that prohibits physicians from alleviating suffering by prescribing marijuana for seriously ill patients is misguided, heavy-handed, and inhumane. Marijuana may have long-term adverse effects and its use may presage serious addictions, but neither long-term side effects nor addiction is a relevant issue in such patients. It is also hypocritical to forbid physicians to prescribe marijuana while permitting them to use morphine and meperidine to relieve extreme dyspnea and pain. With both of these drugs the difference between the dose that relieves symptoms and the dose that hastens death is very narrow; by contrast, there is no risk of death from smoking marijuana. To demand evidence of therapeutic efficacy is equally hypocritical. The noxious sensations that patients experience are extremely difficult to quantify in controlled experiments. What really counts for a therapy with this kind of safety margin is whether a seriously ill patient feels relief as a result of the intervention, not whether a controlled trial "proves" its efficacy.[153]

Some observers suggest that until the federal government relents and becomes more hospitable to marijuana research proposals and more willing to consider moving marijuana to a less restrictive schedule, the medical marijuana issue will continue to be fought at state and local levels of governance. As one patient advocate has stated, "As the months tick away, it will become more

[151] See, for example, Lila Guterman, "The Dope on Medical Marijuana," *Chronicle of Higher Education*, June 2, 2000, p. A21.

[152] IOM Report, p. 14.

[153] "Federal Foolishness and Marijuana," *New England Journal of Medicine*, vol. 336, no. 5 (January 30, 1997), p. 366.

and more obvious that we need to continue changing state laws until the federal government has no choice but to change its inhumane medicinal marijuana laws."[154]

The Medical Marijuana Movement Is Politically Inspired

> *Advocates have tried to legalize marijuana in one form or another for three decades, and the "medical marijuana" concept is a Trojan Horse tactic towards the goal of legalization.*
> —Brief of the Drug Free America Foundation, et al., 2004[155]

Medical marijuana opponents see the movement to promote the use of medical marijuana as a cynical attempt to subvert the Controlled Substances Act and legalize the recreational use of marijuana for all. They see it as a devious tactic in the more than 30-year effort by marijuana proponents to bring an end to marijuana prohibition in the United States and elsewhere.

They point out that between 1972 and 1978, the National Organization for the Reform of Marijuana Laws (NORML) successfully lobbied 11 state legislatures to decriminalize the drug, reducing penalties for possession in most cases to that of a traffic ticket. Also, in 1972, NORML began the first of several unsuccessful attempts to petition DEA to reschedule marijuana from Schedule I to Schedule II on the grounds that crude marijuana had use in medicine.[156]

Later, beginning with California in 1996, "drug legalizers" pushed successfully for passage of medical marijuana voter initiatives in several states, prompting then-Drug Czar Barry McCaffrey, writing in *Newsweek*, to warn that "We're on a Perilous Path." "I think it's clear," he wrote, "that a lot of the people arguing for the California proposition and others like it are pushing the legalization of drugs, plain and simple."[157]

Is it cynical or smart for NORML and other drug reform organizations to simultaneously pursue the separate goals of marijuana decriminalization for all, on the one hand, and marijuana rescheduling for the seriously ill, on the other? It is not unusual for political activists tactically to press for—and accept—half-measures in pursuit of a larger strategic goal. Pro-life activists work to prohibit partial-birth abortions and to pass parental notification laws. Gay rights activists seek limited domestic partner benefits as a stepping stone to full marriage equality. Thus is the tactic used on both sides of the cultural divide in America, to the alarm of those opposed.

It is certainly true that the medical cannabis movement is an offshoot of the marijuana legalization movement. Many individuals and organizations that support medical marijuana also support a broader program of drug law reform. It is also true, however, that many health

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[154] Chuck Thomas, quoted in "National Drug War Leaders Disregard Science in Medicinal Marijuana Debate," Marijuana Policy Project press release dated April 20, 1999, available at http://www.mpp.org/news/press-releases/national-drug-war-leaders-disregard-science-in-medicinal-marijua.html.

[155] Brief for the Drug Free America Foundation, Inc. et al. as Amici Curiae Supporting Petitioners at 9, Gonzales v. Raich, 125 S.Ct. 2195 (2005) (No. 03-1454).

[156] For example, the amici curiae brief of the Drug Free America Foundation et al. reveals this history to discredit the medical marijuana movement (pp. 9-11). Actually, NORML and some other drug reform organizations are open in acknowledging that they support patient access to marijuana as a first step toward decriminalizing or legalizing marijuana for use by adults in general. See, for example, Joab Jackson, "Medical Marijuana: From the Fringe to the Forefront," *Baltimore City Paper*, March 28, 2002, available at http://www.alternet.org/drugreporter/12714.

[157] Barry R. McCaffrey, "We're on a Perilous Path," *Newsweek*, February 3, 1997, p. 27.

professionals and other individuals who advocate medical access to marijuana do not support any other changes in U.S. drug control policy. In the same way, not everyone in favor of parental notification laws supports banning abortions for everyone. And not every supporter of domestic partner benefits believes in same-sex marriage.

In these hot-button issues, ideology and emotion often rule. Marijuana users in general, and medical marijuana users in particular, are demonized by some elements of American society. The ideology of the "Drug Warriors" intrudes on the science of medical marijuana, as pointed out by Grinspoon and Bakalar in the *Journal of the American Medical Association*:

> Advocates of medical use of marihuana are sometimes charged with using medicine as a wedge to open a way for "recreational" use. The accusation is false as applied to its target, but expresses in a distorted form a truth about some opponents of medical marihuana: they will not admit that it can be a safe and effective medicine largely because they are stubbornly committed to exaggerating its dangers when used for nonmedical purposes.[158]

The authors of the IOM Report were aware of the possibility that larger ideological positions could influence one's stand on the specific issue of patient access to medical marijuana when they wrote that

> [I]t is not relevant to scientific validity whether an argument is put forth by someone who believes that all marijuana use should be legal or by someone who believes that any marijuana use is highly damaging to individual users and to society as a whole. (p. 14)

In other words, it is widely believed that science should rule when it comes to medical issues. Both sides in the medical marijuana debate claim adherence to this principle. The House Government Reform Committee's April 2004 hearing on medical marijuana was titled "Marijuana and Medicine: The Need for a Science-Based Approach." And medical marijuana advocates plead with the federal government to permit scientific research on medical marijuana to proceed.

Rescheduling marijuana and making it available for medical use and research is not necessarily a step toward legalizing its recreational use. Such a move would put it on a par with cocaine, methamphetamine, morphine, and methadone, all of which are Schedule II substances that are not close to becoming legal for recreational use. Proponents of medical marijuana ask why marijuana should be considered differently than these other scheduled substances.

It is also arguable that marijuana should indeed be considered differently than cocaine, methamphetamine, morphine, and methadone. Scientists note that marijuana is less harmful and less addictive than these Schedule II substances. Acceptance of medical marijuana could in fact pave the way for its more generalized use. Ethan Nadelmann, head of the Drug Policy Alliance, has observed, "As medical marijuana becomes more regulated and institutionalized in the West, that may provide a model for how we ultimately make marijuana legal for all adults."[159] Medical marijuana opponents have trumpeted his candor as proof of the hypocrisy of those on the other side of the issue. Others note, however, that his comment may be less hypocritical than astute.

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[158] Lester Grinspoon and James B. Bakalar, "Marihuana as Medicine: A Plea for Reconsideration," *Journal of the American Medical Association*, vol. 273, no. 23 (June 21, 1995), p. 1876.

[159] Quoted in MSNBC.com story, "Western States Back Medical Marijuana," November 4, 2004, available at http://msnbc.msn.com/id/6406453.

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Tab 5

Government Accountability Office Report

Government Accountability Office Report

A review of early experiences in four states (Alaska, California, Hawaii, and Oregon) with medical marijuana laws, released November 2002.

United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Criminal Justice, Drug Policy and Human Resources, Committee on Government Reform, U.S. House of Representatives

November 2002

MARIJUANA

Early Experiences with Four States' Laws That Allow Use for Medical Purposes

GAO-03-189

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Abbreviations

CSA	Controlled Substances Act of 1970
DEA	Drug Enforcement Administration
FBI	Federal Bureau of Investigation
HHS	Department of Health and Human Services
UCR	Uniform Crime Reports

GAO
Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

November 1, 2002

The Honorable Mark Souder
Chairman, Subcommittee on Criminal Justice,
Drug Policy and Human Resources
Committee on Government Reform
House of Representatives

Dear Mr. Chairman:

A number of states have adopted laws that allow medical use of marijuana. Federal law, however, does not recognize any accepted medical use for marijuana and individuals remain subject to federal prosecution for marijuana possession. Debate continues over the medical effectiveness of marijuana, and over government policies surrounding medical use. A bill introduced in the House of Representatives in July 2001 would modify the federal classification of marijuana and allow doctors, in states with medical marijuana laws, to recommend or prescribe marijuana.[1] As the debate continues, so has interest in how state medical marijuana programs are operating, and in the issues faced by federal and state law enforcement officials in enforcing criminal marijuana provisions.[2]

This report responds to your request that we examine the implementation of medical marijuana laws in selected states. We did not examine the effectiveness of states' or local jurisdictions efforts to administer their programs and did not judge the validity of their approaches for implementing states' laws. As agreed with your staff, we selected Oregon, Alaska, Hawaii, and California because they had medical marijuana laws in effect for at least 6 months and, according to our preliminary work, some

[1]States' Rights to Medical Marijuana Act, H.R. 2592, 107th Cong. (2001). Status as of August 5, 2002: Referred to House Energy and Commerce, Subcommittee on Health on July 31, 2001.

[2]Throughout this report, we use the phrase medical marijuana to describe marijuana use that qualifies for a medical use exception under state law.

data was available on patient and physician participation.[3] For these states, we are reporting on (1) their approach to implementing their medical marijuana laws and how these approaches compare, and the results of any state audits or reviews; (2) the number, age, gender, and medical conditions of patients that have had doctors recommend marijuana for medical use in each state; (3) how many doctors are known to have recommended marijuana in each state, and what guidance is available for making these recommendations; and (4) the perceptions of federal and state law enforcement officials, and whether data are available to show how the enforcement of state marijuana laws has been affected by the introduction of these states' medical marijuana laws.

In conducting our work, we examined applicable federal and state laws and regulations and spoke with responsible program officials in Oregon, Alaska, Hawaii, and California. In the four states, we obtained and analyzed available information on program implementation, program audits, and program participation by patients and doctors. We also met with various federal, state, and local law enforcement officials—including officials with the Drug Enforcement Administration (DEA) and U.S. Attorneys offices in Washington, D.C., and the four selected states—to discuss data on arrests and prosecutions and views on the impact of the state's medical marijuana laws on their law enforcement efforts.

Results from our review of these states cannot be generalized to other states with state medical marijuana laws, nor are they generalizable across the states selected for review. Similarly, in California, the information from the local jurisdictions we reviewed cannot be generalized to all local jurisdictions in California. We conducted our review between September 2001 and June 2002 in accordance with generally accepted government auditing standards. (Appendix I describes our scope and methodology in greater detail.)

[3]According to *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483, 502 n.4 (2001), eight states have enacted medical marijuana laws. We selected four of those states based on the length of time the laws had been in place and the availability of data. Two of the eight states, Nevada and Colorado, were not selected because their laws had not been in place for at least 6 months when our review began. Also, at the time of our review, two other states, Maine and Washington, did not have state registries to obtain information on program registrants. Alaska, Oregon, and Hawaii have state registries and had laws in place for at least 6 months. California's law was enacted in1996. California does not have a participant registry, but based on our preliminary work, some local registry information was available.

Results in Brief

State laws in Oregon, Alaska, Hawaii, and California allow medical use of marijuana under specified conditions. All four states require a patient to have a physician's recommendation to be eligible for medical marijuana use. Alaska, Hawaii, and Oregon have established state-run registries for patients and caregivers to document their eligibility to engage in medical marijuana use; these states require physician documentation of a person's debilitating condition to register. Laws in these three states also establish maximum allowable amounts of marijuana for medical purposes. California's law does not establish a state-run registry or establish maximum allowable amounts of marijuana. Some local California jurisdictions have developed their own guidelines and voluntary registries. Oregon has changed some verification practices and administrative procedures as a result of a review of their medical marijuana program.

Relatively few people had registered to use marijuana for medical purposes in Oregon, Hawaii, and Alaska. As of Spring 2002, about 2,450 people, or about 0.05 percent of the total population of the three states combined, had registered as medical marijuana users. Statewide figures for California are unknown. In Oregon, Alaska, and Hawaii, over 70 percent of registrants were over 40 years of age or older, and in Hawaii and Oregon, the two states where gender information is collected, about 70 percent of registrants were men. Data from Hawaii and Oregon also showed that about 75 percent and more than 80 percent respectively, of the physician recommendations were for severe pain and conditions associated with muscle spasms, such as multiple sclerosis. Statewide figures on gender and medical conditions were not available for Alaska or California.

Hawaii and Oregon were the only two states that had data on the number of physicians recommending marijuana. As of February 2002, less than one percent of the approximately 5,700 physicians in Hawaii and three percent of Oregon's physicians out of about 12,900 had recommended marijuana to their patients. Oregon also was the only state that maintained data on the number of times individual physicians recommended marijuana—as of February 2002, about 62 percent of the Oregon physicians recommending marijuana made one recommendation. Professional medical associations in all four states provided some guidance to physicians. The associations caution physicians about the legal issues facing them, or give advice on practices to follow and avoid. Most state medical board officials said they would only become involved with physicians recommending marijuana in cases where a complaint was filed against a physician for violating state medical practice standards. California's medical board provides informal guidelines on making marijuana recommendations to their patients.

Data were not readily available to measure how marijuana-related law enforcement has been affected by the introduction of medical marijuana laws. To assess the relationship between trends in marijuana-related law enforcement activities and the passage of medical marijuana laws would require a statistical analysis over time that included measures of law enforcement activities, such as arrests, as well as data on other factors that are not easily measured, such as changes in perceptions about marijuana and shifts in law enforcement priorities. Officials from over half of the 37 selected federal, state, and local law enforcement organizations we interviewed in the four states said that the introduction of medical marijuana laws had not greatly affected their law enforcement activities. These officials indicated that they had not encountered situations involving a medical marijuana defense or they had other drug priorities. However, officials with some of the organizations told us that the laws in their states had made it more difficult to prosecute marijuana cases where medical use might be claimed; there was confusion over how to handle seized marijuana; and that, in their view, the laws had softened public attitudes toward marijuana.

In commenting on a draft of this report, the Department of Justice (DOJ) said that we fully described the current status of the programs in the states reviewed. However, DOJ stated that we failed to adequately address some of the serious difficulties associated with such programs. Specifically, DOJ commented that the report did not adequately address issues related to the (1) inherent conflict between state laws permitting the use of marijuana and federal laws that do not; (2) potential for facilitating illegal trafficking; (3) impact of such laws on cooperation among federal, state, and local law enforcement; and (4) lack of data on the medicinal value of marijuana. DOJ further stated that our use of the phrase "medical marijuana" implicitly accepts a premise that is contrary to existing federal law.

We disagree. We believe the report adequately addresses the issues within the scope of our review. With respect to DOJ's first issue, our report describes how laws in the selected states and federal law treat the use of marijuana—the opening paragraph of our report specifically states that federal law does not recognize any accepted medical use of marijuana and individuals remain subject to federal prosecution for marijuana possession regardless of state medical marijuana laws. With regard to the second and third issues raised by DOJ concerning the potential for facilitating illegal trafficking and the impact on cooperation between federal, state, and local law enforcement officials, respectively, we interviewed federal, state, and local law enforcement officials about their perceptions concerning the impact of state medical marijuana laws on their activities and our report

conveys the views and opinions of those officials. However, based on comments from law enforcement officials on a draft section of this report, we modified our report to discuss some of the issues law enforcement faces when dealing with medical marijuana laws and seized marijuana. Concerning the fourth issue—the lack of data on marijuana's medical value--our report discusses that a continuing debate exists over the medical value of marijuana, but an analysis of the scientific aspects of this debate was beyond the scope of our review.

Finally, we disagree with DOJ's comment that our use of the phrase medical marijuana accepts a premise contrary to federal law. The introduction to our report specifically states that, throughout the report, we use the phrase medical marijuana to describe marijuana use that qualifies for a medical use exception under state law. Our detailed response to DOJ's comments is provided on pages 35 to 38 and we have reprinted a copy of DOJ's comments in appendix V.

Background

The cannabis plant, commonly known as marijuana, is the most widely used illicit drug in the United States. According to recent national survey figures, over 75 percent of the 14 million illicit drug users 12 years or older are estimated to have used marijuana alone or with other drugs in the month prior to the survey.[4] Marijuana can be consumed in food or drinks, but most commonly dried portions of the leaves and flowers are smoked. Marijuana is widely used and the only major drug of abuse grown within the United States borders, according to the Drug Enforcement Administration.

Marijuana is a controlled substance under federal law and is classified in the most restrictive of categories of drugs by the federal government. The federal Controlled Substances Act of 1970 (CSA)[5] places all federally controlled substances into one of five "schedules," depending on the drug's likelihood for abuse or dependence, and whether the drug has an accepted medical use.[6] Marijuana is classified under Schedule I,[7] the classification reserved for drugs that have been found by the federal

[4]U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), *National Household Survey on Drug Abuse 2000*. Hashish is included by SAMHSA in the statistic for marijuana use.

[5]21 U.S.C. §§ 801 to 971.

[6]*Id.* § 812(a), (b).

[7]*Id.* § 812(c), Schedule I (c)(10).

government to have a high abuse potential, a lack of accepted safety under medical supervision, and no currently accepted medical use.[8] In contrast, the other schedules are for drugs of varying addictive properties, but found by the federal government to have a currently accepted medical use.[9] The CSA does not allow Schedule I drugs to be dispensed upon a prescription, unlike drugs in the other schedules.[10] In particular, the CSA provides federal sanctions for possession, manufacture, distribution or dispensing of Schedule I substances, including marijuana, except in the context of a government-approved research project.[11]

The potential medical value of marijuana has been a continuing debate. For example, beginning in 1978, the federal government allowed the first patient to use marijuana as medicine under the "Single Patient Investigational New Drug" procedure, which allows treatment for individual patients using drugs that have not been approved by the Food and Drug Administration. An additional 12 patients were approved under the procedure between 1978 and 1992. When the volume of applicants tripled, the Secretary of the Department of Health and Human Services (HHS) decided not to supply marijuana to any more patients. According to *Kuromiya v. United States*, HHS concluded that the use of the single patient Investigational New Drug procedure would not yield useful data to resolve the remaining safety and effectiveness issues.[12]

[8]Schedule I includes drugs such as heroin, lysergic acid diethylamide (LSD) and other hallucinogenic substances. 21 C.F.R. 1308.11(c), (d).

[9]*Id.* § 812(b)(2)-(5).

[10]*Id.* § 829. DEA rejected petitions in 1992 and 2001 to reschedule marijuana to schedule II. See Notice of Denial of Petition, 66 Fed. Reg. 20038 (2001); Marijuana Scheduling Petition; Denial of Petition; Remand, 57 Fed. Reg. 10499 (1992) (final order affirming the 1989 denial after remand); Marijuana Scheduling Petition; Denial of Petition, 54 Fed. Reg. 53767 (1989).

[11]*Id.* § 823(f), 841(a)(1), 844.

[12]*See* 78 F. Supp. 2d 367 (E.D.Pa.1999). In the *Kuromiya* case, a group of approximately 160 plaintiffs raised an equal protection challenge to the administration of the "Single Patient Investigational New Drug" program. The plaintiffs contended that they were similarly situated to patients currently receiving marijuana under the program and that the government acted unconstitutionally in denying them access to the same program. The court concluded that the government had a rational basis for its decision not to supply marijuana to the plaintiffs through this program and granted the government's motion for summary judgment.

In 1999, an Institute of Medicine study[13] commissioned by the White House Office of National Drug Control Policy recognized both a potential therapeutic value and potential harmful effects, particularly the harmful effects from smoked marijuana. The study called for more research on the physiological and psychological effects of marijuana and on better delivery systems. A 2001 report by the American Medical Association's Council on Scientific Affairs also summarized the medical and scientific research in this area, similarly calling for more research.[14]

In May 1999, HHS released procedures allowing researchers not funded by the National Institute of Health to obtain research-grade marijuana for approved clinical studies. Sixteen proposals have been submitted for research under these procedures, and seven of the proposals had been approved as of May 2002.

Some states have passed laws that create a medical use exception to otherwise applicable state marijuana sanctions. California was the first state to pass such a law in 1996 when California voters passed a ballot initiative, Proposition 215 (The Compassionate Use Act of 1996) that removed certain state criminal penalties for the medical use of marijuana.[15] Since then, voters in Oregon, Alaska, Colorado, Maine, Washington and Nevada have passed medical marijuana initiatives, and Hawaii has enacted a medical marijuana measure through its legislature. While state criminal penalties do not apply to medical marijuana users defined by the state's statute, federal penalties remain, as determined by the Supreme Court in *United States v. Oakland Cannabis Buyers' Cooperative*.[16] (Appendix II provides more information on the Supreme Court's decision.)

In California, Alaska, and Oregon, where voters passed medical marijuana laws through ballot initiatives, each state provided an official ballot pamphlet, which included the text of the proposed law and arguments

[13]National Academy of Sciences, Institute of Medicine, "Marijuana and Medicine: Assessing the Science Base." 1999.

[14]American Medical Association, Council on Scientific Affairs Report: *Medical Marijuana (A-01)*, June, 2001.

[15]The medical use exception in the states we reviewed allows growing or possessing marijuana for the purpose of the patient's personal medical use, and does not extend to other state marijuana prohibitions such as distribution outside the patient-caregiver relationship or any sale of marijuana.

[16]532 U.S. 483 (2001).

from proponents and opponents. Opponents of the initiatives referred to federal marijuana prohibitions, legal marijuana alternatives, and evidence of the dangers of smoked marijuana. Proponents referred to supportive studies and positive statements from medical personnel. In Hawaii, where the state legislature enacted the medical marijuana measure, law enforcement officials, advocacy groups, and medical professionals made similar arguments for or against the proposed law during the legislative process.

Implementation in Oregon, Alaska, Hawaii, and California

Oregon, Alaska, Hawaii, and California laws allow medical use of marijuana under certain conditions.[17] All four states require a patient to have a physician's recommendation to be eligible for medical marijuana. Consistent with their laws, Oregon, Alaska, and Hawaii also have designated a state agency to administer patient registries—which document a patient's eligibility to use medical marijuana based on the written certification of a licensed physician—and issue cards to identify certified registrants. Also, laws in Oregon, Alaska, and Hawaii establish limits on the amounts of marijuana a patient is allowed to possess for medical purposes. California does not provide for state implementation of its law. In particular, California has not delegated authority to a state agency or established a statewide patient registry. In addition, California law does not prescribe a specific amount of marijuana that can be possessed for medical purposes. In the absence of specific statutory language, some local California jurisdictions have established their own registries, physician certification requirements, and guidelines for allowable marijuana amounts for medical purposes. Only Oregon has reviewed its medical marijuana program, and as a result of that review, has changed some of its procedures and practices, including verifying all doctor recommendations.

States and Some Local California Jurisdictions Maintain Medical Marijuana Registries

To document their eligibility to engage in medical marijuana use, applicants in Oregon, Alaska, and Hawaii must register with state agencies charged with implementing provisions of the medical marijuana laws in those states (hereinafter referred to as registry states). In Oregon, the Department of Human Services is responsible, and in Alaska, the

[17]The states' medical marijuana laws appear at Alaska Stat. Ann. 11.71.090, 17.37.010 to 17.37.080; Cal. Health & Safety Code Ann. 11362.5; Haw. Rev. Stat. 329-121 to 329-128; and Ore. Rev. Stat. 475.300 to 475.346. Alaska's Hawaii's and Oregon's administrative regulations appear at Alaska Admin. Code, tit. 7, ch. 34; Haw. Admin. R., tit. 23, ch. 202; and Ore. Admin. R., ch. 333, div. 8. There are no regulations under California's law.

Department of Health and Social Services. In Hawaii, the Narcotics Enforcement Division within the Department of Public Safety is responsible for the state's medical marijuana registry. Applicants meeting state requirements are entered into a registry maintained by each state. In California, a number of counties have established voluntary registries to certify eligibility under the state' s medical marijuana law.[18]

The three registry states, Oregon, Alaska and Hawaii, have similar registry requirements. Potential registrants must supply written documentation by a physician licensed in that state certifying that the person suffers from a debilitating medical condition (as defined by the state statute) and in the physician's opinion would benefit from the use of marijuana. They also must provide information on the name, address, and birth date of the applicant (and of their caregiver, where one is specified) along with identification to verify the personal information. In each state, registry agencies must verify the information in the application based on procedures set in that state's statutes or regulations before issuing the applicant a medical marijuana identification card. All three states allow law enforcement officers to rely upon registry applications in lieu of registry cards to determine whether a medical use exception applies. Figure 1 provides an example of the registry card issued by Oregon. (Appendix III provides examples of registry cards from Alaska and Hawaii.)

[18]Under Alaska's and Hawaii's statutes, patients and caregivers must strictly comply with the registration requirement in order to receive legal protection; unregistered persons may not present a medical use defense to a marijuana prosecution in these states. *See* Alaska Stat. Ann. 11.71.090; Haw. Rev. Stat. 329-125. Under Oregon's statute, unregistered patients who have substantially complied with the act may raise such a defense to a marijuana prosecution, while registered persons are excepted from criminal charges, so long as they meet the act's quantity and use restrictions. *See* Ore. Rev. Stat. 475.306, 475.316, 475.319, 475.342. Because California's law does not establish a state-run registry, a medical use defense may be established by any individual meeting the act's substantive requirements, that is, patients whose doctors have recommended marijuana to treat an allowed medical condition and their primary caregivers. *See* Cal. Health & Safety Code Ann. 11362.5; *see also People v. Mower*, No. S094490, 2002 Cal. Lexis 4520 (July 18, 2002), in which the California Supreme Court interprets California's medical marijuana act.

Figure 1: Example of Oregon's Medical Marijuana Registry Card

Source: Oregon Department of Human Services.

Hawaii's Department of Public Safety requires that doctors submit the completed registry application to the state agency, and if approved, the medical use certification is returned to the doctor for issuance to their patient. By contrast, registry agencies in Oregon and Alaska require that the registry card applicant submit the physician statement as part of the application, and issue the card directly to the patient. Alaska allows registry cards to be revoked if the registrant commits an offense involving a controlled substance of any type, whereas Oregon and Hawaii allow registry cards to be revoked only for marijuana-related offenses, such as sale. Table 1 summarizes registry requirements and verification procedures of the responsible agencies in each registry state as of July 2002.

Table 1: Registry Requirements and Verification Procedures in Oregon, Alaska and Hawaii, as of July 2002

Registry requirements	Oregon	Alaska	Hawaii
Completed application form	x[a] (submitted by applicant)	x (submitted by applicant)	x (submitted by physician)
Written physician documentation	x [b]	x [c]	x [d]
Applicant name, address and date of birth. Must include a copy of a current photographic identification card, such as license, or ID card number	x	x	x
Primary caregiver name, address and date of birth. Must include a copy of a current photographic identification card, such as license, or ID card number	x	x	x
Sworn caregiver statement on department form regarding lack of felony drug conviction, not on probation or parole, and over 21		x	
Address of site where marijuana will be produced	x		x
Annual renewal for registry card	x	x	x
Minors: parents declaration form and agreement to serve as minor's caregiver	x (must be notarized)	x	x
Registration fee	$150	$25 first time $20 renewal	$25
Registry Verification Procedures			
Doctor has a valid license in state	x	x	x
Verification call or letter sent to doctor re: recommendation	x	x[e]	x
Patient contacted to validate application information	x	x[e]	x
Caregiver contacted to validate application information	x[e]	x[e]	x[e]
Registry checked to assure caregiver only serves one patient		x	

[a]A legible written statement with all the form information included will be accepted.

[b]Attending physician completes a state declaration form that the person has been diagnosed with a debilitating medical condition and that the medical use of marijuana may mitigate the symptoms or effects of the patient's condition, or applicant provides medical records of debilitating condition signed by physician that contains all information required on physician form.

[c]Signed physician statement that the patient was examined within bona fide relationship and is diagnosed with a debilitating medical condition, other medications were considered and that patient might benefit from marijuana.

[d]Signed statement that in the physician's opinion, the qualifying patient has a debilitating medical condition and the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient, OR medical records with same information.

[e]Agency officials verify when they believe it is appropriate.

Source: Oregon, Alaska, and Hawaii medical marijuana state statutes, administrative rules and program officials.

California's statute does not establish a state registry or require that a person or caregiver be registered to qualify for a medical use exception. California's law requires that medical use has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana for certain symptoms or conditions. The exception applies based "upon the written or oral recommendation or approval of a

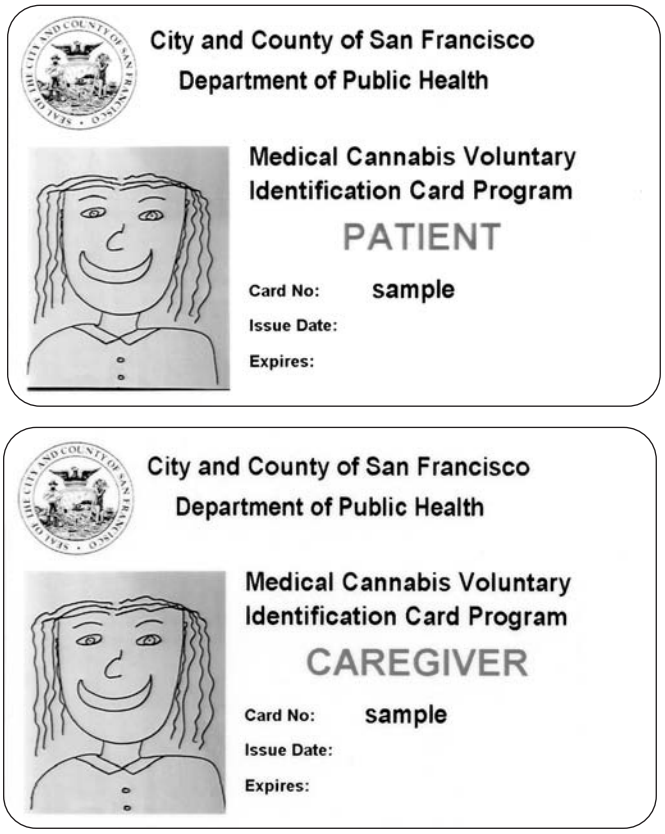
physician." After the medical marijuana law was passed, the California Attorney General assembled a task force to discuss implementation issues in light of the "ambiguities and significant omissions in the language of the initiative." The task force recommended a statewide registry be created and administered by the Department of Health Services, among other things, to clarify California's law.[19] However, a bill incorporating many of the ideas agreed upon by the task force was not enacted by the California legislature.[20]

Some California communities have created voluntary local registries to provide medical marijuana users with registry cards to document that the cardholder has met certain medical use requirements. Figure 2 provides examples of patient and caregiver registry cards issued by San Francisco's Department of Public Health. (See the following section for a discussion of caregivers.)

[19]Office of the Attorney General, State of California, Department of Justice, *Medical Marijuana Task Force* (July 12, 1999). Other recommendations included requiring that the patient's personal physician make the marijuana recommendation, and allowing cooperative marijuana cultivation.

[20]California Senate Bill 187, 2001-2002 Reg. Sess. The bill was introduced by California Senator Vasconcellos on February 7, 2001.

Figure 2: Example of San Francisco's Medical Marijuana Registry Cards



Source: San Francisco Department of Public Health.

According to a September 2000 letter by the California Attorney General, medical marijuana policies have been created in some counties. Local registries have been created in Humboldt, Mendocino, San Francisco, and Sonoma counties. A medical marijuana registry in the city of Arcata, located in Humboldt County, was discontinued, however, the Arcata police department accepts registry cards from Humboldt County. A more recent list of medical marijuana registries operated by a county or city was not available, an official with the Attorney General's office said, because there is no requirement for counties or cities to report on provisions they adopt regarding medical use of marijuana. At least two counties have since approved development of county medical marijuana registries, in San Diego in November 2001, and in Del Norte, in April 2002. Several cannabis buyers' clubs, or cannabis cooperatives may have also established voluntary registries of their members.

(Appendix III provides additional discussion on state registry procedures in Oregon, Alaska, and Hawaii, procedures in selected California county registries, and examples of registry cards.)

Medical Marijuana Patient Primary Caregivers

Laws in Oregon, Alaska, Hawaii, and California allow medical marijuana users to designate a primary caregiver. To qualify as a caregiver in the registry states, persons must be part of the state registry and be issued medical marijuana cards. Registered caregivers may assist registrants in their medical use of marijuana without violating state criminal laws for possession or cultivation of marijuana, within the allowed medical use amounts. Alaska allows registrants to designate a primary and alternate caregiver. Both must submit a sworn statement that they are at least 21 years old, have not been convicted of a felony drug offense, and are not currently on probation or parole. In Hawaii and Alaska, caregivers can serve only one patient at a time. Alaska, however, allows exceptions for patients related to the caregiver by blood or marriage, or with agency approval, such as circumstances where a patient resides in a licensed hospice program. Oregon does not specify a limit to the number of patients one caregiver may serve. Table 2 provides information on definitions and caregiver provisions in Oregon, Alaska, and Hawaii.

Table 2: Definition and Provisions Regarding Caregivers in Oregon, Alaska and Hawaii

	Oregon	Alaska	Hawaii
Definition of Caregiver	"Designated primary caregiver" means an individual eighteen years of age or older who has significant responsibility for managing the well-being of a person who has been diagnosed with a debilitating medical condition and who is designated as such on that person's application for a registry identification card or in other written notification to the division. Designated primary caregiver does not include the person's attending physician.	"Primary caregiver" means a person listed as a primary caregiver (in the state medical use registry) and in physical possession of a caregiver registry identification card: "primary caregiver" also includes an alternate caregiver when the alternate caregiver is in physical possession of the caregiver registry identification card. "Alternate caregiver" means a person who is listed as an alternate caregiver (in the state medical use registry).	"Primary caregiver" means a person, other than the qualifying patient and the qualifying patient's physician, who is eighteen years of age or older, and who has agreed to undertake responsibility for managing the well-being of the qualifying patient with respect to the medical use of marijuana.
Limit to number of caregivers per patient	1	2 (a primary and an alternate)	1
Limit to number of patients per caregiver	Not specified	1 (exceptions may be granted by state agency)	1
Criminal record restriction on serving as caregiver	Not specified	Yes	Not specified

Source: Oregon, Alaska, and Hawaii medical marijuana statutes and administrative rules.

California's statute also allows qualified medical marijuana users to designate a primary caregiver. The statue defines "primary caregiver" to mean "the individual designated by the person exempted under this section who has consistently assumed responsibility for the housing, health or safety of that person." There is no requirement that the patient–caregiver relationship be registered or otherwise documented, nor is there a specified limit to the number of patients that can designate a particular caregiver.

Physician Recommendation Requirements

In all four states, patients must obtain a physician's diagnosis that he or she suffers from a medical condition eligible for marijuana use under that state's statute, and a physician recommendation for the use of marijuana. California does not have a requirement that the diagnosis or recommendation be documented, as the other states do. In the registry states, patients must supply written documentation of their physician's medical determination and marijuana recommendation in their registry applications. This documentation must conform with program requirements, reflecting that the physician made his or her

recommendation in the context of a bona fide physician-patient relationship.

California's law does not require patients to submit documentation of a physician's determination or recommendation to any state entity, nor does it specify particular examination requirements. According to California's law, marijuana may be used for medical purposes "where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana" in treating certain medical conditions; such recommendations may be oral or written.

The physician certification form adopted by Hawaii's Department of Public Safety calls for doctors recommending marijuana to a patient to certify that "I have primary responsibility for the care and treatment of the named patient and based on my professional opinion and having completed a medical examination and/or full assessment of my patient's medical history and current medical condition in the course of a bona fide physician-patient relationship have issued this written certificate." Similarly in Alaska, the recommending physician signs a statement that they personally examined the patient on a specific date, and that the examination took place in the context of a bona fide physician-patient relationship.

Under Oregon's medical marijuana law, the patient's attending physician must supply physician documentation. Oregon's administrative rules defining "attending physician" were amended in March 2002 to more fully describe the conditions for meeting the definition. To qualify, the physician must have established a physician-patient relationship with the patient and must diagnose the patient with a debilitating condition in the context of that relationship.[21] Agency officials stated that they changed the definition of an attending physician in light of information that one doctor responsible for many medical marijuana recommendations had not

[21]As provided in Ore. Admin. R. 333-008-0010, an attending physician is "a physician who has established a physician/patient relationship with the patient, is licensed under ORS chapter 677, and who, with respect to a patient diagnosed with a debilitating medical condition: (a) Is primarily responsible for the care and treatment of the patient; (b) Is primarily responsible for recognized, medical specialty care and treatment of the patient; (c) Has been asked to consult and treat the patient by the patient's primary care physician; or (d) Has reviewed a patient's medical records at the patient's request, has conducted a thorough physical examination of the patient, has provided a treatment plan and/or follow-up care, and has documented these activities in a patient file. "

followed standard physician-patient practices, such as keeping written patient records. (See physician section.) Under its regulations, the Department of Human Services will contact each physician making a medical marijuana recommendation to assure that the physician is an "attending physician" and, with patient approval, the department may review the physician's patient file in connection with this inquiry.

Qualifying State Conditions for Use of Medical Marijuana

The laws in all four states we reviewed identify medical conditions[22] for which marijuana may be used for medical purposes. Table 3 displays the allowed medical conditions for which marijuana may be used in each state. (See appendix IV for descriptions from general medical sources of the allowable conditions identified by the state laws.)

Table 3: Allowable Conditions for Medical Marijuana Use in Four States

Conditions[a]	Oregon	Alaska	Hawaii	California
Cancer	x	x	x	x
Glaucoma	x	x	x	x
HIV positive status	x	x	x	
AIDS	x	x	x	x
Cachexia	x	x	x	
Wasting syndrome			x	
Anorexia				x
Epilepsy and other seizure disorders	x	x	x	
Multiple sclerosis and other disorders characterized by persistent muscle spasticity	x	x	x	x
Crohn's disease			x	
Alzheimer's disease	x			
Arthritis				x
Migraine				x
Severe pain	x	x	x	
Chronic pain				x
Severe nausea	x	x	x	
Any other illness for which marijuana provides relief[b]				x

[a]Oregon's, Alaska's, and Hawaii's medical marijuana statutes use the term "debilitating medical condition" to encompass the conditions eligible for medical marijuana use. California's statute does not use this term, but simply lists the eligible conditions.

[b]California's statute does not define "any other illness for which marijuana provides relief."

[22]For simplicity, we use the general term medical "condition" to encompass, diseases, symptoms, and medical conditions.

Source: California, Oregon, Alaska and Hawaii medical marijuana statutes and Oregon administrative rules.

Allowable Amounts of Marijuana for Medical Use

Statutes in Oregon, Alaska, and Hawaii define the maximum amount of marijuana and the number of plants that an individual registrant and their caregiver may possess under medical marijuana laws, while California's statute does not provide such definitions. Oregon and Hawaii regulations also provide definitions of marijuana plant maturity. Table 4 provides the definitions of quantity and maturity for each registry state.

Table 4: Permissible Amounts of Medical Marijuana and Plant Maturity in Oregon, Alaska, and Hawaii

	Oregon	Alaska	Hawaii
Allowable amount	A patient and a designated primary caregiver may not individually or collectively possess more than three mature plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant, if present at a location at which marijuana is produced, including any residence associated with that location. If not at a location where marijuana is produced, including any residence associated with that location, the allowable amount is one ounce of usable marijuana.[a]	A patient, primary caregiver or alternate caregiver may not possess in the aggregate more than one ounce of marijuana in usable form; and six marijuana plants, with no more than three mature and flowering plants producing usable marijuana at any one time.	"Adequate Supply" means an amount of marijuana jointly possessed between the qualifying patient and the primary caregiver that is not more than is reasonably necessary to assure the uninterrupted availability of marijuana for the express purpose of alleviating the symptoms or effects of a qualifying patient's debilitating medical condition; provided that the "adequate supply" jointly possessed by the qualifying patient and the primary caregiver not exceed three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.
Plant maturity	"Mature plant" means the following: A marijuana plant shall be considered mature when male or female flower buds are readily observed on the plant by unaided visual examination. Until this sexual differentiation has taken place, a marijuana plant will be considered immature.	Not specified	"Immature marijuana plant" means a marijuana plant, whether male or female, that has not yet flowered and which does not yet have buds that are readily observed by unaided visual examination. "Mature plant" means a marijuana plant, whether male or female, that has flowered and which has buds that are readily observed by unaided visual examination.

[a]Registered patients and caregivers in Oregon who exceed the act's quantity restrictions are not immune from prosecution, but may establish an "affirmative defense" in a marijuana prosecution that the greater amount is medically necessary to mitigate the symptoms or effects of the patient's debilitating medical condition. Ore. Rev. Stat. 475.306(2).

Source: Oregon, Alaska, and Hawaii medical marijuana statutes and administrative rules.

California's statute does not specify an amount of marijuana allowable under medical use provisions; however, some local jurisdictions have established their own guidelines. The statute's criminal exemption is for "personal medical purposes" but does not define an amount appropriate

for personal medical purposes. The California Attorney General's medical marijuana task force debated establishing an allowable amount but could not come to a consensus on this issue, proposing that the Department of Health Services determine an appropriate amount. Participants did agree that the amount of marijuana a patient may possess might well depend on the type and severity of illness. They concluded that an appropriate amount of marijuana was ultimately a medical issue, better analyzed and decided by medical professionals. In the absence of state specified amounts, a number of the state's 58 counties and some cities have informally established maximum allowable amounts of marijuana for medical purposes. According to the September 2000 summary by the California Attorney General's office, the amount of marijuana an individual patient and their caregiver were allowed to have varied, with a two-plant limit in one area, and a 48 plant (indoors, with mature flowers) limit in another area. In May 2002, Del Norte County raised their limit from 6 plants to 99 plants per individual patient.

Safety and Public Use Restrictions

California, Oregon, Alaska, and Hawaii prohibit medical marijuana use in specific situations relating to safety or public use. Patients or caregivers who violate these prohibitions are subject to state marijuana sanctions and, in the registry states, may also forfeit their registry cards.[23] Table 5 reflects the various states' safety or public use restrictions.

[23]Alaska's statute provides a one-year suspension from using or obtaining a registry card; Oregon's statute provides up to a 6-month suspension from using or obtaining a registry card; Hawaii's rules provide for revocation of the registry certificate for an indefinite time.

Table 5: Safety and Public Use Restrictions in Oregon, Alaska, Hawaii and California

	Oregon	Alaska	Hawaii	California
Safety restrictions	Oregon's medical marijuana statute prohibits driving under the influence of marijuana.	Alaska's medical marijuana statute prohibits medical use of marijuana that endangers the health or well-being of any person.	Hawaii's medical marijuana statute prohibits medical use of marijuana that endangers the health or well-being of another person.	California's medical marijuana statute provides that, "Nothing in this section shall be construed to supersede legislation prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes."
Public use restrictions	Oregon's medical marijuana statute prohibits patients and caregivers from engaging in the medical use of marijuana in public places as defined in Ore. Rev. Stat. 161.015,[a] or in public view or in a correctional facility as defined in Ore. Rev. Stat. 162.135(2) or youth correction facility as defined in Ore. Rev. Stat 162.135(6).	Alaska's medical marijuana law prohibits the medical use of marijuana in plain view of, or in a place open to, the general public. The law also states that medical marijuana use need not be accommodated in any place of employment; in any correctional facility, medical facility, or facility monitored by the Alaska Department of Administration; on or within 500 feet of school grounds; at or within 500 feet of a recreation or youth center; or on a school bus.	Hawaii's medical marijuana statute prohibits the medical use of marijuana in a school bus, public bus, or any moving vehicle; in the workplace of one's employment; on any school grounds; at any public park, public beach, public recreation center, recreation or youth center; or other place open to the public.	(not specified)

[a]As defined in Ore. Rev. Stat. 161.015, a public place means a place to which the general public has access including, but not limited to, hallways, lobbies and other parts of apartment houses and hotels not constituting rooms or apartments designed for actual residence, and highways, streets, schools, places of amusement, parks, playgrounds and premises used in connection with public passenger transportation.

Source: California, Oregon, Alaska and Hawaii state statutes.

Management Review Results in Oregon Program Changes

Oregon was the only state of the four we reviewed to have conducted a management review of their state's medical marijuana program.[24] The Oregon Department of Human Services conducted the review after concerns arose that a doctor's signature for marijuana recommendations had been forged. The review team reported a number of program areas needing improvement, and proposed a corrective plan of action. Most of

[24]"Oregon's Medical Marijuana Program: A Management Review" Oregon Department of Human Services, June 11, 2001.

the actions had been completed, as of May 2002. Lack of verification of physician signature was a key problem identified by the team. All physician signatures are now verified. A number of other team findings had to do with program management and staffing. The Program Manager was replaced, additional staff was added, and their roles were clarified, according to officials. Another area of recommendation was the processing of applications and database management, such as how to handle incomplete applications, handling of voided applications, edit checks for data entry, and reducing the application backlog. As of May 2002, some action items were still open, such as computer "flags" for problem patient numbers or database checks on patients and caregivers at the same address.

Few Registrants, Most with Severe Pain or Muscle Spasms

A relatively small number of people are registered as medical marijuana users in Oregon, Hawaii, and Alaska. In those states, most registrants were over 40 years old. Severe pain and muscle spasms (spasticity) were the most common medical conditions for which marijuana was recommended in the states where data was gathered.

Small Number of Medical Marijuana Registrants

Relatively few people are registered as medical marijuana users in Alaska, Hawaii and Oregon. In these states, registry data showed that the number of participants registered was below 0.05 percent or less of the total population of each respective state. Data doesn't exist to identify the total population of people with medical conditions that might qualify for marijuana use because not all the conditions specified in the state's laws are diseases for which population data is available. For example, a debilitating condition of "severe pain" may be a symptom for a number of specific medical conditions, such as a back injury, however not all patients with back injury suffer severe pain. Table 6 shows the number of patients registered in Oregon, Hawaii, and Alaska, at the time of our review as compared to the total population from the U.S. Census Bureau population projections for 2002.

Table 6: Medical Marijuana Registrants in Oregon, Hawaii, and Alaska, by Projected 2002 State Population

State	State population	Number of registrants	Percent of registrants by state population
Oregon	3,488,000	1,691	0.05
Hawaii	1,289,000	573	0.04
Alaska	672,000	190	0.03
Totals	**5,449,000**	**2,454**	**0.05**

Note: Oregon data as of February 2002, Alaska and Hawaii data as of April 2002.

Source: Oregon, Hawaii, and Alaska state medical marijuana registries and U.S. Bureau of the Census population projections for 2002.

There is no statewide data on participants in California because the medical marijuana law does not provide for a state registry. We obtained information from four county registries in San Francisco, Humboldt, Mendocino and Sonoma counties.[25] In each of these registries, participation was 0.5 percent or less than the respective county's population. However, because the local registries are voluntary it is unknown how many people in those jurisdictions have received medical recommendations from their doctors for marijuana but have not registered.

Table 7 shows the number of patients registered in four California counties and as a percent of the population for those counties, since each registry was established.

[25]Sonoma County does not maintain a "registry" of approved medical marijuana users, but is included because it does have records of county patients whose doctors have recommended marijuana using Sonoma County Medical Association peer review process.

Table 7: Registrants in Four California Counties by County Population

Registrant source	County population	Number of registrants	Percent of registrants by county population
San Francisco Department of Public Health	793,729	3551	0.44
Sonoma County Medical Association	468,754	435	0.09
Humboldt County Department of Public Health	127,754	182	0.14
Mendocino County	87,273	430	0.49

Note: San Francisco and Sonoma county data as of July 2002, Humboldt county data as of January 2002, and Mendocino county data as of April 2002.

Sources: California State Association of Counties (as of January 2002), and California medical marijuana county registries.

Medical Marijuana Registrant Demographics

Most medical marijuana registrants in Hawaii and Oregon—the states where both gender and age data were available—were males over 40 years old. Hawaii and Oregon were the only states that provided gender information; in both cases approximately 70 percent of registrants were men. In Alaska, Hawaii, and Oregon state records showed that over 70 percent of all registrants in each state were 40 years of age or older. Only in one state was there a person under the age of 18 registered as a medical marijuana user. Table 8 shows the distribution of registrants by age in the registry states.

Table 8: Registrant Age in Alaska, Hawaii and Oregon

(Percent in each age category)			
Age	**Alaska**	**Hawaii**	**Oregon**
Under 18	1 (1%)	0	0
19-29	10 (5%)	16 (3%)	145 (9%)
30-39	42 (22%)	70 (12%)	247 (15%)
40-49	84 (44%)	197 (34%)	613 (36%)
50-59	42 (22%)	216 (38%)	550 (33%)
Over 60	11 (6%)	74 (13%)	136 (8%)
Total	**190**	**573**	**1691**

Note: Oregon data as of February 2002, Alaska and Hawaii data as of April 2002.

Source: Medical Marijuana registries in Alaska, Hawaii and Oregon.

In California, none of the local jurisdictions we met with kept information on participants' gender, and only Sonoma County Medical Association provided information on their registrants' age. The age of medical association registrants was similar to participants in the state registries, only slightly younger. Over 60 percent of participants that have had their records reviewed by medical associations were 40 years or older.

Medical Marijuana Registrant Conditions

Most medical marijuana recommendations in states where data are collected have been made for applicants with severe pain or muscle spasticity as their medical condition. Conditions allowed by the states' medical marijuana laws ranged from illnesses such as cancer and AIDS, to symptoms, such as severe pain. Information is not collected on the conditions for which marijuana has been recommended in Alaska or California. However, data from Hawaii's registry showed that the majority of recommendations have been made for the condition of severe pain or the condition of muscle spasticity. Likewise, data from Oregon's registry showed that, 84 percent of recommendations were for the condition of severe pain or for muscle spasticity. Table 9 shows the number and percentage of patients registered by types of conditions in Oregon and Hawaii.

Table 9: Registrant Conditions in Oregon and Hawaii

	Oregon		Hawaii	
	Number of recommendations per condition	Percent with condition	Number of recommendations per condition	Percent with condition
Cancer	43	3	9	2
Glaucoma	31	2	10	2
HIV positive status or AIDS	47	3	66	12
Cachexia	18	1	-	-
Cachexia or wasting syndrome	-	-	9	2
Epilepsy and other seizure disorders	43	3	5	1
Multiple Sclerosis and other disorders characterized by persistent muscle spasms, or spasticity	459	28	240	43
Alzheimer's disease	1	Under 1	-	-
Severe pain	915	56	172	31
Severe nausea	83	5	12	2
Severe nausea/severe pain	-	-	31	6
Total	**1640**[a]		**554**[b]	

Note: Oregon data as of February 2002, Hawaii data as of March 2002.

[a]Information on 51 cases not available.

[b]The number of registrants for Hawaii differs in tables 8 and 9 due to differences in the reporting dates.

Source: Oregon and Hawaii medical marijuana registries.

On the basis of records from the Oregon registry, we reviewed the information provided by doctors for additional insight into the conditions for which registrants use marijuana. The Oregon registry keeps track of secondary conditions in cases where the recommending doctor specified more than one condition. We examined the pool of secondary conditions associated with severe pain[26] and muscle spasms,[27] the two largest condition categories. About 40 percent of those with severe pain reported muscle spasms, migraines, arthritis, or nausea as a secondary medical condition. The most common secondary conditions reported by those with

[26]Of the 915 registrants that reported severe pain as their primary condition, over half reported only one secondary condition, some included up to five secondary conditions. The percentages reported here include those with only one secondary condition.

[27]Of the 459 registrants that reported spasms as a primary condition over 40 percent reported only one secondary condition, some included up to four secondary conditions. The percentages reported here include those with only one secondary condition.

spasms were pain, multiple sclerosis, and fibromyalgia,[28] accounting for 37 percent of the secondary conditions for spasms. A variety of other secondary conditions were identified in the Oregon data, such as acid reflux, asthma, chronic fatigue syndrome, hepatitis C, and lupus.

Few Physicians Make Marijuana Recommendations; Some Guidance Available

In the two states, Hawaii and Oregon, where data on physicians is maintained, few physicians have made medical marijuana recommendations. Of the pool of recommending physicians in Oregon, most physicians made only one to two recommendations. Over half of the medical organizations we contacted provide written guidance for physicians considering recommending marijuana.

Low Physician Participation

Only a small percentage of physicians in Hawaii and Oregon were identified by state registries as having made recommendations for their patients to use marijuana as medicine. These two states maintain information on recommending physicians in their registry records. No information was available on physician participation in California and Alaska. In Hawaii, at the time of our review, there were 5,673 physicians licensed by the state's medical board. Of that number, 44 (0.78 percent) physicians had recommended marijuana to at least one of their patients since the legislation was passed in June 2000. In Oregon, at the time of our review, 435 (3 percent) of the 12,926 licensed physicians in the state had participated in the medical marijuana program since May 1999.

Both Hawaii and Oregon's medical marijuana registration programs are relatively new, which may account for the low level of participation by physicians in both states. Oregon's program has operated for a year longer than Hawaii's, however physician participation overall is low in both states. A Hawaii medical association official told us that he believes physicians consider a number of factors when deciding whether to recommend marijuana as medicine, such as the legal implications of recommending marijuana, lack of conclusive research results on the drug's medical efficacy, and a doctor's own philosophical stance on the use of marijuana as medicine.

[28]Fibromyalgia: Chronic pain, stiffness, and tenderness of muscles, tendons, and joints without detectable inflammation. Fatigue and sleep disorders are common in fibromyalgia patients.

The lower federal courts are divided in terms of whether doctors can make medical marijuana recommendations without facing federal enforcement action, including the revocation of doctors' DEA registrations that allow them to write prescriptions for federally controlled substances. In one case, the district court for the Northern District of California held that the federal government could not revoke doctors' registrations, stating that the de-registration policy raised "grave constitutional doubts" concerning doctors' exercise of free speech rights in making medical marijuana recommendations.[29] In the other case considering this issue, the district court for the District of Columbia ruled that the federal government could revoke doctors' registrations, stating that "[e]ven though state law may allow for the prescription or recommendation of medicinal marijuana within its borders, to do so is still a violation of federal law under the CSA," and "there are no First Amendment protections for speech that is used 'as an integral part of conduct in violation of a valid criminal statute."[30]

Oregon is the only state we reviewed which has registry records that identify recommendations by doctor. Few Oregon physicians made recommendations to use medical marijuana to more than two patients. According to registry data, 82 percent of the participating physicians made one or two recommendations, and 18 percent made three or more recommendations. Table 10 shows a breakdown of the frequency by which physicians made marijuana recommendations.

[29]*See Conant v. McCaffrey*, No. C-97-00139, 2000 U.S. Dist. LEXIS 13024 at *19 (N.D. Cal. Sept. 7, 2000) (permanent injunction granted); *see also Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997) (preliminary injunction granted). On October 29, 2002, the Ninth Circuit Court of Appeals affirmed, finding that the district court convincingly explained how the government's professed enforcement policy threatened to interfere with doctors' First Amendment rights. *See Conant v. Walters*, No. 00-17222, 2002 U.S. App. LEXIS 22942 at *2 (9th Cir. Oct. 29, 2002)

[30]*See Pearson v. McCaffrey*, 139 F. Supp. 2d 113, 121 (D.D.C. 2001).

Table 10: Number of Marijuana Recommendations Made by Oregon Physicians, as of February 2002

Number of recommendations	Number of physicians making recommendations	Percentage of recommending physicians
1	269	61.8
2	87	20.0
3	33	7.6
4	22	5.1
5	8	1.8
6	2	0.5
7	2	0.5
9	2	0.5
10	1	0.2
11	1	0.2
12	1	0.2
13	2	0.5
14	1	0.2
18	1	0.2
23	1	0.2
38	1	0.2
823	1	0.2

Source: Oregon Department of Human Services.

State or law enforcement officials in Oregon, California, and Hawaii indicated that they were each aware of a particular physician in their state that had recommended marijuana to many patients.[31] In Alaska, a state official knew of no physician that had made many recommendations. In Oregon and California the state medical boards have had formal complaints filed against these physicians for alleged violations of the states' Medical Practices Acts, which establish physician standards for medical care. The complaints charge the physicians with unprofessional conduct violations such as failure to conduct a medical examination, failure to maintain adequate and accurate records, and failure to confer with other medical care providers. In Oregon, the physician

[31]Program officials in the registry states verify that a physician recommendation has been made in accordance with program requirements, and that the physician is licensed; they are not authorized to determine whether a doctor's recommendation is medically appropriate.

recommending marijuana to over 800 patients was disciplined.[32] The California case was still pending. At the time of our review, there was no medical practice complaint filed against the Hawaiian doctor known to have made many marijuana recommendations.

Physician Guidance for Making Medical Marijuana Recommendations

In all four states, professional medical associations provide some guidance for physicians in regards to recommending marijuana to patients. State medical boards, in general, have limited involvement in providing this type of guidance. Table 11 indicates the type of guidance available from these medical organizations in each state.

Table 11: Doctor Guidance Provided by Selected State Medical Organizations

State Medical Organizations	Guidance provided	Description
Oregon State Board of Medical Examiners	No	
Oregon Medical Association	Yes	The association has a document informing members of the legal issues facing doctors and advising them on doctor-patient discussions and documentation concerning the use of marijuana for medicine, and actions to avoid.
Alaska State Medical Board	No	
Alaska Medical Association	Yes	Those inquiring about recommending marijuana are directed to seek legal counsel.
Hawaii State Board of Medical Examiners	No	
Hawaii Medical Association	Yes	Those inquiring about recommending marijuana are informed of the association's official position against medical marijuana and advised of the legal implications involved.
Medical State Board of California	Yes	The board has a document that describes the standards physicians recommending marijuana should apply to their practice and advises them on how to best protect themselves.
California Medical Association	Yes	The association provides a document covering the legal issues facing doctors, doctor-patient discussions and documentation concerning the use of marijuana for medicine, actions to avoid, and other topics under the law that may be of concern to physicians.

Note: Guidance provided as of the time of our review.

Source: State Medical Boards and Medical Associations in Oregon, Alaska, Hawaii, and Oregon.

The guidance to physicians considering recommending marijuana to a patient in Oregon, for example, includes avoiding engaging in any

[32]The April 2002 order by the Oregon Board of Medical Examiners reprimanded the physician, fined him $5,000, suspended his license for 90 days, and specified conditions under which any future marijuana recommendations would be made, and other disciplinary actions.

discussions with a patient on how to obtain marijuana, and to avoid providing a patient with any written documentation other than that in the patient's medical records. The medical association also advises physicians to clearly document in a patient's medical records conversations that take place between the physician and patient about the use of marijuana as medicine. Oregon's medical association notes that until the federal government advises whether it considers a physician's medical marijuana recommendation in a patient chart to violate federal law, no physician is fully protected from federal enforcement action.

Most of the state medical board officials we contacted stated that the medical boards do not provide guidance for physicians on recommending marijuana to patients. The medical boards do become involved with physicians making marijuana recommendations if a complaint for violating state medical practices is filed against them. Once a complaint is filed, the boards investigate a physician's practice. Any subsequent action occurs if the allegations against a doctor included violations of the statutes regulating physician conduct.

California medical board's informal guidance states that physicians recommending marijuana to their patients should apply the accepted standards of medical responsibility such as the physical examination of the patient, development of a treatment plan, and discussion of side effects. In addition, the board warns physicians that their best legal protection is by documenting how they arrived at their decision to recommend marijuana as well as any actions taken for the patient.

Difficult to Measure the Impact of State Medical Marijuana Laws on Law Enforcement Activities

Data are not readily available to show whether the introduction of medical marijuana laws have affected marijuana-related law enforcement activities. Assessing such a relationship would require a statistical analysis over time that included measures of law enforcement activities, such as arrests, as well as other measures that may influence law enforcement activities. It may be difficult to identify the relevant measures because crime is a sociological phenomena influenced by a variety of factors.[33] Local law enforcement officials we spoke with about trends in marijuana law enforcement noted several factors, other than medical marijuana laws, important in assessing trends. These factors included changes in general perceptions about marijuana, shifts in funding for various law

[33]According to the FBI introduction to users of Uniform Crime Report data.

enforcement activities, shifts in local law enforcement priorities from one drug to another, or changes in emphasis from drugs to other areas, such as terrorism. Demographics might also be a factor.

The limited availability of data on marijuana-related law enforcement activity illustrates some of the difficulties in doing a statistically valid trend analysis. To fully assess the relationship between the passage of state's medical marijuana laws and law enforcement, one would need data on marijuana related arrests or prosecutions over some period of time, and preferably an extended period of time. Although state-by-state data on marijuana-related arrests is available from the FBI Uniform Crime Reports (UCR), at the time of our review, only data up to the year 2000 was available. Yearly data would be insufficient for analytic purposes since the passage of the medical marijuana initiatives or law in three of the states—Oregon (November 1998), Alaska (November 1998), and Hawaii (June 2000)—is too recent to permit a rigorous appraisal of trends in arrests and changes in them.[34] Furthermore, although California's law took effect during 1996 providing a longer period of data, it is also important to note that the FBI cautions about UCR data comparisons between time periods because of variations in year-to-year reporting by agencies.[35]

Similar data limitations would occur using marijuana prosecutions as a measure of trends in law enforcement activity. Data on marijuana prosecutions are not collected or aggregated at the federal level by state. At the state level, for the four states we reviewed, the format for collecting the data, or time period covered also had limitations. For example in California, the state maintains "disposition" data that includes prosecutions, but reflects only the most serious offenses, so that marijuana possession that was classified as a misdemeanor would not be captured if the defendant was also charged with possession of other drugs, or was involved with theft or other non-misdemeanor crimes. Further, the data is grouped by the year of final disposition, not when the offense

[34]Programs to implement the laws in Oregon, Alaska and Hawaii were developed somewhat later. Alaska's registry was established in June 1999, Oregon's program began operating in May 1999, and Hawaii issued its first card in January 2001.

[35]As described in the methodology section of UCR's annual publication, *Crime in the United States* (2000) UCR excludes trend statistics if the reporting units have not provided comparable data for the periods under consideration, or when it is ascertained that unusual fluctuations, such as improved record keeping or annexations are involved. Although most law enforcement agencies submit crime reports to the UCR program, data are sometimes not received for complete annual periods. If data on other factors was available for California to analyze the relationship of its medical marijuana law and arrests, one would also need to assess the comparability of arrest data from different time periods.

occurred. Hawaii does not have statewide prosecution data. At the time of our review, prosecution data from Oregon's statewide Law Enforcement Data System was only available for 1999 and 2000.

Perceptions of Officials with Selected Law Enforcement Organizations Regarding the Impact of Medical Marijuana Laws

We interviewed officials from 37 selected federal, state, and local law enforcement organizations in the four states to obtain their views on the effect, if any, state medical marijuana laws had on their law enforcement activities. Officials representing 21 of the organizations we contacted indicated that medical marijuana laws had had little impact on their law enforcement activities for a variety of reasons, including very few or no encounters involving medical marijuana registry cards or claims of a medical marijuana defense. For example:

- The police department on one Hawaiian island had never been presented a medical marijuana registry card, and only 15 registrants lived on the island.
- In Alaska, a top official for the State Troopers Drug Unit had never encountered a medical marijuana registry card in support of claimed medical use.
- In Oregon, one district attorney reported having less than 10 cases since the law was passed where the defendant presented a medical marijuana defense.[36]
- In Los Angeles County, an official in the District Attorney's office stated that only three medical marijuana cases have been filed in the last two years in the Central Branch office, two of the cases involving the same person.

Some of the federal law enforcement officials we interviewed indicated that the introduction of medical marijuana laws has had little impact on their operations. Senior Department of Justice officials said that the Department's overall policy is to enforce all laws regarding controlled substances, however they do have limited resources. Further, the federal process of using a case-by-case review of potential marijuana prosecutions has not changed as a consequence of the states' medical marijuana laws. These officials said that U.S. Attorneys have their own criteria or guidelines for which cases to prosecute that are based on the Department's overall strategies and objectives.

[36]The District Attorney noted that they had won these cases because the defendants were not operating within the parameters of the state medical marijuana law.

Law enforcement officials in the selected states also told us that, given the range of drug issues, other illicit drug concerns, such as rampant methamphetamine abuse or large-scale marijuana production are higher priorities than concerns about abuse of medical marijuana. In at least one instance, this emphasis was said to reflect community concerns—in Hawaii, one prosecuting attorney estimated that one-third to one-half of the murders and most hostage situations in the county involved methamphetamines. He said businesses ask why law enforcement is bothering with marijuana when they have methamphetamines to deal with.

Although many of the officials with other organizations we contacted did not clearly indicate whether medical marijuana laws had, or had not, had major impact on their activities, officials with two organizations said that medical marijuana laws had become a problem from their perspective. Specifically, an official with the Oregon State Police Drug Enforcement Section said that during 2000 and 2001, there were 14 cases in which the suspects had substantial quantities of processed or growing marijuana and were arrested for distribution of marijuana for profit, yet were able to obtain medical marijuana registry cards after their arrests. Because the same two defense attorneys represented all the suspects, the police official expressed his view that the suspects might have been referred to the same doctor, causing the official to speculate about the validity of the recommendations. In Northern California—an area where substantial amounts of marijuana are grown[37]—officials with the Humboldt County Drug Task Force[38] told us that they have encountered growers claiming to be caregivers for multiple medical marijuana patients. With a limit of 10 plants per person established by the Humboldt County District Attorney, growers can have hundreds of plants officials said, and no documentation to support their medical use claims is required.[39]

Over one-third of officials from the 37 law enforcement organizations told us that they believe that the introduction of medical marijuana laws have, or could make it, more difficult to pursue or prosecute some marijuana

[37]According to the senior DEA official for the area, three northern counties are the source region for much of the domestically produced marijuana in the United States, and this production is a major contributor to the local economies.

[38]Headed by a Commander from the California Bureau of Narcotics and staffed by officers from local law enforcement.

[39]The 10 plant limit can be exceeded if the grower claims to grow 10 plants for patient A, 10 plants for patient B, and so on. Documentation of caregiver status is not required under the state's law.

cases. In California, some local law enforcement officials said that their state's medical marijuana law makes them question whether it is worth pursuing some criminal marijuana cases because of concerns about whether they can effectively prosecute (e.g., with no statutory limit on the number of marijuana plants allowed for medical use, the amount consistent with a patient's personal medical purposes is open to interpretation). In Oregon, Hawaii, and Alaska where specific plant limits have been established, some law enforcement officials and district attorneys said that they were less likely to pursue marijuana cases that could be argued as falling under medical use provisions. For example, one Oregon District Attorney stated that because they have limited resources the District Attorneys might not prosecute a case where someone is sick, has an amount of marijuana within the medical use limit, and would probably be approved for a card if they did apply. Officers in Hawaii reported reluctance of a judge to issue a search warrant until detectives were certain that cultivated marijuana was not being grown for medical use, or that the growth was over the 25-plant limit qualifying for felony charges.

Less concrete, but of concern to law enforcement officials were the more subtle consequences attributed to the passage of state medical marijuana laws. Officials in over one-fourth of the 37 law enforcement organizations we interviewed indicated they believe there has been a general softening in public attitude toward marijuana, or public perception that marijuana is no longer illegal. For example, state troopers in Alaska said that they believe that the law has desensitized the public to the issue of marijuana, reflected in fewer calls to report illegal marijuana activities than they once received. Hawaiian officers stated that it is their view that Hawaii's law may send the wrong message because people may believe that the drug is safe or legal.

Several law enforcement officials in California and Oregon cited the inconsistency between federal and state law as a significant problem, particularly regarding how seized marijuana is handled. According to a California Attorney General official, state and local law enforcement officials are frequently faced with this issue if the court or prosecutor concludes that marijuana seized during an arrest was legally possessed under California law, and law enforcement is ordered to return the marijuana. To return it puts officials in violation of federal law for dispensing a Schedule I narcotic, according to the California State Sheriffs' Association, and in direct violation of the court order if they don't return it. The same issue has arisen in Portland, Oregon, officials said, when the Portland police seized 2.5 grams of marijuana from an individual. After the state dismissed charges, the court ordered the return of the marijuana to

the individual, who was a registered medical marijuana user. The city of Portland appealed the court order on grounds that its police officers could not return the seized marijuana without violating federal law, but the Oregon court of appeals rejected this argument in *Oregon v. Kama*.[40] Oregon officials said that DEA then obtained a federal court order to seize the marijuana from the Portland police department. The Department of Justice stated in comments on a draft of this report that they believe conflicts between federal and non-federal law enforcement over the handling of seized marijuana has been and will continue to be a problem.

Law enforcement officials in all four states identified areas of their medical marijuana laws that can hamper their marijuana enforcement activities because the law could be clearer or provide better control. In California, key issues were lack of a definable amount of marijuana for medical use, and no systematic way to identify who qualifies for the exemption. In Oregon, officers were concerned about individuals registering as medical marijuana users after they have been arrested, and timely law enforcement access to the registry information. Officials with about one-fourth of the law enforcement organizations in Hawaii, California and Oregon shared the concern about the degree of latitude given to physicians in qualifying patients for medical use.

Agency Comments and Our Evaluation

We provided a copy of a draft of this report to the Department of Justice for review and comment. In a September 27, 2002 letter, DOJ's Acting United States Assistant Attorney General for Administration commented on the draft. DOJ's comments are summarized below and presented in their entirety in appendix V.

In its comments, DOJ noted that the report fully described the current status of the programs in the states reviewed. However, DOJ stated that the report failed to adequately address some of the serious difficulties associated with such programs. Specifically, according to DOJ, the report

[40]39 P.3d 866 (Or. Ct. App. 2002); *rev. den.*, 47 P.3d 484 (Or. S. Ct. 2002). In *Kama*, the city argued that, because marijuana is a Schedule I controlled substance, its police officers would commit the federal crime of delivering a controlled substance if they returned seized marijuana. The court of appeals disagreed, reasoning that the federal Controlled Substances Act, 21 U.S.C. 885(d), confers immunity on state or local law enforcement officials "lawfully engaged in the enforcement of any law or municipal ordinance relating to controlled substances." The court concluded that, because the officers were required to return the seized marijuana under Oregon's medical marijuana act, Or. Rev. Stat. 475.323(2), federal law granted them immunity for doing so.

does not adequately address, through any considered analysis, issues related to the (1) inherent conflict between state laws permitting the use of marijuana and federal laws that do not; (2) potential for facilitating illegal trafficking; (3) impact of such laws on cooperation among federal, state, and local law enforcement; and (4) lack of data on the medicinal value of marijuana. DOJ further stated that our use of the phrase "medical marijuana" implicitly accepts a premise that is contrary to existing federal law.

In regard to the first issue—state laws that permit the use of marijuana and federal laws that do not—DOJ pointed out that the most fundamental problem with the report is that it failed to emphasize that there is no federally recognized medicinal use of marijuana and thus possession or use of this substance is a federal crime. We disagree, and believe that we have clearly described federal law on the use of marijuana. On page 1 of our report, we specifically state that federal law does not recognize any accepted medical use for marijuana and individuals remain subject to federal prosecution for marijuana possession regardless of state medical marijuana laws.

In other comments about state and federal laws, DOJ also pointed out that our report failed to mention that state medical marijuana laws undermine (1) the closed system of distribution for controlled substances under the Controlled Substances Act and (2) the federal government's obligations under international drug control treaties which, according to DOJ, prohibit the cultivation of marijuana except by persons licensed by, and under the direct supervision of, the federal government. As discussed in our report, the legal framework for our work was the Supreme Court's opinion in *United States v. Oakland Cannabis Buyers Cooperative*, 532 U.S. 483 (2001) which held that the federal government can enforce marijuana prohibitions without regard to a medical necessity defense, even in states with medical marijuana laws. During our review, we saw no reason to expand our analysis beyond that set forth in the Supreme Court's decision. This is especially true since the scope of our work was to examine how the selected states were implementing their medical marijuana laws—not the issues raised in DOJ comments.

Regarding the second issue concerning the potential for illegal trafficking, DOJ commented that our report did not mention that state medical marijuana laws are routinely being abused to facilitate traditional illegal trafficking. DOJ also highlighted the lack of guidance provided by the California state government to implement its medical marijuana law as contributing to the problem in California. Our report discusses the views

of law enforcement officials representing 37 organizations in the four states—including federal officials—regarding the impact of state medical marijuana laws on their law enforcement efforts. Our report presented the views they conveyed to us. Thus, in those instances where law enforcement officials, including representatives of DEA and U.S. Attorneys' offices, discussed what they considered instances of abuse or potential abuse, we discussed it in our report. During our review, none of the federal officials we spoke with provided information to support a statement that abuse of medical marijuana laws was routinely occurring in any of the states, including California. DOJ further asserted that we should include information on the "underlying criminal arena," on homicides related to marijuana cultivation, and on illegal marijuana production and diversion. These issues were beyond the scope of our work.

In regard to its third comment pertaining to cooperation among federal, state, and local law enforcement officials, DOJ stated that our report did not reflect DEA's experience—a worsening of relations between federal, state, and local law enforcement. DOJ's comments provided specific examples of incidents involving conflicts between DEA and non-federal law enforcement officials, but these examples were not provided to us during our fieldwork. In comments on a summary of law enforcement opinions, some of the non-federal law enforcement officials we interviewed also stated we should discuss the conflict between state medical marijuana laws and federal laws as it related to seized marijuana.[41] We modified our draft to include a discussion of these concerns, and have likewise included DOJ's comment. It is also important to note, however, that contrary to DOJ's suggestion, our report included a discussion about the concerns of the law enforcement officials regarding a "softening" of the public perception about marijuana. Finally, DOJ's point that Oregon's medical marijuana law negatively impacts federal seized asset sharing was an issue outside the scope of our review.

In regard to the fourth issue—lack of data on the medicinal value of marijuana—DOJ stated that our discussion of the debate over the medical value of marijuana is inadequate and does not present an accurate picture. We believe our report adequately discusses that a continuing debate exists. The overall objective of our review was to examine the implementation of state medical marijuana laws, and an analysis of the

[41]A summary of law enforcement opinions was sent to those we spoke with for their comments.

scientific aspects of the medical marijuana debate was beyond the scope of our work. We do, however, footnote various studies so that readers can access additional information on the studies if they desire.

Finally, we disagree with DOJ's comment that our use of the term medical marijuana accepts a premise contrary to federal law, given that we specifically defined the term in relation to state, not federal, law. As mentioned earlier, our report specifically states that federal law does not recognize any accepted medical use for marijuana and individuals remain subject to federal prosecution for marijuana possession regardless of state medical marijuana laws. Furthermore, the introduction to the report clearly points out that, throughout the report, we use the phrase medical marijuana to describe marijuana use that qualifies for a medical use exception under state law.

DOJ also provided technical comments, which we have included in this report, where appropriate. In addition, as mentioned earlier, some of the representatives of state law enforcement organizations provided comments on the section of the report dealing with their perceptions, and we have made changes to the report, where appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Ranking Minority Member, Subcommittee on Criminal Justice, Drug Policy and Human Resources, and the Chairman and Ranking Minority Member, House Committee on Government Reform; the Chairman and Ranking Minority Member of the House Judiciary Committee; the Chairman and Ranking Minority Member of the Senate Judiciary Committee; the Attorney General; and the Director, Office of Management and Budget. We will also make copies available to others on request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions on this report, please contact me or John Mortin on (202) 512 –8777. Key contributors are acknowledged in appendix V.

Sincerely yours,

Paul Jones
Director, Justice Issues

Appendix I: Objectives, Scope, and Methodology

Objectives

Our overall objectives were to provide fact-based information on how selected states implement laws that create a medical use exception to specified state marijuana prohibitions, and to document the impact of those laws on law enforcement efforts. Specifically, for selected states, our objectives were to provide information on (1) their approach to implementing their medical marijuana laws and how they compare, and the results of any state audits or reviews, (2) the number of patients that have had doctors recommend marijuana for medical use in each state, for what medical conditions, and by age and gender characteristics, (3) how many doctors are known to have recommended marijuana in each, and what guidance is available for making these recommendations, and (4) perceptions of federal and state law enforcement officials, and whether data are available to show how law enforcement activities have been affected by the exceptions provided by these states' medical marijuana laws.

We conducted our review between September 2001 and June 2002 in accordance with generally accepted government auditing standards.

Scope and Methodology: State Selection and Data

Eight states have enacted medical marijuana statutes.[1] We selected four of those states based on the length of time the laws had been in place, the availability of data, and congressional interest. Two of the eight states, Nevada and Colorado, were not selected because their laws had not been in place for at least 6 months when our review began. Another two states, Maine and Washington, were not selected because they do not have state registries to obtain information on program registrants. Alaska, Oregon and Hawaii do have state registries and had laws in place for at least 6 months. California's law was enacted in 1996; however, the state does not have a participant registry. We included it because some local registry information was available, and the requestor specifically requested information on California and Oregon. Our sample consists of these four states: California, Oregon, Alaska, and Hawaii.

We conducted on-site data collection and interviews with senior officials at state registries in Oregon and Hawaii, county offices in selected California counties, and the senior official in Alaska by phone and email. We examined applicable federal and state laws and regulations and

[1]These eight states were identified in the Supreme Court's decision in *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483, 502 n.4 (2001).

obtained and analyzed available information on program implementation, program audits, and program participation by patients and doctors.

Data Reliability

State and California county officials voluntarily supplied data on medical marijuana program registrants and some provided data on physician participation. Officials did not provide names to protect participants' confidentiality. We reviewed the data for reasonableness and followed up with appropriate individuals about any questions concerning the data. Given the confidentiality of the information, we could not check the data back to source documents. We also interviewed knowledgeable state and county officials to learn how the data was collected and processed, and to gain a full understanding of the data. We determined the data was reliable enough for the limited purposes of this report. However, the data only reflects those that have registered with state and county programs. No estimate is available on the number of medical marijuana users that have not registered with a program. Additionally, data from the three state registries are not representative of participation in other states for which we did not collect data. Similarly, data from select California counties only reflect each county, not other counties where we did not conduct audit work.

Scope and Methodology: Law Enforcement Opinions

We used a nonprobability sample to select law enforcement representatives to provide examples of the policies, procedures, experiences, and opinions of law enforcement regarding state medical marijuana laws. Our selection of these law enforcement representatives was not designed to enable us to project their responses to others, in this case, other law enforcement officials. Feedback was requested from officials at law enforcement organizations we visited, and incorporated where appropriate.

We discussed state medical marijuana laws with federal, state and local law enforcement officials in the states of California, Hawaii, Oregon and Alaska. On-site interviews were conducted in all but Alaska.[2] Federal officials in each state included representatives from the office of the U.S. Attorney and the Drug Enforcement Administration (DEA). The specific

[2]As a result of phone discussions with law enforcement officials in Alaska, and the low number of registrants in Alaska's medical marijuana program, we decided that interviews could be conducted by email and phone.

U.S. Attorney and DEA office and officials we met with were selected by the Department of Justice as the most knowledgeable on the subject. For a statewide perspective, we interviewed representatives from the Attorney General's office and at least one statewide association in California and Oregon representing law enforcement officials. This included representatives from the following:

Oregon Attorney General
Oregon Association of Chiefs of Police
California Attorney General
California District Attorney Association
California State Sheriff's Association
Hawaii Attorney General
Hawaii Department of Public Safety
Alaska Attorney General
Alaska State Troopers

For a local law enforcement perspective, we interviewed district attorney and local police department officials. Selection was judgmental and based on a number of factors, including: suggestions by federal or state officials, jurisdictions where trips were planned to interview state medical marijuana registry program officials or state officials, or large portions of the state population were covered by the department. Local law enforcement representatives included the following:

Marion County Oregon District Attorney
Portland Oregon District Attorney
Portland Oregon Bureau of Police
Oregon State Police
Oregon Association of Chiefs of Police (Dallas Oregon Police Chief participated)
Clackamus County Oregon Sheriff's Office
Los Angeles California District Attorney
Los Angeles California Police Department
San Bernardino California Police Department
Orange California Police Department
Eureka California Police Department/ Humboldt (state) Drug Task Force
Arcata California Police Department
San Francisco California Police Department
Hawaii County Hawaii Prosecuting Attorney
Honolulu County Hawaii Prosecuting Attorney
Hawaii County Hawaii Police Department
Honolulu Hawaii Police Department

Maui Hawaii Police Department
Anchorage Alaska District Attorney
Anchorage Alaska Police Department
Juneau Alaska Police Department

We requested comments from DOJ on a draft of this report in August 2002. The comments are discussed near the end of the letter and are reprinted as appendix V. DOJ also provided technical comments on the draft of this report and we incorporated DOJ's comments where appropriate. In addition, we requested comments from the law enforcement officials we interviewed pertaining to the section of this report dealing with their perceptions and included their comments where appropriate. Finally, we verified the information we obtained on the implementation of state medical marijuana laws with the officials we contacted during our review.

Appendix II: The Supreme Court's Decision in *United States v. Oakland Cannabis Buyers' Cooperative*

Under the federal Controlled Substances Act of 1970 (CSA), marijuana is classified as a Schedule I controlled substance, a classification reserved for drugs found by the federal government to have no currently accepted medical use. 21 U.S.C. 812(c), Schedule I (c)(10).

Consistent with this classification system, the CSA does not allow Schedule I drugs to be dispensed upon a prescription, unlike drugs in the less restrictive drug schedules. *Id.* 829. In particular, the CSA prohibits all possession, manufacture, distribution or dispensing of Schedule I substances, including marijuana, except in the context of a government-approved research project. *Id.* 823(f), 841(a)(1), 844.

Some states have passed laws that create a medical use exception to otherwise applicable state marijuana sanctions. California was the first state to pass such a law, when, in 1996, California voters passed a ballot initiative, Proposition 215, which removed certain state criminal penalties for the medical use of marijuana.

In the wake of Proposition 215, various cannabis clubs formed in California to provide marijuana to patients whose physicians had recommended such treatment. In 1998, the United States sued to enjoin one of these clubs, the Oakland Cannabis Buyers' Cooperative, from cultivating and distributing marijuana. The United States argued that, whether or not the Cooperative's actions were legal under California law, they violated the CSA. Following lower court proceedings, the U.S. Supreme Court granted the government's petition for a writ of certiorari to review whether the CSA permitted the distribution of marijuana to patients who could establish "medical necessity." *United States v. Oakland Cannabis Buyers' Cooperative*, 532 U.S. 483 (2001).

Although the tension between California's Proposition 215 and the broad federal prohibition on marijuana was the backdrop for the *Oakland Cannabis* case, the legal issue addressed by the Supreme Court did not involve the constitutionality of either the federal or state statute. Rather, the Court confined its analysis to an interpretation of the CSA and whether there was a medical necessity defense to the Act's marijuana prohibitions. The Court held that there was not. While observing that the CSA did not expressly abolish the defense, the Court stated that the statutory scheme left no doubt that the defense was unavailable for marijuana. Because marijuana appeared in Schedule I, it reflected a determination that marijuana had no currently accepted medical use for purposes of the CSA. The Court concluded that a medical necessity defense could not apply under the CSA to a drug determined to have no medical use.

The *Oakland Cannabis* case upheld the federal government's power to enforce federal marijuana prohibitions without regard to a claim of medical necessity. Thus, while California (and other states) exempt certain medical marijuana users and their designated caregivers from state sanctions, these individuals remain subject to federal sanctions for marijuana use.

Appendix III: Medical Marijuana Registries in Oregon, Alaska, Hawaii, and Select California Counties

How states implemented registry requirements in the three registry states, such as which agency administers the registry or the number of staff to manage it, varied in some ways and were similar in other ways. Similarly, the county-based registries in California had some differences and commonalities.

Oregon

In Oregon, the Department of Human Services is designated to maintain the state medical marijuana registry. A staff of six is responsible for reviewing and verifying incoming applications and renewals, including following up on those that are incomplete, and input and update of the database. Recommending physicians are sent, and must respond to a verification letter for the application to be approved. By statute in Oregon, an applicant can be denied a card for only two reasons—submitting incomplete or false information. According to the State Public Health Officer, the scope of the Department of Human Services responsibility is to see to that there is a written determination of the patient's condition by a legitimate doctor, and includes an attending physician recommendation that the patient might benefit from using marijuana. He stated that the staff does not question a doctor's recommendation for medical marijuana use. The law is clear, he said. It is up to the physician to decide what is best.

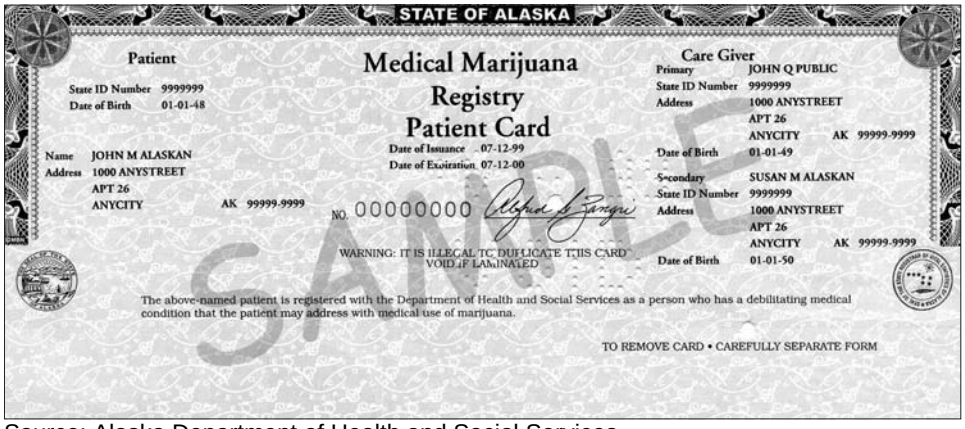
The Oregon Department of Human Services also considers the addition of new conditions to the list of those acceptable for medical use of marijuana, as authorized by Oregon's medical marijuana statute. At the time of our review, only one of the eight petitions that had been reviewed by the Department had been approved—agitation due to Alzheimer's disease. Most of the petitioned conditions have had a psychological basis, the State Public Health Officer said.

Alaska

Alaska's statute designates the Department of Health and Social Services to manage the state medical marijuana registry. The full time equivalent of one half-time person is responsible for registry duties, including checking applications for accuracy and completeness and entering the information into the registry. The physician's license is checked for approval to practice in Alaska, and if a caregiver is designated the registry is checked to assure they are only listed as a caregiver for one person unless otherwise approved by the Department. Patients, physicians and caregivers are also contacted to verify information as appropriate. If all Alaska statutory requirements are met, a medical marijuana registry identification card is issued (see fig. 4). Registry cards are denied in Alaska

if the application is not complete, the patient is not otherwise qualified to be registered, or if the information in the application is found to be false.

Figure 3: Example of Alaska's Medical Marijuana Certification Card



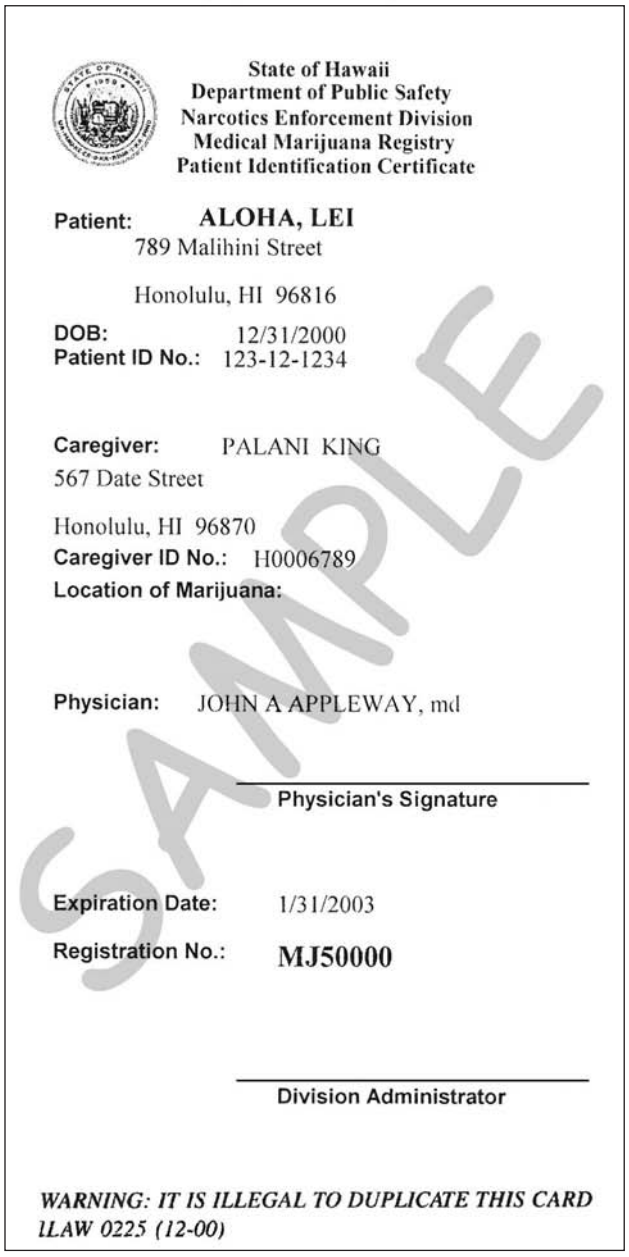
Source: Alaska Department of Health and Social Services.

Alaska's statute allows the Department to add debilitating medical conditions to the approved list for use of marijuana. A procedure for requesting new conditions is outlined in state regulations. To date, there have been no requests to consider new conditions and none have been added.

Hawaii

The medical marijuana law passed by the Hawaiian legislature designates the state Department of Public Safety to administer the Hawaiian medical marijuana registry. One person within Public Safety's Narcotics Enforcement Division staffs the registry. This person is responsible for reviewing and approving applications and renewals as complete, inputting applicant information into the database, and responding to any law enforcement inquiries. Verification procedures in Hawaii are similar to those followed in other states. See figure 4 for an example of Hawaii's registry card.

Figure 4: Example of Hawaii's Medical Marijuana Registry Card



Source: State of Hawaii Department of Public Safety.

California

Registration application requirements and procedures for the voluntary California registries we reviewed were unique to each county, but shared some procedures with the programs established in the registry states.

In Humboldt County, the patient must submit an application and physician recommendation to the county Department of Health and Human Services, with a $40.00 fee. Applicants are interviewed, photographed, and their county residency documents are checked during an in-person interview. To protect the confidentiality of doctors, after the physician recommendation has been verified, the physician portion of the application is detached and shredded. Applications are denied if the patient is not a county resident, the physician is not licensed in California, or there is not a therapeutic relationship between the patient and physician.

The San Francisco Medical Cannabis ID Card Program applications are made available through the city's Department of Public Health, where the registry is maintained, and also from clinics, doctor's offices and medical cannabis organizations that have requested them. Applicants must bring a physician's statement form, or form documenting that an oral recommendation was received, medical records release form, proof of identification and residence in San Francisco and the fee. For an applicant the fee is $25.00, plus $25.00 for each primary caregiver, up to a maximum of three caregivers. Registry cards are valid for up to 2 years, based on a physician's recommendation. After verifying the application documents to its satisfaction, the Department returns the entire application package to the applicant, and issues cards to the applicant and caregivers. The department does not copy the materials, or keep the name of registrants. Information kept on file is limited to the serial number of the cards issued, the serial number of the identification card submitted, the date the registry card was issued, and when it expires.

The Mendocino County Public Heath Department and the Sheriff's office jointly run the County Pre-identification Program for county residents. The Health Department accepts the applicant's Medical Marijuana Authorization forms, which includes patient and caregiver information, and a section for the physician to complete. The physician section requires checking "yes" or "no" to a recommendation, and the expiration length for the recommendation in months, years or for the patient's lifetime. No condition information is requested. After verifying the physician recommendation, that section is destroyed, and the approved authorization sheet is sent to the Sheriff's office. The Sheriff's office interviews registrants and caregivers, requiring that they sign a declaration

as to the caregiver's role in patient care. Program identification cards with photographs of patients and caregivers are issued by the Sheriff's office.

In Sonoma County, the Sonoma County Medical Association, in conjunction with the Sonoma County District Attorney, developed a voluntary process for the medical association to provide peer review of individuals' medical records and physician recommendations for medical use of marijuana. Based on the review, the patient's physician is sent a determination regarding whether the patient's case met criteria established regarding the patient-physician relationship, whether marijuana was approved of, and whether the condition is within the California state code allowing medical marijuana use. Upon receiving the determination from their doctor, patients decide whether to voluntarily submit the results to the District Attorney for distribution to the appropriate police department or to the sheriff's office. According to the medical association director, some patients will go through the process but prefer to keep the letter themselves rather than have their name in a law enforcement database.

Appendix IV: Descriptions of Allowable Conditions under State Medical Marijuana Laws

Medical marijuana laws in California, Oregon, Hawaii and Alaska identify medical conditions or symptoms eligible for medical marijuana use, but do not specifically define the conditions or symptoms. The following descriptions are based on definitions in the Merriam Webster Medical Dictionary and selected other sources.

Alzheimer's Disease: Alzheimer's is a brain disease that usually starts in late middle or old age. It is characterized as a memory loss for recent events spreading to memories for more distant events and progressing over the course of five to ten years to a profound intellectual decline characterized by impaired thought and speech and finally complete helplessness.

Anorexia: Anorexia is a lack, or severe loss of appetite, especially when prolonged. Many patients develop anorexia as a secondary condition to other diseases.

AIDS: Acquired Immune Deficiency Syndrome is a severe disorder caused by the human immunodeficiency virus, resulting in a defect in the cells responsible for immune response that is manifested by increased susceptibility to infections and to certain rare cancers.

Arthritis: Arthritis refers to the inflammation of joints, usually accompanied by pain, swelling, and stiffness.

Cachexia: Cachexia is a general physical wasting and malnutrition usually associated with chronic disease, such as AIDS or cancer.

Cancer: Cancer is an abnormal growth that tends to grow uncontrolled and spread to other areas of the body. It can involve any tissue of the body and can have many different forms in each body area. Cancer is a group of more than 100 different diseases. Most cancers are named for the type of cell or the organ in which they begin.

Crohn's Disease: Crohn's disease is a serious inflammatory disease of the gastrointestinal tract, it predominates in parts of the small and large intestine causing diarrhea, abdominal pain, nausea, fever, and at times loss of appetite and subsequent weight loss.

Epilepsy: Epilepsy is a disorder marked by disturbed electrical rhythms of the central nervous system and typically manifested by convulsive attacks, usually with clouding of consciousness.

Glaucoma: Glaucoma is a disease of the eye marked by increased pressure within the eyeball that can result in damage to the part of the eye referred to as the blind spot and if untreated leads to gradual loss of vision.

HIV: Human Immunodeficiency Virus is a virus that reduces the number of the cells in the immune system that helps the body fight infection and certain rare cancers, and causes acquired immune deficiency syndrome (AIDS).

Migraine: A migraine is a severe recurring headache, usually affecting only one side of the head, characterized by sharp pain and often accompanied by nausea, vomiting, and visual disturbances.

Multiple Sclerosis: Multiple Sclerosis is a disease of the central nervous system marked by patches of hardened tissue in the brain or the spinal cord causing muscular weakness, loss of coordination, speech and visual disturbances, and associated with partial or complete paralysis and jerking muscle tremor.

Nausea: Nausea refers to a stomach distress with distaste for food and an urge to vomit. Severe Nausea refers to nausea of a great degree.

Pain: Pain refers to an unpleasant sensation that can range from mild, localized discomfort to agony. Pain has both physical and emotional components. The physical part of pain results from nerve stimulation. Pain may be contained to a discrete area, as in an injury, or it can be more diffuse, as in disorders that are characterized as causing pain, stiffness, and tenderness of the muscles, tendons, and joints. Severe pain refers to pain causing great discomfort or distress. Chronic pain is often described as pain that lasts six months or more and marked by slowly progressing seriousness.

Spasticity: Spasticity is a condition in which certain muscles are continuously contracted. This contraction causes stiffness or tightness of the muscles and may interfere with gait, movement, and speech. Symptoms may include increased muscle tone, a series of rapid muscle contractions, exaggerated deep tendon reflexes, muscle spasms, involuntary crossing of the legs, and fixed joints. The degree of spasticity varies from mild muscle stiffness to severe, painful, and uncontrollable muscle spasms.

Wasting Syndrome: A condition characterized by loss of ten percent of normal weight without obvious cause. The weight loss is largely the result of depletion of the protein in lean body mass and represents a metabolic derangement frequent during AIDS.

Appendix V: Comments from the Department of Justice

U.S. Department of Justice

Washington, D.C. 20530

SEP 27 2002

Mr. Paul Jones
Director
Justice Issues
U.S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Jones:

On August 26, 2002, the General Accounting Office (GAO) provided the Department of Justice (DOJ) copies of its draft report entitled "MEDICAL MARIJUANA: Early Experiences With Four States' Laws." While we note that the report fully describes the current status of the programs in the states reviewed, we are concerned that it fails to adequately address some of the serious difficulties associated with such programs. The DOJ believes the report does not adequately address, through any considered analysis, issues related to the 1) inherent conflict between state laws permitting the use of marijuana and federal laws that do not; 2) potential for facilitating illegal trafficking; 3) impact of such laws on cooperation among federal, state, and local law enforcement; and 4) lack of data on the medicinal value of marijuana. Further, the GAO's continued use of the term "medical marijuana" implicitly accepts the fact that there is a 1) proven medicinal value to marijuana and 2) legitimate exception to federal law for this use. Neither of these premises are true. Finally, we note that the GAO fails to consider what the existence of state "medical marijuana" laws communicates. We believe such laws send society the wrong message.

Conflict Between Laws

The most fundamental problem with the draft GAO report is that it fails to emphasize the fact that there is no federally recognized medicinal use of marijuana and thus possession or use of this substance is a federal crime. Further, the GAO fails to even mention that state laws purporting to approve marijuana for medical use undermine the closed system of distribution for controlled substances established by the Controlled Substances Act (CSA). The time-proven safeguards that have made the medical drug supply in the United States the safest in the world are lacking. State medical marijuana legislation does not and could not require the cultivators and distributors of marijuana to comply with the federal requirement that all manufacturers and distributors of Schedule I controlled Substances be registered with the Drug Enforcement Administration (DEA). The registration process and record-keeping requirements established by federal law and administered by DEA are critical components of DEA's

effort to restrict abuse of marijuana and other controlled substances. In this regard, there is no analysis nor comparison of state controls of marijuana subject to state "medical marijuana" laws with federal and state controls of other prescribed medicines covered by the CSA. The regulation of the production and distribution of prescribed medicines is a critical component in preventing the diversion of controlled substances that are properly prescribed for medical use. A comparison of DEA's controls of other legitimately prescribed controlled substances would highlight the lack of proper oversight of marijuana as a "medicine."

The registration process is also an important aspect of the United States Government's implementation of international drug control treaties. These treaties obligate the federal government to prohibit the cultivation of marijuana except by persons licensed by, and under the direct supervision of, the federal government. The treaties also obligate the federal government to control the distribution of marijuana. This is required even if the federal government determines that marijuana has an accepted medical use. Any state legislation purporting to authorize medical use of marijuana is inconsistent with the CSA as none of these state laws require the cultivation of marijuana that is federally licensed and supervised by the federal government. These state laws undermine the ability of the federal government to meet its obligations under international law. The GAO Draft Report makes no mention of this critical issue.

Abuse of State Laws to facilitate Illegal Drug Trafficking

The GAO Draft Report does not mention that state "medical marijuana" laws are routinely being abused to facilitate traditional illegal marijuana trafficking and use. Information acquired by DEA during its investigations of cannabis clubs would provide specific examples of this abuse. The report focuses exclusively on so-called medical use of marijuana and omits any mention of the abuse of state "medical marijuana" laws. The report fails to reflect the underlying criminal arena in which marijuana is produced and consumed and the significant profitability that drives the marijuana market. Because of that factor, there is a blurred line between medical and illegal commercial markets. Further, some U.S. Attorney's Offices have indicated that in their district violent crimes associated with marijuana cultivation (such as homicides) create significant law enforcement and social issues. Without addressing the illegal production and diversion of marijuana, the GAO Draft Report provides an incomplete analysis of the impact of the "medical" marijuana laws on the enforcement of drug control laws.

The passage of Proposition 215 in California and similar legislation in other states has created unfortunate circumstances for state and local law enforcement officers. The state initiatives also have provided legal loopholes for drug dealers and marijuana cultivators to avoid arrest and prosecution. This is due in part to California state government's lack of guidance as to the implementation of the law and their seeming unwillingness to enforce state drug laws against traffickers who claim to be involved with marijuana under the state "medical marijuana" law. Further, those counties that have taken a public position on proposition 215 have contributed to the dilemma now being experienced by state and local law enforcement. The vague guidelines established throughout the counties in California sends a message to many that anyone who has a "recommendation" from a doctor is permitted to grow and possess certain (varying) amounts of marijuana.

Impact on Law Enforcement Operations and Cooperation

The GAO Draft Report states that "[s]ome of the federal law enforcement officials we interviewed indicated that the introduction of state "medical marijuana" laws has had little impact on their operations." This statement does not accurately reflect DEA's experience in addressing state "medical marijuana" laws. One of the major effects of the states legislation is the worsening of relations between federal, state, and local law enforcement.

As a result of these circumstances the most significant issue that now appears to be occurring is the recognizable rift that the laws have created between state and local law enforcement and federal drug agents, who are mandated to enforce the federal law. There have been and undoubtedly will continue to be instances that occur in the affected states where local officers working joint investigations with DEA have been ordered or instructed not to seize contraband plants and/or marijuana by their district attorney or state's attorney office. In some cases, DEA has been required to obtain Federal warrants to seize marijuana being held by local police agencies to prevent the return of the marijuana to persons pursuant to State court orders. This conflict has lead to several heated incidences on the West Coast.

For example, in one recent case, where federal agents were cooperating with local officers to serve a state search warrant at a residence, the District Attorney of Butte County, California, advised a Butte County detective to arrest a DEA Special Agent if the agent confiscated six marijuana plants that were found during the operation. The District Attorney asserted that under California's "medical marijuana" law the plants were lawfully possessed; however, such possession violates federal law. The plants were seized and submitted to the DEA laboratory for destruction without incident only after negotiations between the U.S. Attorney, the District Attorney, and DEA representatives to resolve the issue. In another instance, the Oakland Police Department referred to the DEA a shooting incident involving the theft of a pound of marijuana because the city of Oakland prohibits its officers from pursuing any investigation of marijuana that may be claimed to be subject to the state "medical marijuana" law. In this instance the "victim" of the robbery was a marijuana recipient under the state "medical marijuana" law who was attempting to sell the marijuana he had to his robbers. Such conflicts over individual mandates have required frequent intervention by DEA's Office of Chief Counsel and the DOJ due to the clear lack of a coordinated drug law enforcement policy.

Because state and local law enforcement cannot work on certain marijuana cases under these laws, federal seized asset sharing has been negatively impacted. In the state of Oregon, the state legislation prevents the federal government from sharing seized assets directly with state/local law enforcement entities in cases involving asset seizure without criminal prosecution initiated following marijuana grow seizures.

It is much more difficult for federal and state officials to prosecute marijuana cases where medicinal use can be claimed. There is growing local sentiment that because of these laws, federal law enforcement resources should not be devoted to marijuana prosecutions. This sentiment also manifests itself in jury

trials where prosecutors have jury nullification concerns (as a result of softened public attitudes towards marijuana).

In these states, the perception that marijuana is accepted by the public has significantly impacted law enforcement. According to Oregon State Police authorities, outlaw motorcycle gang members are now applying for marijuana caregiver status, believing that this will officially authorize their marijuana grow operations. Marijuana grow operations have always presented problems to law enforcement, and marijuana potentially subject to state "medical marijuana" laws only serve to further confuse the general public on this drug. Public perception on this issue appears to be further softened as a result of strong marketing strategies by pro-legalization/medicinal use advocates. Groups supporting the legalization of marijuana in Alaska are now preparing new proposals to legalize all marijuana. The public confusion on this issue can be demonstrated by the fact that the voters in these states approved the medical use of marijuana but *do not allow use* in *public places* (Oregon) or in *medical facilities*, or nearby school grounds, recreation centers or youth centers (Alaska). This sends a mixed message to the public as no other medicines are restricted in this way.

Marijuana As Medicine

The GAO Draft Report's discussion of the debate over the medical value of marijuana is inadequate and does not present an accurate picture. The draft states that "[t]he potential medical value of marijuana has been a continuing debate." It fails to mention, however, that smoked marijuana has never been approved as medicine by the Food and Drug Administration (FDA) and has never been proven safe and effective in sound scientific studies. Further, at its 2001 Annual Meeting, the American Medical Association (AMA)adopted the following as its policy on the medicinal use of marijuana:

> "The AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease; (2) The AMA recommends that marijuana be retained in Schedule I of the Controlled Substances Act pending the outcome of such studies. (3) The AMA urges the National Institutes of Health (NIH) to implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research into the medical utility of marijuana. . . . (4) The AMA believes that the NIH should use its resources and influence to support the development of a smoke-free inhaled delivery system for marijuana or delta-9-tetrahydrocannabinol (THC) to reduce the health hazards associated with the combustion and inhalation of marijuana."

We also believe the GAO Draft Report should at least reference DEA final orders concerning petitions to reschedule marijuana published in 1992 and 2001. These reports contain a comprehensive explanation of the scientific and legal bases for keeping marijuana in Schedule 1.

In addition, the GAO Draft Report fails to mention that medical "marijuana" is legally available in the prescription drug Marinol. A pharmaceutical product, Marinol is widely available by prescription. It comes in the form of a pill and is also being studied by researchers for suitability via other delivery methods, such as an inhaler or patch, The active ingredient in Marinol is synthetic THC, which has been found to relieve the nausea and vomiting associated with chemotherapy for cancer patients and to assist with loss of appetite with AIDS patients. Unlike smoked marijuana–which contains more than 400 different chemicals, including most of the hazardous chemicals found in tobacco smoke–Marinol has been studied and approved by the medical community and the FDA. Information about Marinol is necessary to understand the debate over medical use of marijuana.

There is no mention in the report on the prescription of Marinol in these states, or more specifically the doctors identified in the study, as compared to doctors not prescribing marijuana under state "medical marijuana" laws versus their prescriptions authored for Marinol, if any. Although the information concerning the prescription of Marinol may not yet be available, it would be available through a longer term study by DEA Office of Diversion Control. It would be informative to determine if Marinol is sold in any quantity to pharmacies in these states by distributors for the manufacturer, both before and after state "medical marijuana" legislation was passed.

As noted by the above comments, we believe that the report falls short by not adequately addressing these significant issues. I urge you will consider our concerns in preparing the final GAO report on this important subject. If you have any questions regarding the Department's comments, you may contact Vickie L. Sloan, Director, Audit Liaison Office, on (202) 514-0469.

Sincerely,

Robert F. Diegelman
Acting Assistant Attorney General
for Administration

Appendix VI: GAO Contacts and Staff Acknowledgments

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Staff Acknowledgments

Tanya Cruz, Christine Davis, Francisco Enriquez, Evan Gilman, and Monica Kelly made key contributions to this report.

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Tab 6

Registrant Characteristics by State

Registrant Characteristics by State

An article published in the Journal of Drug Policy Analysis that analyzed the medical conditions of medical marijuana users in California in 2006, released January 2011.

January 2011

An Analysis of Applicants Presenting to a Medical Marijuana Specialty Practice in California

Journal of Drug Policy Analysis

Volume 4, *Issue* 1 2011 *Article* 1

An Analysis of Applicants Presenting to a Medical Marijuana Specialty Practice in California

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An Analysis of Applicants Presenting to a Medical Marijuana Specialty Practice in California

Helen Nunberg, Beau Kilmer, Rosalie Liccardo Pacula, and James R. Burgdorf

Abstract

While 15 states and the District of Columbia provide allowances for medical marijuana, little is known about the individuals who seek a physician's recommendation to use marijuana. This study provides descriptive information about 1,655 applicants in California who sought a physician's recommendation for medical marijuana, the conditions for which they sought treatment, and the diagnoses made by the physicians. It presents a systematic analysis of physician records and questionnaires obtained from consecutive applicants seen during a three-month period at nine medical marijuana specialty practices operating throughout the state. The analysis yields insights that may be useful for future research on medical marijuana and marijuana policy, including: 1) very few of those who sought a recommendation had cancer, HIV/AIDS, glaucoma, or multiple sclerosis; 2) most applicants presented with chronic pain, mental health conditions, or insomnia; and 3) half of the applicants reported using marijuana as a substitute for prescription drugs.

KEYWORDS: medical marijuana, California, ballot, drug policy

Author Notes: Dr. Nunberg received compensation from MediCann, Inc. for performance of patient evaluations. She received no compensation for her role in this study. MediCann had no role in the design of the study or in preparation of the manuscript. Funding for data collection was provided by the RAND Drug Policy Research Center Core Funding. Additional support for Dr. Kilmer, Dr. Pacula, and Mr. Burgdorf was provided by a grant from the National Institute on Drug Abuse to the RAND Corporation (R01DA12714). We would like to thank MediCann for providing administrative support, including support with medical records and HIPAA compliance. We would also like to thank Andrew Morral of RAND for his early contributions to this project.

I. INTRODUCTION

As of December 2010, 15 states and the District of Columbia provide allowances for medical marijuana (National Conference of State Legislatures, 2010).[1] There is a small literature about whether these laws influence the overall demand for marijuana (Gorman and Charles, 2007; Pacula et al., 2010), and a tremendous amount of discussion about how medicinal marijuana is distributed, especially in California (see e.g., Hoeffel, 2010a; 2010b). What remains largely missing from the literature and policy discussions is a good understanding of the individuals who seek a medical allowance for marijuana.

This paper helps fill this gap by systematically evaluating the characteristics, ailments, and medical histories of a large group of applicants who sought a medicinal marijuana recommendation. Data were collected from medical charts and doctor interviews with 1,655 individuals seen in June, July and August of 2006 from nine medical marijuana specialty practices dispersed throughout California. The results provide some interesting insights as to the characteristics of those seeking medicinal allowances nearly a decade after the policy was introduced in California.

The remainder of this paper is organized as follows. In Section 2 we briefly review the literature on the therapeutic value of cannabinoids, provide details of the specific allowances provided for within California state law, and review previously published surveys of populations of medical marijuana users. In Section 3 we discuss the methods that were used in the current study, including our data collection procedures, and in Section 4 we present our results. A general discussion of these findings and the limitations of our study are presented in Section 5.

II. BACKGROUND AND LITERATURE REVIEW

Research on the Therapeutic Value of Cannabinoids

Cannabinoids are compounds found in the cannabis plant (phytocannabinoids), in animals (endocannabinoids), and synthesized in laboratories (e.g., THC analogues, cannabinoid receptor agonists) (Pertwee, 2006). Cannabinoid receptors are found in all animals; in humans, cannabinoid receptors are concentrated in the brain but are also found in other parts of the body.

The use of cannabis as a medicine originated thousands of years ago. After being introduced to the West in the mid-nineteenth century, cannabis-based

[1] This excludes Maryland. While Maryland does allow those arrested for marijuana possession to use a medical necessity defense, those found to be using for medical purposes are still convicted and can be fined up to $100.

medicines were popular through the early decades of the twentieth century (Grinspoon, 2005; Zuardi, 2006). The virtual disappearance of cannabis-based medicines by the mid-1900s was due to the introduction of new pharmaceuticals (e.g., aspirin, chloral hydrate, barbiturates) for the same conditions, such as pain, migraines, menstrual cramps, and sedation, as well as the legal restrictions associated with the 1937 Marihuana Tax Act (Fankhauser, 2002; Grinspoon, 2005).

The Institute of Medicine's (IOM) 1999 report *Marijuana and Medicine: Assessing the Science Base*, concluded: "Scientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of nausea and vomiting, and appetite stimulation; smoked marijuana, however, is a crude THC delivery system that also delivers harmful substances" (4). The report further noted that, "For the most part, the logical categories for the medical use of marijuana are not based on particular diseases but on symptoms…[that] can be caused by various diseases or even by treatments for diseases" (IOM, 1999; pp. 137-138). Based on these findings, the panel recommended that "clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems" (4). In addition to focusing on pain relief, control of nausea and vomiting, and appetite stimulation, the IOM report also recommended that clinical trials focus on the suitability of cannabinoid drugs to address anxiety reduction and sedation.

Reviews published since the IOM report also highlight the potential therapeutic value of cannabinoid drugs; however, few of the studies focus on inhaled marijuana. A review of 72 randomized, double-blind, placebo-controlled studies from 1975 to 2004 that evaluated the therapeutic effects of cannabinoids concludes: "Cannabinoids present an interesting therapeutic potential as antiemetics, appetite stimulants in debilitating diseases (cancer and AIDS), analgesics, and in the treatment of multiple sclerosis, spinal cord injuries, Tourette's syndrome, epilepsy and glaucoma" (Ben Amar, 2006). A more recent review focusing on clinical studies published from 2005 to 2009 (Hazekamp and Grotenhermen, 2010) concluded that cannabinoids have "therapeutic potential mainly as analgesics in chronic neuropathic pain, appetite stimulants in debilitating diseases (cancer and AIDS), as well as in the treatment of multiple sclerosis." For both reviews, a minority of the trials evaluated inhaled marijuana (six and eight studies, respectively). The others used a synthetic THC isomer or analog for oral administration, or plant extract in oral or sublingual preparations.[2]

[2] Hazekamp and Grotenhermen included recent studies of nabilone, a prescription drug that is a THC analog. Skrabek et al. (2008) performed a randomized, controlled trial to assess the benefit of nabilone on pain reduction and quality of life improvement in patients with fibromyalgia. They found significant decreases in pain and anxiety. Similarly, Ware et al. (2010) concluded that nabilone "is effective in improving sleep in patients with fibromyalgia and is well tolerated."

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In February 2010, the Center for Medicinal Cannabis Research (CMCR) at the University of California San Diego submitted a report to the Legislature and Governor of California describing five completed clinical trials with inhaled marijuana (Grant et al., 2010). Four demonstrated pain relief effects in conditions secondary to injury or disease of the nervous system (Abrams et al., 2007; Wallace et al., 2007; Wilsey et al., 2008; Ellis et al., 2009), and one suggested a reduction of spasticity in multiple sclerosis (Corey-Bloom et al., 2008).

Medicinal Marijuana in California

In California, patients with a physician's recommendation, along with their designated caregivers and recommending physicians, are exempted from state criminal laws against marijuana. Although provision and use remain illegal under federal law, U.S. Attorney General Eric Holder made a statement in March 2009 suggesting that the federal government would not target those who complied with state medical marijuana laws. This was made more official in an October 2009 memo to U.S. Attorneys which noted: "As a general matter, pursuit of these priorities should not focus federal resources in your States on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana."

The California medical marijuana law, passed through voter referendum (Proposition 215) in 1996, permits the use of marijuana for "cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief." California Senate Bill 420, signed into law on October 12, 2003, named additional ailments such as severe nausea, cachexia, seizures, and persistent muscle spasms (regardless of whether they are associated with multiple sclerosis). In an effort to provide better guidance to law enforcement agencies, SB 420 allowed patients and primary caregivers to possess up to six mature plants (or 12 immature plants) and eight ounces of marijuana; however, it granted local governments the authority to establish larger maximum quantities.

Many of the early studies about medicinal marijuana users in California focused on individuals with HIV or AIDS (e.g., Harris et al., 2000; Sidney, 2001; de Jong et al., 2005; Prentiss et al., 2004). Based on analyses of several unpublished surveys of clients entering cannabis buyer clubs in the San Francisco Bay Area, Gieringer (2002) found that the share of clients that were AIDS and cancer patients declined after the passage of Proposition 215. More recent research in California shows that medicinal marijuana patients are largely men

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Finally, in a more recent observational study (Bestard and Toth, 2010), nabilone was found to be as effective as gabapentin, a first line medication for peripheral neuropathy, in measures of pain, sleep, depression and anxiety.

who present with pain and/or emotional/mental health concerns (O'Connell and Bou-Matar, 2007; Reiman, 2007; Reiman, 2009). An informal survey of several California medical marijuana specialty physicians revealed that more than 95% of the patients of each physician were already "self-medicating" prior to the receipt of their recommendation, leading Mikuriya et al. (2007) to conclude that the physicians were really "approving" the medical use of marijuana as opposed to "recommending" it.

III. DATA AND METHODS

The data used in this study come from medical records of 1,745 applicants consecutively presenting to nine MediCann clinics located in large and small cities throughout California.[3] The sample is based on visits in June, July, and August 2006, roughly ten years after the original law was enacted. Medical charts were reviewed and data entered within a few weeks of the visit. Our final sample excludes 90 individuals who are either missing diagnosis information (N=35) or did not report using marijuana before seeking a recommendation (N=55).[4] There are no statistically significant differences in terms of age, race/ethnicity, and gender between those included and excluded in the analysis sample.

We drew on consecutive visits from all nine clinics in hopes of approximating a representative sample of applicants seeking recommendations at these medical marijuana specialty practices. The sample is not generalizable to all individuals applying for a medical marijuana recommendation as it only represents those individuals selecting this particular network of physicians.

In general, the MediCann policy was to provide a 12-month recommendation to those with an acceptable medical condition who had supporting medical record documentation.[5] Those without medical record documentation received a provisional three-month recommendation conditional upon them providing the MediCann physician with a copy of the relevant supporting medical record, or, if not currently under the care of a medical professional, seeking care and providing those records. Applicants were only denied if they did not report having an eligible medical condition or if they

[3] Since 2006, MediCann has expanded to 21 locations throughout California.

[4] While in many ways the applicants who report not using marijuana prior to seeking this recommendation are perhaps the most interesting, there are an insufficient number of these individuals in our sample for robust comparisons.

[5] Qualifying patients would be given a recommendation and would be reassessed periodically to review the course of treatment and any new information about their health, as well as to monitor response to treatment as indicated by a decrease in symptoms, an increase in level of function, or an improvement in quality of life.

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refused to be under the care of a medical professional. For our sample the denial rate was less than 2%.

MediCann's medical records include two standard forms specifically created for MediCann. One form is filled out by the applicant and includes demographic information, medical history, and marijuana use history. The second form is filled out by the evaluating physician and contains clinical information related to the health problem and symptoms for which the applicant is seeking help. Clinic physicians relied on medical histories, physical exams, and the supporting medical documents when they assigned diagnoses. The supporting medical documents included laboratory and radiological evaluations to validate applicant claims of use of marijuana for relief of symptoms due to a medical condition. Over two-thirds of applicants (67.8%) brought medical record documentation with them at the time of the visits analyzed in our study.

In light of the limited information on this population of interest, we examine simple means or sample proportions for several variables of interest, including patient characteristics and stated therapeutic needs, physician diagnoses, and medical history. Results are provided for the entire sample and then broken down by gender.

IV. RESULTS

Applicant Characteristics

Applicant demographic information is shown in Table 1 both for the full sample and by gender, since almost 73% of the applicants seeking a recommendation were male. This is not much different than the share of those in the 2006 National Household Survey on Drug Use and Health who reported purchasing marijuana in the previous month (70%). Female applicants seeking recommendations were, on average, older and more likely than men to be African American, have some college education, have Medicaid (Medi-Cal) health insurance, or to be unemployed and disabled (19.5% of women reported being unemployed due to disability). In general, those seeking recommendations were insured (73.0% currently insured, of whom 24.2% were covered through Medicare or Medicaid), have at least a high school degree (only 8.8% had less than a high school degree), and were generally employed (68.7%).

As for the age distribution, at least half of the population that sought medical recommendations through this physician group was over the age of 35. For comparison, the median age category for those 18 and older in the 2006 NSDUH who reported purchasing marijuana in the previous month was 26-29 years.

Table 1. Characteristics of applicants seeking physician recommendations for medical marijuana

	All	**Females**	**Males**	**P-value**
	N=1655	N=452	N=1203	
Male	72.7%	--	--	--
White	58.5%	60.0%	58.0%	0.477
Hispanic	14.5%	13.1%	15.0%	0.305
Black	10.9%	14.2%	9.7%	*0.010*
Native American/Asian	6.9%	5.3%	7.6%	0.108
Mixed race or other	8.9%	8.0%	9.3%	0.393
12-18 years old	0.2%	0.0%	0.2%	0.288
18-24 years old	17.8%	12.6%	19.8%	*0.001*
25-34years old	27.9%	26.8%	28.3%	0.546
35-44 years old	21.8%	19.9%	22.5%	0.251
45-54 years old	19.3%	26.1%	16.8%	*0.000*
55+ years old	13.0%	14.6%	12.4%	0.232
Not a high school graduate	8.8%	8.6%	8.9%	0.866
High school graduate	42.5%	35.7%	45.1%	*0.001*
Some college	27.1%	31.0%	25.6%	*0.031*
College graduate	21.6%	24.7%	20.4%	0.064
Employed	68.7%	60.4%	71.8%	*0.000*
Disabled	15.5%	19.5%	14%	*0.006*
Previous military service	10.5%	2.1%	13.6%	*0.000*
Currently insured	73.0%	78.2%	71.1%	*0.004*
Workers' compensation	3.5%	2.9%	3.7%	0.394
Medicare	9.2%	11.9%	8.2%	*0.020*
Medi-Cal	15.0%	21.7%	12.6%	*0.000*
Private	42.4%	41.4%	42.7%	0.619
Veterans Administration	3.2%	2.0%	3.7%	0.086

Notes: Missing employment/disability data for 3 applicants, insurance information for 13 applicants, education information for 51 applicants, and military information for 86 applicants. Education variables denote highest level obtained. P-values below 0.05 are printed in italics.

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Table 2. Self report of therapeutic benefits of medical marijuana

	All	Females	Males	P-value
	N=1655	N=452	N=1203	
To relieve:				
Pain	82.6%	82.7%	82.5%	0.924
Spasms	41.3%	44.2%	40.1%	0.132
Headache	40.8%	49.3%	37.6%	*0.000*
Anxiety	38.1%	51.1%	33.3%	*0.000*
Nausea	27.7%	44.9%	21.3%	*0.000*
Depression	26.1%	35.4%	22.6%	*0.000*
Cramps	19.0%	33.4%	13.5%	*0.000*
Panic	16.9%	27.2%	13.1%	*0.000*
Diarrhea	4.8%	4.9%	4.7%	0.913
Itching	2.7%	1.1%	3.3%	*0.013*
To improve:				
Sleep	70.6%	69.0%	71.2%	0.397
Relaxation	55.6%	60.2%	53.9%	*0.023*
Appetite	38.0%	35.0%	39.2%	0.117
Focus	23.3%	19.7%	24.6%	*0.035*
Energy	15.5%	17.7%	14.7%	0.135
To prevent:				
Anger	22.7%	21.9%	22.9%	0.653
Medication side effects	22.6%	27.0%	20.9%	*0.009*
Involuntary movements	6.2%	7.3%	5.8%	0.266
Seizure	3.0%	3.8%	2.7%	0.239
As a substitute for:				
Prescription medicine	50.8%	51.1%	50.7%	0.885
Alcohol	13.2%	11.3%	13.9%	0.164

Note: P-values below 0.05 are printed in italics.

Applicants' Self Reports of the Therapeutic Benefits of Marijuana

In light of the IOM's argument that "the logical categories for the medical use of marijuana are not based on particular diseases but on symptoms" (IOM; pp. 137-138), we examined the self-reported therapeutic benefit received from marijuana and the symptoms it helped relieve. Applicants were asked: "Which of the following best describe the therapeutic benefit you receive from medicinal cannabis? (Check the most important reasons you use cannabis.)" The results are presented in Table 2.

Applicants most frequently reported using medical marijuana for pain relief (82.6%), improved sleep (70.6%), and relaxation (55.6%). The next most frequently reported benefits included relief of muscle spasms (41.3%), headache (40.8%), relief of anxiety (38.1%), improved appetite (38.0%), relief of nausea and vomiting (27.7%), and relief of depression (26.1%). Half the applicants (50.8%) reported using marijuana as a substitute for prescription medication and 13.2% reported using marijuana as a substitute for alcohol.

Interestingly, women were statistically more likely than men to report that they used marijuana to relieve most of the indications listed, including headaches, anxiety, nausea, depression, panic, and medication side-effects. The only indication for which men were more likely than women to report use of marijuana was to help with focus (24.6% and 19.7%, respectively).

Physician Diagnoses

Table 3 presents the highest frequency diagnoses made by MediCann physicians and the diagnoses specifically listed in the Compassionate Use Act. Recall that treating physicians make their diagnoses based on a review of the applicant's history, the medical records from treating physicians (in two-thirds of the cases), and on their own physical examination. Evaluating physicians were then asked to "circle only diagnoses related to patient's medicinal marijuana use" from a list of 162 diagnoses.

In general, chronic pain disorders were the most common diagnoses made by physicians, with nearly 60 percent (58.2%) of applicants being diagnosed with some sort of musculoskeletal or neuropathic chronic pain condition. Low back pain was diagnosed for over one quarter (26.2%) of patients seen during this three month period, with lumbar and cervical degenerative disc disease (together 21.8%) and arthritis (18%) the next most common diagnoses in the chronic pain group. Mental health disorders were the next largest group of diagnoses made (22.9%), followed closely by sleep disorders (21.3%). Diagnoses in the grouping "neurological disorders," including migraine and other headache, were made in

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16.6% of applicants. Only 3% of the applicants were diagnosed with either cancer or HIV/AIDS.

Table 3. High frequency diagnoses and diagnoses listed in Proposition 215 and SB 420

	All	Females	Males	P-value
	N= 1655	N= 452	N= 1203	
Musculoskeletal and neuropathic chronic pain				
Low back pain	26.2%	20.4%	28.4%	*0.001*
Arthritis	18.0%	17.0%	18.4%	0.529
Lumbar degenerative disc disease	15.6%	16.6%	15.3%	0.518
Muscle spasm	11.7%	9.5%	12.5%	0.095
Cervicalgia	8.9%	11.7%	7.9%	*0.015*
Cervical degenerative disc disease	6.2%	6.2%	6.2%	0.976
Peripheral neuropathy	5.8%	8.8%	4.7%	*0.001*
Fibromyalgia	1.6%	4.0%	0.7%	*0.000*
Spasticity	0.2%	0.0%	0.2%	0.288
Any of these chronic pain ICDs	58.2%	57.3%	58.5%	0.654
Mental disorders				
Anxiety disorders	18.7%	28.5%	15.0%	*0.000*
Depression	9.3%	14.2%	7.5%	*0.000*
Bipolar disorder	2.5%	4.9%	1.7%	*0.000*
Attention deficit disorder	3.1%	2.0%	3.6%	0.100
Any of these mental disorder ICDs	22.9%	33.6%	18.9%	*0.000*
Sleep disorders				
Persistent insomnia	13.5%	13.9%	13.4%	0.769
Insomnia due to pain	8.0%	8.4%	7.9%	0.734
Any of these sleep disorder ICDs	21.3%	21.9%	21.1%	0.727
Gastrointestinal disorders				
Nausea and vomiting	7.4%	9.5%	6.6%	*0.041*
Anorexia	4.6%	4.4%	4.7%	0.842
Abdominal pain	2.9%	4.9%	2.2%	*0.004*
Gastritis and GERD	2.5%	4.0%	1.9%	*0.016*
Irritable bowel syndrome	1.1%	0.4%	1.3%	0.121
Any of these gastrointestinal disorder ICDs	13.3%	16.6%	12.1%	*0.015*
Neurologic disorders				
Migraine headache	9.2%	16.2%	6.7%	*0.000*
Other headache	6.5%	6.6%	6.5%	0.910
Seizure	1.4%	1.5%	1.3%	0.735
Multiple sclerosis	0.6%	1.1%	0.4%	0.106
Any of these neurologic disorder ICDs	16.6%	24.8%	13.5%	*0.000*

Gynecologic disorders				
Dysmenorrhea		7.7%		
Endometriosis		1.8%		
Any of these gynecologic disorder ICDs		9.3%		
Other				
HIV/AIDS	1.6%	0.9%	1.9%	0.142
Cancer	1.5%	2.4%	1.1%	*0.040*
Glaucoma	1.3%	1.1%	1.3%	0.717

Note: Does not include all ICD9s, and excludes those that were written in. P-values below 0.05 are printed in italics.

Previous Treatments Reported by Applicants

Because self-reported information was collected from applicants and most provided medical documentation from their treating physician, it was possible to consider the extent to which previous therapies had been used to cope with or treat the primary symptoms for which they were seeking a medical allowance. In Table 4 we provide a list of therapies or approaches that were previously tried or currently being used. Almost half of the applicants (47.6%) reported taking prescription medication at the time of their evaluation, and nearly 4 out of 5 (79.5%) reported having taken prescription medication in the past for their problems. As chronic pain was the leading diagnosis for which marijuana was being recommended, we were curious to see what percent of applicants had used opioids or opiate medication to deal with their problem. On the physician evaluation form, evaluating physicians were asked to check yes or no if the applicant was currently using or had used in the past opioids or opiate medication prescribed by another physician for their chronic pain. Evaluating physicians determined that almost half of all applicants (48.0%) experiencing chronic pain either currently or in the past had been prescribed opioids or opiate medication.

Non-prescription therapies tried by applicants seeking medicinal marijuana allowances included physical therapy (48.6%), chiropractic services (37.2%), surgery (21.9%), psychological counseling (20.7%), and acupuncture (19.6%). Thus, these data do not suggest that applicants immediately seek marijuana recommendations as the first strategy to deal with their symptoms. In many cases, these individuals tried more traditional forms of medicine first.

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Table 4. Previous treatments and physician recommendations for additional treatment

	All	Females	Males	P-value
	N=1655	N=452	N=1203	
Other treatment modalities applicants tried for medical conditions				
Current prescription medication	47.6%	57.1%	44.2%	*0.000*
1-2 prescriptions	36.7%	36.1%	37.0%	0.727
3-5 prescriptions	4.4%	9.1%	2.7%	*0.000*
6+ prescriptions	6.5%	11.9%	4.5%	*0.000*
Previous prescription medication	79.5%	86.5%	76.8%	*0.000*
Past or current Rx for opioids for pain	48.0%	52.3%	46.4%	*0.040*
Physical therapy	48.6%	54.4%	46.5%	*0.004*
Chiropractic	37.2%	42.3%	35.2%	*0.009*
Surgery	21.9%	22.3%	21.8%	0.804
Psychological counseling	20.7%	33.4%	16.0%	*0.000*
Acupuncture	19.6%	26.8%	16.9%	*0.000*
Therapeutic injection	15.0%	21.5%	12.6%	*0.000*
Other types of treatment	8.6%	11.1%	7.7%	*0.032*
Referrals for further evaluation and treatment				
Primary care provider	22.4%	22.6%	22.3%	0.900
Medical specialist	16.2%	16.2%	16.2%	0.977
Physical therapy	8.2%	7.1%	8.6%	0.327
Chiropractor	6.5%	3.8%	7.5%	*0.006*
Psychological counseling	5.6%	7.1%	5.0%	0.098
Acupuncture	1.8%	2.2%	1.6%	0.382
Homeopathy	0.2%	0.2%	0.2%	0.815
Biofeedback	0.1%	0.0%	0.1%	0.540

Note: P-values below 0.05 are printed in italics.

V. DISCUSSION

This study provides descriptive information from 1,655 applicants who sought to obtain a physician's recommendation for medical marijuana in California, the conditions for which they sought treatment, and the diagnoses made by the physicians. The most common diagnoses reported were for chronic pain, mental health conditions (primarily anxiety and depression), and sleep disorders

(insomnia). For physicians who make medical marijuana recommendations, the risk of being deceived is not dissimilar to the risk of deception faced by those who prescribe oxycodone and other painkillers; however, those prescribing the latter can limit the number of pills and refills.[6] For medical marijuana, existing laws and policies only allow physicians to make recommendations, they cannot control the number of purchases, what is purchased (e.g., % THC or other cannabinoid content), where it is purchased, or the route of administration (e.g., inhale smoke or vapor, ingest an edible, apply topically).

The majority of applicants reported that they tried other therapies, including prescription drugs, to manage their symptoms prior to seeking the medicinal allowance. Fifty percent of the sample reported that they used marijuana as a substitute for prescription medicine. This is consistent with other studies (e.g., Reiman, 2007; 2009) and raises important questions about the specific drugs they are replacing. Future research with this population should focus on previous and concurrent prescription medication use to examine claims that marijuana enables people to reduce or eliminate their use of prescription medications. These data could also be useful for understanding whether there could be cost-savings or quality of life gains associated with substituting certain prescription medicines with marijuana.

This also raises the issue about whether the legalization of marijuana for non-medicinal purposes would influence the consumption of prescription drugs. Not only would full-scale legalization increase the availability and reduce the price of marijuana (Kilmer et al., 2010), but the reduced stigma may increase the likelihood that some individuals try it for medicinal purposes. It could also be the case that doctors may be more willing to discuss marijuana use with patients if it was not prohibited.

Less than 5% of the applicants in our sample were diagnosed with HIV/AIDS, cancer, or glaucoma. While these were not the only diseases and conditions discussed when Proposition 215 was on the ballot, they did receive a lot of attention. This low figure is not surprising; we would expect the number of applicants presenting with HIV/AIDS, cancer, or glaucoma to be relatively low compared to the number presenting with pain, anxiety, and insomnia, due to the relative prevalence of these conditions in the general population. However, it is also important to note that many of those receiving recommendations did so for conditions other than those listed by the IOM.

Finally, the age profile observed in the sample of applicants is intriguing, especially when compared with those who report purchasing marijuana in the previous month in the 2006 NSDUH. One should not assume the larger median age for these applicants is statistically meaningful given sampling differences and

[6] However, doctors prescribing oxycodone cannot prevent patients from crushing the pill to deactivate the time-release functionality and then snorting or injecting it.

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the fact that our sample is drawn exclusively from California. However, if these age differences appear in future studies, it could offer important insight about age-related risk aversion and/or age-specific access to distribution networks—each with different policy implications. Thus, future work should explore the robustness of these differences and consider their implications for policy.

We conclude by reminding readers that we did not examine a randomly-selected representative sample of all individuals in California seeking a medical recommendation for the use of marijuana. We were merely able to collect data from a sample of individuals who presented themselves within a three month window to a group of doctors that they most likely expected would be willing to provide them with a recommendation. The applicants receiving recommendations from these doctors may differ from those in the general population in important ways that we are unable to know. As applicants receiving physician recommendations are not required by law to register with county or state health officials, we have no way of knowing the extent to which the population served by this particular physician group might differ from that served by other medical marijuana specialists or by primary care physicians. Knowledge about the number and type of individuals that receive recommendations from other specialists or from primary care physicians would improve our understanding of medical marijuana users in California.

Since California law allows for medical marijuana use for any "illness for which marijuana provides relief," we have an enormous opportunity to further our understanding of the risks and benefits of marijuana with careful questioning of some of the thousands of patients willing to discuss their use of marijuana. Detailed information about the doses, frequency, methods, and forms of marijuana consumed, as well as information about past and present alcohol, illicit drug, and prescription medication consumption would be of great interest.

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Registrant Characteristics by State

A summary of medical marijuana registrants and conditions by state by the New York City Comptroller's Office published in August 2013. The full report is available at: http://comptroller.nyc.gov/wp-content/uploads/2013/08/RegMarij_Summary_8-29b.pdf

APPENDIX: METHODOLOGY

There are approximately 1,030,887 registered medical marijuana patients (MMP) in the U.S. We arrived at this number using a combination of state-reported MMP registry data and estimates when those were unavailable. The Comptroller's office located 2012 or 2013 registry data that was reported by state agencies in eight states: Arizona, Colorado, Hawaii, Michigan, Montana, Nevada, Oregon, and Rhode Island. California and Washington do not have registries, and so these numbers were estimated by ProCon.org, a non-partisan nonprofit research group that attempts to present balanced information on controversial issues. For the remaining states, we were unable to find state-reported data and relied upon ProCon.org for numbers of medical marijuana patients, which were current as of December 2012.[49]

STATES THAT LEGALIZED MEDICAL MARIJUANA			
State	**Year**	**Population**	**Registered Patients**
California	1996	38,041,430	553,684
Alaska	1998	731,449	1,246
Oregon	1998	3,899,353	55,937
Washington	1998	6,897,012	99,943
Maine	1999	1,329,192	16,444
Colorado	2000	5,187,582	106,817
Hawaii	2000	1,392,313	11,183
Nevada	2000	2,758,931	4,173
Montana	2004	1,005,141	7,099
Vermont	2004	626,011	559
Rhode Island	2006	1,050,292	4,849
New Mexico	2007	2,085,538	8,188
Michigan	2008	9,883,360	124,131
Arizona	2010	6,553,255	36,634
Subtotal		**81,440,859**	**1,030,887**
DC	2010	632,323	N/A
New Jersey	2010	8,864,590	N/A
Delaware	2011	917,092	N/A
Connecticut	2012	3,590,347	N/A
Massachusetts	2012	6,646,144	N/A
Illinois	2013	12,875,255	N/A
New Hampshire	2013	1,320,718	N/A
20 States + D.C. TOTALS		**116,287,328**	**1,030,887**

Source: Census Bureau; ProCon.org; Arizona Medical Marijuana Act, Monthly Report, 2013; Colorado Department of Health; Hawaii Department of Public Safety, Annual 2012 Report; Michigan Department of Health; Montana Marijuana Program May 2013 Registry Information; Nevada Health Division, Medical Marijuana Program; Oregon Health Authority; and Rhode Island Department of Health.

49 ProCon.org, "Medical Marijuana, How Many People in the United States Use Medical Marijuana," last updated December 2012, http://medicalmarijuana.procon.org/view.answers.php?questionID=001199, accessed on August 20, 2013.

Although medical marijuana legislation has passed in 20 states and the District of Columbia, our analysis includes only 14 states. We excluded D.C., New Hampshire, Illinois, Connecticut, Massachusetts, Delaware, and New Jersey, largely because they are new programs that have few or no patients. Delaware and New Jersey, which ProCon.org reports have 21 and 239 MMP respectively, are excluded because, as previously noted, their programs have experienced significant hurdles, greatly limiting the number of people who can access medical marijuana. New Hampshire and Illinois just passed medical marijuana in 2013. Connecticut and Massachusetts passed their laws in 2012. D.C. legalized medical marijuana in 2010, but its first medical marijuana patient just received the drug in July 2013.[50]

According to the Census Bureau 2012 population estimates, there are 81,440,859 people living in the 14 states we examined. To estimate the MMP population in NYC if medical marijuana were to be legalized, we created a ratio of MMPs to the general population in those 14 states: 1,030,887/81,440,859 = 1.27 percent. Applying this rate to the City's estimated 8,336,697 residents yields 105,527 New Yorkers that would likely register for medical marijuana today.

ESTIMATING NYC'S POTENTIAL MEDICAL MARIJUANA PATIENTS (MMPS)	
14 states	
Total Population	81,440,859
MMPs	1,030,887
Rate	1.27%
NYC	
Total Population	8,336,697
MMP Estimate	**105,527**

Certain states provide detailed reporting of registered medical marijuana patients by condition. The table below presents the number of patients registered to receive medical marijuana for each recognized condition in Arizona, Colorado, Hawaii, Michigan, Montana, Nevada, Oregon, and Rhode Island. For each state, we include each condition's share of that state's registered MMPs. For instance, in Colorado, 93.7 percent of MMPs are registered for chronic pain. The eight states generally report the same categories, although Montana lumps all cancer, glaucoma, and HIV/AIDS patients into single category.

50 DeBonis, Mike, "D.C. Records its First Pot Deal in at least 75 Years," *D.C. Politics*, July 29, 2013. http://www.washingtonpost.com/local/dc-politics/dc-records-its-first-legal-pot-deal-in-at-least-75-years/2013/07/29/17521b42-f889-11e2-b018-5b8251f0c56e_story.html, accessed on August 21, 2013.

NUMBER OF REGISTERED MEDICAL MARIJUANA PATIENTS FOR REPORTED CONDITIONS AND SHARE OF STATE'S PATIENTS REPORTING EACH CONDITION																	ESTIMATES	
	Arizona		Colorado		Hawaii		Michigan		Montana		Nevada		Oregon		Rhode Island		Ave. share	NYC
Chronic or severe pain	26,039	89.5%	100,112	93.7%	6,817	90.7%	79,313	66.0%	4,503	63.4%	3,808	91.3%	54,342	97.1%	3,504	72.3%	83.0%	87,594
Muscle spasms (including MS*)	543	1.5%	15,664	14.7%	156	2.1%	22,250	18.5%	118	1.7%	924	22.1%	14,990	26.8%	1,393	28.7%	14.5%	15,311
Severe Nausea	357	1.0%	11,216	10.5%	132	1.8%	9,084	7.6%	908	12.8%	719	17.2%	8,310	14.9%	858	17.7%	10.4%	10,996
Cancer	696	1.9%	2,843	2.7%	152	2.0%	2,526	2.1%			143	3.4%	2,332	4.2%	354	7.3%	3.4%	3,555
Seizures/epilepsy	255	0.7%	1,824	1.7%	48	0.6%	1,414	1.2%	207	2.9%	100	2.4%	1,362	2.4%	125	2.6%	1.8%	1,919
Wasting Syndrome (Cachexia)	40	0.1%	1,137	1.1%	46	0.6%	1,273	1.1%	405	5.7%	145	3.5%	1,063	1.9%	265	5.5%	2.4%	2,558
HIV/AIDS	186	0.5%	638	0.6%	72	1.0%	556	0.5%			57	1.4%	690	1.2%	146	3.0%	1.2%	1,227
Glaucoma	324	0.9%	1,070	1.0%	92	1.2%	1,112	0.9%			77	1.8%	911	1.6%	85	1.8%	1.3%	1,396
Hepatitis C	655	1.8%					1,617	1.3%							291	6.0%	3.0%	3,213
Other**	7,539		0		3,649		2,593		1,858				56		1,023	21.1%		
TOTAL PATIENTS	36,634		106,817		11,183		124,131		7,099		4,173		55,937		4,849		105,527	

Sources: Arizona Medical Marijuana Act, Monthly Report, 2013; Colorado Department of Health; Hawaii Department of Public Safety, Annual 2012 Report; Michigan Department of Health; Montana Marijuana Program May 2013 Registry Information; Nevada Health Division, Medical Marijuana Program; Oregon Health Authority; and Rhode Island Department of Health.

** "MS" means multiple sclerosis*

*** "Other" includes illnesses that were not reported in all states, such as Alzheimer's, Crohn's Disease, painful peripheral neuropathy, Central Nervous System disorder with pain, Admittance to hospice, ALS, Nail Patela, and a category for "Two or More Conditions." For Rhode Island, "other" also includes diagnoses that were not entered in the license system.*

ADDITONAL NOTES: Michigan's total number of patients in FY2012 was not reported outright. The report shows that adding patients by county yields 124,131 non-minor patients, but adding patients by condition yields 120,121. We use the lower count to calculate percentages in the table, but present the 124,131 as the total number of patients in this table and to calculate total MMPs in the 14 states. Similarly, in Hawaii, the reported total of 11,183 is higher than the sum of the reported conditions (11,164). The Annual Report that presents this information makes no attempt to explain the difference.

Some reporting differences among state are worth noting. Arizona and Hawaii report the number of people registered with multiple conditions (7,338 and 3,648, respectively), but do not distribute them among the different categories. Therefore, we calculated the share of MMPs registered for each condition without including the patients with two or more conditions. For instance, in Arizona, 88.9 percent of registered patients for which conditions are reported have chronic pain, or 26,039 divided by 29,095, which is the sum of patients in each category listed. Colorado, Montana, Nevada, Oregon, and Rhode Island do not separate out the number of patients registered for multiple conditions, so we were able to determine the share of patients for each condition by dividing by the total number of patients. These states count each patient under multiple conditions if they are registered for more than one, so the total number of patients is less than the sum of all conditions. Michigan only appears to report each patient once.

On the right side of the table we present an average across the eight states for the share that each condition comprises of the MMP population. We then apply these average rates to our estimate of patients who would register for medical marijuana in NYC: 105,527. These rough estimates suggest that more than 87,000 New Yorkers suffering from chronic pain and more than 15,000 New Yorkers with muscle spasms, including multiple sclerosis, could benefit from medical marijuana.

Tab 7

2013 Session Legislation

2013 Legislative Session

Senate Bill 1250 from the 2013 legislative session is not directly related to the petition initiative. The detailed provisions of the bill may differ in material respects from the petition initiative language. The bill is included for background information only.

The Florida Senate

SB 1250: Medical Cannabis

Track This Bill

GENERAL BILL by Clemens ; (CO-INTRODUCER) Bullard

Medical Cannabis; Creating the "Cathy Jordan Medical Cannabis Act"; authorizing a qualifying patient to possess and administer medical cannabis, and possess and use paraphernalia for a specified purpose; requiring a qualifying patient or the patient's caregiver to present to a law enforcement officer a registry identification card to confirm that the person is authorized to possess, use, or administer medical cannabis or paraphernalia; requiring a qualifying patient or the patient's caregiver to possess, use, or administer only medical cannabis that is obtained from a dispensary or medical cannabis farm, etc.

Senate Committee References: Health Policy (HP) , Judiciary (JU) , Criminal Justice (CJ) , Appropriations (AP)

Last Action: 05/03/2013 Died in Health Policy

Effective Date: July 1, 2013

Bill History

DATE	CHAMBER	ACTION
02/27/2013	Senate	• Filed
03/01/2013	Senate	• Referred to Health Policy; Judiciary; Criminal Justice; Appropriations -SJ 94
03/05/2013	Senate	• Introduced -SJ 94
05/03/2013	Senate	• Died in Health Policy

Related Bills

BILL NUMBER	SUBJECT	FILED BY	RELATIONSHIP	LAST ACTION	TRACK BILLS
S 1214	Public Records/Medical Use of Cannabis/DOH/DBPR/DOR	Clemens	Link	05/03/2013 S Died in Health Policy	Track Bill
H 1139	Medical Cannabis	Edwards	Identical	05/03/2013 H Died in Health Quality Subcommittee	Track Bill

Bill Text

VERSION	POSTED	FORMAT
S 1250	02/27/2013 at 12:01 PM	Web Page | PDF

Committee Amendments

NO COMMITTEE AMENDMENTS AVAILABLE

Floor Amendments

NO FLOOR AMENDMENTS AVAILABLE

Vote History - Committee

NO COMMITTEE VOTE HISTORY AVAILABLE

Vote History - Floor

NO VOTE HISTORY AVAILABLE

Citations - Statutes

- 468.901
- 468.902
- 468.903
- 468.904
- 468.905
- 468.906
- 468.907
- 468.908
- 468.909
- 468.910
- 468.911
- 468.912
- 468.913
- 468.914
- 468.915
- 468.916
- 468.917
- 468.918
- 468.919
- 468.920
- 499.801
- 499.802
- 499.803
- 499.804
- 499.805
- 499.806
- 499.807
- 499.808
- 499.809
- 499.810
- 499.811
- 499.812
- 499.813
- 499.814
- 812.14 - Trespass and larceny with relation to utility fixtures; theft of utility services.
- 893.03 - Standards and schedules.
- 893.13 - Prohibited acts; penalties.
- 893.1351 - Ownership, lease, rental, or possession for trafficking in or manufacturing a controlled substance.
- 893.145 - "Drug paraphernalia" defined.
- 921.0022 - Criminal Punishment Code; offense severity ranking chart.

Citations - Constitution

NO CONSTITUTIONAL CITATIONS FOUND FOR SENATE BILL 1250.

By Senator Clemens

27-00511B-13 20131250__

A bill to be entitled

An act relating to medical cannabis; creating part III of ch. 499, F.S.; creating s. 499.801, F.S.; providing a short title; creating s. 499.802, F.S.; providing legislative findings; creating s. 499.803, F.S.; providing a legislative purpose; creating s. 499.804, F.S.; providing definitions; creating s. 499.805, F.S.; authorizing a qualifying patient to possess and administer medical cannabis, and possess and use paraphernalia for a specified purpose; authorizing the patient's caregiver to possess and administer medical cannabis to a qualifying patient and to possess and use paraphernalia for a specified purpose; providing that a registry identification card, or its equivalent, which is issued from another jurisdiction has the same force and effect as a registry identification card issued by the Department of Health; requiring a qualifying patient or the patient's caregiver to present to a law enforcement officer a registry identification card to confirm that the person is authorized to possess, use, or administer medical cannabis or paraphernalia; requiring a qualifying patient or the patient's caregiver to possess, use, or administer only medical cannabis that is obtained from a dispensary or medical cannabis farm; authorizing a qualifying patient who is a minor to possess, use, or administer medical cannabis only if the parent or legal guardian signs a written statement; providing requirements for the

written statement; providing a procedure to change the patient's designation of a caregiver; providing a procedure for replacing a lost registry identification card; providing that a registration form to obtain a registry identification card is deemed valid if the Department of Health fails to issue or deny the registration form within a specified number of days; authorizing the department to revoke a cardholder's registry identification card; creating s. 499.806, F.S.; providing restrictions for the use of medical cannabis; requiring a person who wishes to be a qualifying patient or the patient's caregiver to register with the department; providing the maximum amount of medical cannabis which a qualifying patient or the patient's caregiver may possess; prohibiting medical cannabis from being administered in a public place or at a dispensary; authorizing medical cannabis to be administered in certain medical treatment facilities; requiring a qualifying patient or the patient's caregiver to transport medical cannabis in a labeled container or sealed package; providing that the act does not allow a person to undertake a task under the influence of medical cannabis when doing so constitutes negligence or malpractice; providing that the use of medical cannabis does not create a defense to certain offenses; providing that evidence of a person's voluntary intoxication that results from the use of medical cannabis is not admissible for certain reasons; authorizing a person or entity to provide

information about the existence or operation of a medical cannabis farm or dispensary to another person; prohibiting a law enforcement officer from further stopping or detaining a person if the law enforcement officer determines that the person is in compliance with the use of medical cannabis or paraphernalia; creating s. 499.807, F.S.; authorizing a physician to recommend use of medical cannabis under certain circumstances; requiring the physician to sign a written recommendation if he or she recommends the use of medical cannabis; providing requirements for the written recommendation; providing that a physician is not subject to penalty, arrest, prosecution or disciplinary proceedings or denial of a right or privilege for advising a qualifying patient about the use of medical cannabis, recommending the use of medical cannabis, providing a written recommendation for a patient's medical use of cannabis, or stating that, in the physician's professional opinion, the potential benefits of medical cannabis would likely outweigh the health risks for a patient; prohibiting a physician from having a professional office located at a medical cannabis farm or dispensary or receiving financial compensation from a medical cannabis farm or dispensary or its directors, officers, members, incorporators, agents, or employees; creating s. 499.808, F.S.; requiring the Department of Business and Professional Regulation to regulate the permitting and licensure of medical cannabis farms and

dispensaries; requiring each medical cannabis farm to apply for permitting and each dispensary to apply for licensure with the Department of Business and Professional Regulation before manufacturing, cultivating, dispensing, possessing, or distributing medical cannabis, or manufacturing, possessing, using, or distributing paraphernalia; creating s. 499.809, F.S.; authorizing a dispensary or medical cannabis farm to possess, cultivate, manufacture, or possess medical cannabis and to manufacture, purchase, possess, and distribute paraphernalia for a specified purpose; authorizing a dispensary to dispense to a qualifying patient or the patient’s caregiver medical cannabis and distribute paraphernalia; authorizing a qualifying patient or the patient’s caregiver to obtain medical cannabis and paraphernalia from a dispensary under certain circumstances; prohibiting a dispensary from directly dispensing to a qualifying patient or through the patient’s caregiver more than specified amount of medical cannabis, mature marijuana plants, immature marijuana plants, or marijuana plant seedlings within a specified time period; requiring each medical cannabis farm and dispensary to implement a security plan; requiring the Department of Business and Professional Regulation to develop educational materials that a dispensary must distribute to a qualifying patient or the patient’s caregiver; prohibiting a director, officer, member, incorporator, agent, or employee of a medical cannabis farm or

dispensary from having certain felony convictions; providing that a person who violates or has violated the act may not be a director, officer, member, incorporator, agent, or employee of a medical cannabis farm or dispensary; requiring the Department of Business and Professional Regulation to revoke the permit or license of the medical cannabis farm or dispensary until the convicted or formerly convicted person is no longer a director, officer, member, incorporator, agent, or employee of the medical cannabis farm or dispensary; creating s. 499.810, F.S.; providing that certain qualifying patients, their caregivers, nurse practitioners, registered nurses, pharmacists, and other persons are not subject to arrest, prosecution, penalty, or denial of any right or privilege regarding the medical use of medical cannabis under certain circumstances; prohibiting a school, employer, or property owner from refusing to enroll, employ, or lease to or penalize a person who is a cardholder; providing that a presumption is created when a qualifying patient or the patient’s caregiver is engaged in the authorized use of medical cannabis; authorizing the use of evidence to rebut that presumption; authorizing the patient’s caregiver to be reimbursed for certain costs; providing that such reimbursement is not the sale of a controlled substance; providing that certain interests or rights to property related to the medical use of cannabis may not be forfeited under the Florida

Contraband Forfeiture Act; providing that a qualifying patient's medical use of cannabis is the equivalent to the authorized use of any other medication used at the direction of a physician; providing that such use does not constitute the use of an illicit drug under s. 893.03, F.S.; providing for affirmative defenses; authorizing the clerk of the court to assess a fee for dismissal of a case in certain circumstances; authorizing a qualifying patient to operate, navigate, or be in actual physical control of a motor vehicle, aircraft or vessel under certain circumstances; providing that a person who makes a fraudulent representation to a law enforcement officer relating to activities involving medical cannabis or paraphernalia is subject to a criminal fine in addition to other penalties under law; creating s. 499.811, F.S.; providing additional defenses to a prosecution involving cannabis; authorizing a person to assert the medical purpose for using cannabis in a motion to dismiss; providing that certain interests or rights to property related to a qualifying patient's use of cannabis for medical purposes may not be forfeited under the Florida Contraband Forfeiture Act under certain circumstances; providing that a person who cultivates, manufactures, possesses, administers, dispenses, distributes, or uses cannabis, or manufactures, possesses, distributes, or uses paraphernalia, in a manner not authorized by this act is subject to criminal prosecution and sanctions under

the Florida Comprehensive Drug Abuse Prevention and Control Act; creating s. 499.812, F.S.; providing that the act does not require a governmental, private, or other health insurance provider or health care services plan to cover, or prohibit it from covering, a claim for reimbursement for the use of medical cannabis; creating s. 499.813, F.S.; prohibiting an employer, laboratory, employee assistance program, and alcohol and drug rehabilitation program and their agents from releasing certain information without a written consent; providing requirements for the written consent; prohibiting information regarding a qualifying patient or the patient's caregiver from being released or used in a criminal proceeding; providing that such information is inadmissible as evidence; authorizing the Department of Health and its employees to have access to information regarding a qualifying patient or the patient's caregiver under certain circumstances; creating s. 499.814, F.S.; requiring the Department of Health, the Department of Business and Professional Regulation, and the Department of Revenue to adopt rules by a specified date; requiring the fees collected by the departments to be applied first to the cost of administering the act; authorizing a state resident to commence an action in a court of competent jurisdiction if the departments fail to adopt rules by a specified date; creating part XVII of ch. 468, F.S.; creating s. 468.901, F.S.; providing a purpose; creating s.

468.902, F.S.; providing legislative findings and intent; creating s. 468.903, F.S.; providing definitions; creating s. 468.904, F.S.; requiring the Department of Business and Professional Regulation to adopt certain rules; establishing the medical cannabis section within the Department of Business and Professional Regulation; requiring the medical cannabis section of the department to require medical cannabis farms and dispensaries to maintain certain records and information; requiring the medical cannabis section of the department to develop education materials, conduct inspections, and revoke or suspend licenses or permits; requiring the medical cannabis section of the department to adopt rules; creating s. 468.905, F.S.; authorizing a medical cannabis farm to possess, cultivate, and manufacture medical cannabis, medical cannabis-based products, and marijuana plants for wholesale in this state; requiring a medical cannabis farm to be registered with the department before possessing, manufacturing, cultivating, and wholesaling medical cannabis, medical cannabis-based products, or marijuana plants; requiring agricultural classification for land used as a medical cannabis farm; prohibiting a medical cannabis farm from conducting retail sales or transactions; requiring a medical cannabis farm to implement a security plan and maintain procedures in which medical cannabis-based products are accessible only to authorized personnel; providing that the

active ingredient in all medical cannabis-based products cultivated, manufactured, and wholesaled to a licensed dispensary in this state must be wholly derived from marijuana plants cultivated and grown in this state, except for marijuana seeds and seedlings; providing that a medical cannabis farm is provided certain protections and is not deemed a public nuisance solely because its farm product includes production of marijuana; creating s. 468.906, F.S.; authorizing a dispensary to dispense and sell to a qualifying patient or patient's caregiver medical cannabis, medical cannabis-based products, marijuana plants, and medical cannabis-related paraphernalia and to manufacture, purchase, possess, and distribute medical cannabis-related paraphernalia; requiring each dispensary to be registered with the department before possessing, purchasing, or retailing medical cannabis, medical cannabis-based products, marijuana plants, or medical cannabis-related paraphernalia; prohibiting a dispensary from conducting wholesale sales or transactions; authorizing a dispensary to retail to a qualifying patient or patient's caregiver medical cannabis, medical cannabis-based products, marijuana plants, or medical cannabis-related paraphernalia if the qualifying patient or patient's caregiver meets certain conditions; requiring a dispensary to purchase its medical cannabis-based products from a medical cannabis farm that has a department-issued permit; prohibiting a dispensary from dispensing a certain

amount of medical cannabis and marijuana plant seedlings to a qualifying patient or caregiver within a certain time period; requiring a dispensary to maintain certain records for a specified number of years; requiring a dispensary to make available educational materials; requiring a dispensary to prohibit a qualifying patient or patient's caregiver from using or administering any form of medical cannabis while on the property of the dispensary; creating s. 468.907, F.S.; prohibiting a person from engaging in the business of a medical cannabis farm except in conformity with part XVII of ch. 468, F.S.; providing factors for standards for qualifying for a permit or for renewing a permit to operate a medical cannabis farm; requiring the department to establish permitting fees; providing maximum amounts for the fees; requiring a person who cultivates, manufactures, or wholesales medical cannabis, medical cannabis-based products, or marijuana plant products at one or more locations to possess a current valid permit for each location; authorizing an applicant for a permit to operate a medical cannabis farm to commence an action in a court of competent jurisdiction to compel the Department of Business and Professional Regulation to perform certain actions if the department fails to adopt rules by a specified date; creating s. 468.908, F.S.; prohibiting a person from operating a dispensary in this state except in conformity with part XVII of ch. 468, F.S.; providing factors for standards for

qualifying for a license or for renewing a license to operate a dispensary; requiring the Department of Business and Professional Regulation to establish by rule licensure fees; providing maximum amounts for the fees; requiring a person who conducts the wholesale purchase or retail sale of any form of medical cannabis products at more than one location to possess a current valid license for each location; authorizing an applicant for a license to operate a dispensary to commence an action in a court of competent jurisdiction to compel the department to perform certain actions if the department fails to adopt rules by a specified date; creating s. 468.909, F.S.; requiring the department to prescribe application forms; providing requirements for submitting an application for a license or a permit; authorizing the department to require an applicant to furnish other information or data; creating s. 468.910, F.S.; providing requirements for licenses and permits; authorizing the department to include other information on a license or permit; providing that a license or permit may not be issued, renewed, or allowed to remain in effect for certain circumstances; prohibiting a person from knowingly submitting information or presenting to the department a false, fictitious, or misrepresented application, identification, document, information, statement, or data intended or likely to deceive the department in order to obtain a license or permit; authorizing the

department to adopt rules regarding persons who legally possess medical cannabis for the purpose of teaching, research, or testing in a laboratory setting; authorizing the department to issue letters of exemption; providing that a person who violates or has violated any provision of this part may not be a director, officer, member, incorporator, agent, or employee of a medical cannabis farm or dispensary; providing that any prior authorization of such person shall be immediately revoked; requiring the department to suspend the license or permit of the medical cannabis farm or dispensary until the person is removed from the position of director, officer, member, incorporator, agent, or employee; creating s. 468.911, F.S.; providing that certain terms may be used to designate a medical cannabis farm that has a department-issued permit or a licensed dispensary; requiring for conspicuous display of a license or permit; providing specified dates for validity and expiration of licenses and permits; providing application procedures for obtaining initial licenses and permits and renewal of licenses and permits; providing the fee structure for reactivating an inactive license or permit; creating s. 468.912, F.S.; requiring the reporting of a loss, theft, or unexplained shortage of medical cannabis product to the local law enforcement agency and the department; requiring any sheriff, police department, or law enforcement officer in this state to give immediate

notice to the department of a theft, illegal use, or illegal possession of medical cannabis and to forward a copy of his or her final written report to the department; requiring an investigating law enforcement agency to forward a copy of its written report to the department; requiring the department to retain the reports; creating s. 468.913, F.S.; providing procedures for the issuance of a cease and desist order; creating s. 468.914, F.S.; authorizing the department to impose administrative fines for violations for part XVII of ch. 468, F.S., and applicable department rules; providing procedures for payment of administrative fines; providing that all fines, monetary penalties, and costs received by the department in connection with this part shall be deposited in the Professional Regulation Trust Fund of the Department of Business and Professional Regulation; creating s. 468.915, F.S.; authorizing the department to seek injunctive relief and to apply for temporary and permanent orders for certain violations; creating s. 468.916, F.S.; providing circumstances that warrant immediate suspension of a license or permit; requiring the department to enter an order revoking or suspending all licenses or permits of a licensee or permittee under certain circumstances; providing requirements for an order of suspension and an order of revocation; providing for application of an order of revocation or suspension to a newly issued permit or license; providing that a person whose

permit or license has been suspended or revoked may not be issued a new permit or license under any other name or company name until the expiration of the suspension or revocation; creating s. 468.917, F.S.; providing that all hearings and review of orders from the department must be conducted in accordance with ch. 120, F.S.; creating s. 468.918, F.S.; providing for criminal penalties; creating s. 468.919, F.S.; prohibiting a county or municipality from creating or imposing an ordinance or rule that is more restrictive than the provisions contained in this part and the applicable department rules; creating s. 468.920, F.S.; providing that all fees collected for licenses and permits are deposited in the Professional Regulation Trust Fund; providing that all moneys collected and deposited in the Professional Regulation Trust Fund must be used by the department in the administration of part XVII of ch. 468, F.S.; requiring the department to maintain a separate account in the Professional Regulation Trust Fund for the Drugs, Devices, and Cosmetics program; amending ss. 812.14, 893.03, 893.13, 893.1351, 893.145, and 921.0022, F.S.; conforming provisions to changes made by the act; providing for severability; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Part III of chapter 499, Florida Statutes,

consisting of sections 499.801, 499.802, 499.803, 499.804, 499.805, 499.806, 499.807, 499.808, 499.809, 499.810, 499.811, 499.812, 499.813, and 499.814, is created to read:

499.801 Short title.—This part may be cited as the "Cathy Jordan Medical Cannabis Act."

499.802 Legislative findings.—The Legislature finds that:

(1) Modern medical research has discovered beneficial uses for cannabis in treating or alleviating pain, nausea, and other symptoms associated with certain qualifying medical conditions, as indicated by the National Academy of Sciences' Institute of Medicine (IOM) in its report dated March 1999, cited by the United States Department of Health and Human Services, that "there is substantial consensus among experts in the relevant disciplines on the scientific evidence about potential medical uses of marijuana."

(2) The prohibition against the use of cannabis has been in effect for 75 years and is rooted in outdated scientific evidence that does not make a reasonable distinction between its recreational use and beneficial medicinal use.

(3) This state leads the southeast region of the United States in farm income, and the second largest industry in the state is agriculture. In 2011, this state ranked first in the United States in the value of production of oranges and grapefruit; first in value of production of fresh-market snap beans, cucumbers for fresh market, bell peppers, squash, sweet corn, fresh-market tomatoes, and watermelons; and second in value of production of cucumbers for pickles, strawberries, tangerines, and sugarcane for sugar and seed.

499.803 Legislative purpose.—

(1) The purpose of this act is to make a distinction between the medical and nonmedical use of cannabis and to protect patients who have qualifying medical conditions, their physicians, and their caregivers from arrest, criminal prosecution, property forfeiture, and other penalties if such patients engage in the medical use of cannabis. Compassionate medicinal use of cannabis will also reduce state law enforcement costs, including, but not limited to, state prison costs, local jail costs, felony prosecution costs, court and probation costs, costs associated with felony and misdemeanor arrests, and alternative treatment costs by reducing the incidence of arrest and prosecution of nonviolent medicinal cannabis and traffickers in the state.

(2) The economic impact of this act is expected to create jobs, generate tax revenue, revitalize vacant farmlands, add to the sale of farming machinery and supplies, and generate occupancy of vacant commercial real estate. This economic impact can be accomplished using this state's existing infrastructure without the need for new appropriations.

(3) The Legislature enacts this part pursuant to its police power to enact legislation for the protection of the health of its residents, as reserved to the state in the Tenth Amendment to the United States Constitution.

499.804 Definitions.—As used in this part, unless the context clearly indicates otherwise, the term:

(1) "Administer" or "administration" means the direct introduction of medical cannabis, whether by inhalation, ingestion, vaporization, topical application, or other means onto or into the body of a person.

(2) "Bona fide physician-patient relationship" means a relationship between a physician and patient in which the physician:

(a) Has completed a full assessment of the patient's medical history and current medical condition, including a personal physical examination; and

(b) Has responsibility for the ongoing care and treatment of the patient.

(3) "Cannabis" has the same meaning as provided in s. 893.02.

(4) "Cardholder" means a qualifying patient, or the patient's caregiver, who has been issued and possesses a valid registry identification card. The department shall adopt rules that establish eligibility requirements for a cardholder.

(5) "Department" means the Department of Health.

(6) "Dispensary" means a facility operated by an organization or business that is licensed under the Department of Business and Professional Regulation pursuant to ss. 499.808 and 499.809 from or at which medical cannabis is possessed and dispensed and paraphernalia is possessed and distributed to a qualifying patient or the patient's caregiver.

(7) "Dispense" means to distribute medical cannabis to a qualifying patient or the patient's caregiver in accordance with this part and department rule.

(8) "Distribute" means the actual, constructive, or attempted transfer from one person to another.

(9) "Manufacture" means the production, preparation, propagation, compounding, conversion, or processing of cannabis and marijuana, directly or indirectly, by extraction from

substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes the packaging or repackaging of the substance and the labeling or relabeling of its container.

(10) "Marijuana" means a pistillate hemp plant with the scientific name of *Cannabis sativa* whose dried leaves and flowering tops yield the psychoactive ingredient tetrahydrocannabinol (THC), which can be ingested, vaporized, smoked, sprayed, applied topically, or manufactured as a component ingredient in food, drink, or pill, or in hemp oil form, to produce an intoxicating or physiological healing effect.

(11) "Mature marijuana plant" means a female marijuana plant that has flowers or buds that are readily observable in an unaided visual examination.

(12) "Medical cannabis" means any part of the cannabis plant used as a physician-recommended form of medical or herbal therapy, or a synthetic form of specific cannabinoids such as tetrahydrocannabinol, which is used as a physician-recommended form of medicine and is cultivated, manufactured, possessed, distributed, dispensed, obtained, consumed, smoked, eaten, digested, vaporized, or otherwise administered in accordance with this part and the rules adopted pursuant to s. 499.814. The term does not include a controlled substance listed in Schedule II, Schedule III, Schedule IV, or Schedule V of s. 893.03.

(13) "Medical cannabis farm" means land that:

(a) Has received a current agricultural classification pursuant to s. 193.461 by the county property appraiser, a value adjustment board, a court of competent jurisdiction, or the

board of county commissioners of the county in which the land is situated, before application for a permit to use the land to cultivate marijuana plants is granted, as defined in this section; and

(b) Is or will be used primarily for bona fide agricultural purposes.

(14) "Medical treatment facility" means:

(a) A facility that provides human medical diagnostic services as its primary purpose;

(b) A facility that provides nonsurgical human medical treatment; or

(c) The practice of medicine in which the patient is admitted to and discharged from a facility, including a hospital, within the same working day or for a duration of days.

The term does not include a facility that exists for the primary purpose of performing terminations of pregnancies or an office maintained by a dentist or endodontist for the practice of dentistry or endodontics.

(15) "Medical use" means the acquisition, possession, cultivation, manufacture, use, delivery, transfer, or transportation of cannabis or paraphernalia relating to the consumption of cannabis to treat a qualifying medical condition and the symptoms associated with that condition or to alleviate the side effects of a qualifying medical treatment.

(16) "Minor" means a person under 18 years of age.

(17) "Paraphernalia" means:

(a) Objects and electronic devices, including vaporizers, which are used, intended for use, or designed for use in

preparing, storing, ingesting, inhaling, spraying, applying, or otherwise introducing medical cannabis into the human body; and

(b) Kits, objects, devices, or equipment used, intended for use, or designed for use in planting, propagating, manufacturing, cultivating, growing, harvesting, processing, or preparing medical cannabis.

(18) "Patient's caregiver" or "caregiver" means a person who:

(a) Is designated by a qualifying patient and registered with the department as the person authorized, on the qualifying patient's behalf, to possess, obtain from a dispensary, dispense, and assist in the administration of medical cannabis; and

(b) Is at least 18 years of age.

(19) "Physician" means a person who is licensed under chapter 458 or chapter 459 and who holds a valid federal controlled substance registry number.

(20) "Qualifying medical condition" means:

(a) Acquired immune deficiency syndrome (AIDS) or positive status for human immunodeficiency virus (HIV);

(b) Alzheimer's disease or agitation of Alzheimer's disease;

(c) Amyotrophic lateral sclerosis (ALS);

(d) Anorexia;

(e) Cachexia;

(f) Cancer;

(g) Chronic debilitating pain;

(h) Damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity;

(i) Decompensated cirrhosis;

(j) Epilepsy and other disorders characterized by seizures;

(k) Fibromyalgia;

(l) Glaucoma;

(m) Hepatitis C;

(n) Inflammatory bowel disease, including Crohn's disease;

(o) Multiple sclerosis and other disorders characterized by muscle spasticity;

(p) Muscular dystrophy;

(q) Nail-patella syndrome;

(r) Persistent nausea or severe vomiting;

(s) Neuroborreliosis;

(t) Organ transplantation;

(u) Painful peripheral neuropathy;

(v) Parkinson's disease;

(w) Post-traumatic stress disorder (PTSD); or

(x) Terminal illness, if the physician has determined a prognosis of less than 12 months of life.

(21) "Qualifying medical treatment" means:

(a) Chemotherapy;

(b) Radiotherapy;

(c) The use of azidothymidine or protease inhibitors; or

(d) Treatment of a qualifying medical condition as defined in this section.

(22) "Qualifying patient" means a person who is a resident of this state and registered with the department as a person who has been diagnosed by a physician as having a qualifying medical condition or undergoing a qualifying medical treatment.

(23) "Registry identification card" means a nontransferable

document issued by the department which identifies a person as a qualifying patient or the patient's caregiver.

499.805 Medical cannabis usage.—

(1) Notwithstanding any provision of law, a qualifying patient may possess and administer medical cannabis and possess and use paraphernalia in accordance with this part and department rule only for treatment of a qualifying medical condition or the side effects of a qualifying medical treatment and only after obtaining a signed, written recommendation from a physician in accordance with s. 499.807, and a nontransferable registry identification card from the department.

(2) Notwithstanding any provision of law, a patient's caregiver may possess and administer medical cannabis to a qualifying patient and possess and use paraphernalia for the sole purpose of assisting in the administration of medical cannabis to the patient in accordance with this part and department rule.

(3) A registry identification card, or its equivalent, which is issued under the laws of another state, district, territory, commonwealth, or insular possession of the United States which allow the use of medical cannabis by a visiting qualifying patient or allow a person to assist with a visiting qualifying patient's medical use of cannabis, has the same force and effect as a registry identification card issued by the department.

(4) A qualifying patient, or the patient's caregiver, shall, upon demand, present to a law enforcement officer his or her registry identification card to confirm that he or she is authorized to possess, use, or administer medical cannabis or

paraphernalia.

(5) A qualifying patient or the patient's caregiver shall possess, use, or administer only medical cannabis obtained from a dispensary or medical cannabis farm that is issued a license or permit from the Department of Business and Profession Regulation.

(6) A qualifying patient who is a minor may possess, use, or administer medical cannabis only if the parent or legal guardian of the minor has signed a written statement affirming that the parent or legal guardian:

(a) Understands the minor's qualifying medical condition or qualifying medical treatment;

(b) Understands the potential benefits and potential adverse effects of the use of medical cannabis, generally and specifically, in the case of the minor;

(c) Consents to the use of medical cannabis for the treatment of the minor's qualifying medical condition or treatment of the side effects of the minor's qualifying medical treatment; and

(d) Consents to the designation of, or designates, an authorized person to serve as the patient's caregiver and to control the acquisition, possession, dosage, and frequency of use of medical cannabis by the qualifying patient.

(7) If a qualifying patient who possesses a registry identification card changes his or her designation of a caregiver, the department shall notify the patient's current caregiver within 10 days after the department has issued a registry identification card to the patient's new caregiver. The patient's current caregiver's registry identification card

expires 10 days after notification by the department.

(8) If a cardholder loses his or her registry identification card, he or she shall notify the department and submit a $25 fee within 10 days after reporting the lost card. Within 5 days after being notified, the department shall issue a new registry identification card to the cardholder.

(9) If the department fails to act upon a request for a registry identification card within 35 days after receiving the registration form, the card is deemed granted, and the copy of the registration form is deemed a valid registry identification card.

(10) If the department determines that a cardholder willfully violates this part, the department may revoke the cardholder's identification card.

499.806 Restrictions on the use of medicinal cannabis.—

(1) A person who seeks designation as a qualifying patient or the patient's caregiver must register with the department.

(2) The maximum amount of medical cannabis which a qualifying patient or the patient's caregiver may possess at any given time is 4 ounces of dried medical cannabis, eight mature marijuana plants, or eight immature marijuana plants. However, the department, by rule, may increase the quantity of dried medical cannabis which may be possessed. The department shall adopt by rule limits on medical cannabis in a form other than the dried form.

(3) Medical cannabis may not be administered by or to a qualifying patient in a public place or at a dispensary. Medical cannabis may be administered at a medical treatment facility, if allowed by the facility, if a qualifying patient is receiving

medical care for a qualifying medical condition or treatment.

(4) A qualifying patient or the patient's caregiver shall transport medical cannabis in a labeled container or sealed package in a manner and method established by rule.

(5) This part does not allow a person to undertake a task under the influence of medical cannabis when doing so constitutes professional negligence or professional malpractice.

(6) The medical use of cannabis as authorized by this part and by department rule does not create a defense to an offense proscribed by law which is not otherwise excepted in this chapter or in chapter 468. Evidence of a person's voluntary intoxication from use of medical cannabis is not admissible in a judicial proceeding to show that the person lacked the specific intent to commit an offense or to show that the person was insane at the time of the offense, except when the consumption was pursuant to a lawful prescription issued to the person by a physician.

(7) Notwithstanding any provision of law, a person or entity may provide information about the existence or operations of a medical cannabis farm or dispensary to another person pursuant to this part.

(8) A qualifying patient, the patient's caregiver, or an employee of a medical cannabis farm or a dispensary who is stopped by a law enforcement officer upon reasonable suspicion or probable cause that he or she is in possession of cannabis may not be further detained or arrested on this basis alone, if the law enforcement officer determines that the person is in compliance with this part and department rule.

499.807 Physicians; recommendations.—

(1) A physician may recommend the use of medical cannabis to a qualifying patient if the physician:

(a) Is in a bona fide physician-patient relationship with the qualifying patient; and

(b) Makes the recommendation based upon the physician's assessment of the qualifying patient's medical history, current medical condition, and a review of other approved medications and treatments that might provide the qualifying patient with relief from a qualifying medical condition, its symptoms, or the side effects of a qualifying medical treatment.

(2) If a physician recommends to a qualifying patient the use of medical cannabis, the physician shall sign a written recommendation that must include:

(a) A statement that the qualifying patient may use medical cannabis;

(b) The physician's medical license number; and

(c) A statement that the use of medical cannabis is necessary:

1. For the treatment of a qualifying medical condition or the side effects of a qualifying medical treatment; or

2. To lessen the side effects of a qualifying medical treatment.

(3) A physician's recommendation is valid only if it is written on a form prescribed by the department.

(4) A physician is not subject to arrest, prosecution, or penalty, including, but not limited to, civil penalty or disciplinary action by the department or by any other business, occupational, or professional licensing board or bureau, or denial of any right or privilege, solely for advising a patient

about the use of medical cannabis, recommending the medical use of cannabis in accordance with this part and department rule, providing a written recommendation in accordance with this section, or stating that, in the physician's professional opinion, the potential benefits of medical cannabis would likely outweigh the health risks for a patient.

(5) A physician who recommends the use of medical cannabis to a qualifying patient may not have a professional office located at a medical cannabis farm or dispensary or receive financial compensation from a medical cannabis farm or dispensary, or a director, officer, member, incorporator, agent, or employee of a medical cannabis farm or dispensary.

499.808 Licensure of dispensaries and medical cannabis farms.—

(1) The Department of Business and Professional Regulation shall regulate the permitting of medical cannabis farms and the licensing of dispensaries in accordance with part XVII of chapter 468, in order to regulate the manufacture, cultivation, possession, wholesale distribution, and delivery of medical cannabis and the manufacture, possession, purchase, sale, and use of paraphernalia by medical cannabis farms and dispensaries.

(2) Each medical cannabis farm shall apply for permitting and each dispensary shall apply for licensure with the Medical Cannabis Licensing Board within the Department of Business and Professional Regulation before manufacturing, cultivating, dispensing, possessing, or distributing medical cannabis, or manufacturing, possessing, using, or distributing paraphernalia.

499.809 Medical cannabis farms and dispensaries.—

(1) Notwithstanding any provision of law, a dispensary may

possess medical cannabis for the purpose of dispensing the medical cannabis to a qualifying patient or the patient's caregiver and may manufacture, purchase, possess, distribute, and use paraphernalia in accordance with this part, part XVII of chapter 468, and department rule.

(2) Notwithstanding any provision of law, a medical cannabis farm may cultivate, manufacture, and possess medical cannabis for the purpose of distribution to a dispensary and may manufacture, purchase, possess, and use paraphernalia in accordance with this part, part XVII of chapter 468, and department rule.

(3) A dispensary may dispense medical cannabis and distribute paraphernalia to a qualifying patient or the patient's caregiver, and a qualifying patient or the patient's caregiver may obtain medical cannabis and paraphernalia from a dispensary only if the qualifying patient or the patient's caregiver:

(a) Is registered to receive medical cannabis from that dispensary;

(b) Has been issued a valid registry identification card from the department; and

(c) Is in possession of the registry identification card at the time and place of purchase.

(4) A dispensary may not directly dispense within a 30-day period:

(a) More than 4 ounces of dried medical cannabis, eight mature marijuana plants, or eight immature marijuana plants to a qualifying patient or the patient's caregiver.

(b) More than 6 marijuana plant seedlings to a qualifying

patient or 18 marijuana plant seedlings to the patient's caregiver.

(5) Each medical cannabis farm and dispensary shall implement a security plan to prevent the theft or diversion of medical cannabis, including maintaining all medical cannabis in a secure, locked room that is accessible only by authorized persons.

(6) The Department of Business and Professional Regulation shall develop educational materials regarding potential harmful drug interaction which a dispensary shall regularly distribute to a qualifying patient or the patient's caregiver.

(7) A director, officer, member, incorporator, agent, or employee of a medical cannabis farm or dispensary may not have:

(a) A drug-related felony conviction; or

(b) A nondrug-related felony conviction for which the person has not been pardoned or has not had his or her civil rights restored.

(8) A person found to have violated this part may not be a director, officer, member, incorporator, agent, or employee of a medical cannabis farm or dispensary. The Department of Business and Professional Regulation shall immediately revoke the permit or license of the medical cannabis farm or dispensary until the person is no longer a director, officer, member, incorporator, agent, or employee of the medical cannabis farm or dispensary.

499.810 Arrest and prosecution.—

(1)(a) A qualifying patient who has in his or her possession a valid registry identification card is not subject to arrest, prosecution, or penalty, including, but not limited to, civil penalty or disciplinary action by a business,

occupational, or professional licensing board or bureau, and may not be denied any right or privilege, for the use of medical cannabis if the qualifying patient possesses an amount of cannabis which does not exceed eight mature marijuana plants, eight immature marijuana plants, 4 ounces of dried medical cannabis, or a measure of an end-product containing tetrahydrocannabinol and cannabinoids in an amount to be determined by department rule.

(b) A patient's caregiver who has in his or her possession a valid registry identification card is not subject to arrest, prosecution, or penalty, including, but not limited to, civil penalty or disciplinary action by a business, occupational, professional licensing board or bureau, and may not be denied any right or privilege, for assisting a qualifying patient to whom he or she is connected through the department's registration process with the medical use of cannabis if the patient's caregiver possesses an amount of cannabis which does not exceed 4 ounces of dried medical cannabis, eight mature marijuana plants, or eight immature marijuana plants for each qualifying patient to whom he or she is connected through the department's registration process.

(c) A nurse practitioner, registered nurse, or pharmacist is not subject to arrest, prosecution, or penalty, including, but not limited to, civil penalty or disciplinary action by a business, occupational, or professional licensing board or bureau, and may not be denied any right or privilege, solely for discussing with a patient the benefits or health risks of medical cannabis or its interaction with other substances.

(d) A person is not subject to arrest or prosecution for

constructive possession, conspiracy, aiding and abetting, being an accessory, or other offense for being in the presence or vicinity of the medical use of cannabis as allowed under this part or for assisting a qualifying patient in using or administering medical cannabis as the patient's caregiver.

(2) A school, employer, or property owner may not refuse to enroll, employ, or lease to or otherwise penalize a person solely for his or her status as a cardholder.

(3) A presumption is created that a qualifying patient or the patient's caregiver is engaged in the authorized use of medical cannabis if the qualifying patient or the patient's caregiver is in possession of:

(a) A valid registry identification card; and

(b) An amount of cannabis or marijuana which does not exceed the amount allowed under this section.

(4) A presumption of the authorized use or possession of medical cannabis under this section may be rebutted by evidence that the conduct related to medical cannabis was not intended to treat a qualifying medical condition or the symptoms associated with that condition or to alleviate the side effects of a qualifying medical treatment.

(5) The patient's caregiver may be reimbursed for actual costs associated with assisting a qualifying patient's medical use of cannabis. This reimbursement does not constitute the sale of a controlled substance.

(6) For the purposes of medical care, a qualifying patient's authorized medical use of cannabis or marijuana shall be considered the equivalent of the authorized use of other medication used at the direction of a physician. Such use does

not constitute the use of an illicit drug under s. 893.03.

(7) A qualifying patient may operate, navigate, or be in actual physical control of a motor vehicle, aircraft, or vessel while being in possession of a legal limit of medical cannabis or paraphernalia if a qualifying patient's hair specimen taken at the time of the alleged violation of state law does not test positive for marijuana in excess of 10 pg/10 mg of hair specimen when tested in a manner consistent with s. 112.0455(13)(b)1., or does not test positive for marijuana metabolites in excess of 1 pg/10 mg of hair specimen (Delta-9-tetrahydrocannabinol-0-carboxylic acid) when tested in a manner consistent with s. 112.0455(13)(b)2.

(8) A person who cultivates, manufactures, possesses, administers, dispenses, distributes, or uses cannabis, or manufactures, possesses, distributes, or uses paraphernalia, in a manner not authorized by this part, part XVII of chapter 468, or by department rule is subject to criminal prosecution and sanctions under chapter 893.

(9) A person who makes a fraudulent representation to a law enforcement officer of any fact or circumstance relating to the person's cultivation, manufacture, possession, administration, dispensing, distribution, or use of medical cannabis, or possession or use of paraphernalia, to avoid arrest or prosecution is subject to a criminal fine not to exceed $1,000. The imposition of the fine is in addition to penalties that may otherwise apply for the making of a false statement or for the cultivation, manufacture, possession, administration, dispensing, distribution, or use of medical cannabis or possession or use of paraphernalia.

499.811 Defenses.—

(1) The following circumstances may be raised as an affirmative defense to a criminal charge of possession or distribution of cannabis or marijuana, or possession with intent to distribute cannabis or marijuana:

(a) The person charged with the offense is in possession of a valid registry identification card;

(b) The person charged with the offense is 18 years of age or older; and

(c)1. The possession or distribution, or possession with intent to distribute, does not occur in a public place;

2. The possession or distribution, or possession with intent to distribute, occurs at a medical facility that allows the medical use of cannabis; or

3. The possession, distribution, or intent to distribute, occurs in a medical cannabis farm or dispensary.

(2) The following circumstances may be raised as an affirmative defense to a criminal charge of possession, use, or administration of a legal amount of medical cannabis or paraphernalia by a cardholder who:

(a) Upon demand by a law enforcement officer, is unable to present to the law enforcement officer a registry identification card to confirm that the cardholder is authorized to possess, use, or administer legal limits of medical cannabis or paraphernalia; and

(b) Before, or at the time of, the cardholder’s court appearance, produces in court or to the clerk of the court in which the charge is pending his or her registry identification card that was valid at the time of the cardholder’s arrest.

The clerk of the court may dismiss such case before the cardholder's appearance in court and may assess a dismissal fee of $25.

(3) Except as provided in subsections (1) and (2), a qualifying patient and the patient's caregiver may assert the medical purpose for using cannabis as a defense to any prosecution involving cannabis, and such defense is presumed valid where the evidence shows that:

(a) The qualifying patient's physician has stated that, in the physician's professional opinion, after having completed a full assessment of the patient's medical history and current medical condition made in the course of a bona fide physician-patient relationship, the potential benefits of using medical cannabis would likely outweigh the health risks for the qualifying patient; and

(b) The qualifying patient and the patient's caregiver, if any, were collectively in possession of a quantity of cannabis or marijuana which was not more than what is allowed under this part to ensure the uninterrupted availability of cannabis for the purpose of alleviating the side effects of the qualifying patient's qualifying medical treatment or treating the qualifying patient's qualifying medical condition or the symptoms associated with the qualifying medical condition.

(4) A person may assert the medical purpose for using cannabis in a motion to dismiss, and the charges shall be dismissed following an evidentiary hearing if the person presents the evidence specified in subsection (3).

(5) The Florida Contraband Forfeiture Act, contained in ss.

932.701-932.706, does not apply to any interest in or right to property that is possessed, owned, or used in connection with the medical use of cannabis, or acts incidental to such use.

499.812 Insurance.—This part does not require a governmental, private, or other health insurance provider or health care services plan to cover, or prohibit it from covering, a claim for reimbursement for the use of medical cannabis.

499.813 Confidentiality.—

(1) An employer, laboratory, employee assistance program, alcohol and drug rehabilitation program, and their agents may not release information obtained pursuant to this part without a written consent form signed voluntarily by the qualifying patient or the patient's caregiver, unless such release is compelled by a hearing officer or a court of competent jurisdiction pursuant to an appeal taken under this part, or where deemed appropriate by a business, professional, or occupational licensing board in a related disciplinary proceeding. The consent form must contain, at a minimum:

(a) The name of the person who is authorized to obtain the information.

(b) The purpose of the disclosure.

(c) The precise information to be disclosed.

(d) The duration of the consent.

(e) The signature of the person authorizing release of the information.

(2) Information regarding a qualifying patient or the patient's caregiver may not be released or used in a criminal proceeding against the qualifying patient or the patient's

caregiver. Information released contrary to this section is inadmissible as evidence in a criminal proceeding.

(3) This section does not prohibit the department or its employees and agents from obtaining access to information regarding a qualifying patient or the patient's caregiver if the department or its employees and agents consult with legal counsel in connection with actions brought under or related to this part or where the information is relevant to the department's defense in a civil or administrative proceeding.

499.814 Rules.—

(1)(a) By October 1, 2013, the department shall adopt rules to:

1. Create a registration form, a procedure, and eligibility requirements to obtain and renew a registry identification card for a qualifying patient and the patient's caregiver. The department shall, by rule, establish registration and renewal fees that generate revenues sufficient to offset all expenses of implementing and administering this part.

2. Adopt manufacturing practices with which medical cannabis farms and dispensaries must comply in order to ensure that medical cannabis sold by medical cannabis farms and dispensaries is of pharmaceutical grade.

3. Ensure that the labeling on medical cannabis sold by medical cannabis farms and dispensaries provides sufficient information for qualifying patients to be able to make informed choices about grades and forms of medical cannabis.

(b) The department may adopt rules to inspect and audit medical cannabis farms and dispensaries to ensure compliance with department rule.

(2) By October 1, 2013, the Department of Business and Professional Regulation shall adopt rules that:

(a) Create an application form and a procedure for obtaining a permit to own or operate a medical cannabis farm.

(b) Create an application form and a procedure for obtaining a license to own or operate a dispensary.

(c) Determine the licensing and permitting fees to own or operate a dispensary or medical cannabis farm.

(d) Determine the appropriate signage, outdoor lighting, security system, security plan, and theft prevention plan for medical cannabis farms and dispensaries.

(e) Determine the hours during which medical cannabis farms and dispensaries may operate.

(f) Establish the inspection and audit procedures for medical cannabis farms and dispensaries to ensure compliance with the rules of the Department of Business and Professional Regulation.

(3) By October 1, 2013, the Department of Revenue shall adopt rules that govern the manner in which:

(a) Medical cannabis farms are subject to taxation and reporting for the wholesale distribution of medical cannabis.

(b) Dispensaries are subject to taxation and reporting for the retail distribution of medical cannabis.

(4) The fees collected by the Department of Health, the Department of Business and Professional Regulation, and the Department of Revenue pursuant to this part shall be applied first toward the cost of administering this part.

(5) If the Department of Health, the Department of Business and Professional Regulation, or the Department of Revenue fails

to adopt rules to administer this part by November 1, 2013, a resident of this state may commence an action in a court of competent jurisdiction to compel performance of the actions mandated pursuant to this section.

Section 2. Part XVII of chapter 468, Florida Statutes, consisting of sections 468.901, 468.902, 468.903, 468.904, 468.905, 468.906, 468.907, 468.908, 468.909, 468.910, 468.911, 468.912, 468.913, 468.914, 468.915, 468.916, 468.917, 468.918, 468.919, and 468.920, is created to read:

468.901 Purpose.—The purpose of this part is to provide for consumer protection by regulating the cultivation, manufacturing, wholesaling, and retailing of medical cannabis, medical cannabis-based products, marijuana plants, and medical cannabis-related paraphernalia in the state in order to:

(1) Safeguard the public health, safety, and welfare.

(2) Protect the public from being misled by unscrupulous and unauthorized persons or criminal activity.

(3) Ensure the highest degree of regulatory conduct on the part of directors, officers, members, agents, and employees of medical cannabis farms and dispensaries.

(4) Ensure the availability of high quality and controlled distribution and use of medical cannabis, medical cannabis-based products, and marijuana plants in the state for the benefit of persons in need of such products.

468.902 Legislative findings and intent.—

(1) The Legislature finds that:

(a) Although federal law currently prohibits any use of marijuana and cannabis, the laws of Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Maine, Massachusetts,

Michigan, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, Washington, and the District of Columbia allow the medical use of cannabis and the cultivation of marijuana. The State of Florida joins in this effort for the health and welfare of its residents through enacting the Cathy Jordan Medical Cannabis Act and creating license and permit regulations in this part.

(b) Medical cannabis-based products offer a substantial benefit to the health, safety, and welfare of the residents of this state, and it is the intent of the Legislature that this part be liberally construed to make these benefits available to the residents of this state.

(c) The states are not required to enforce federal law or prosecute people for engaging in activities prohibited by federal law. Therefore, compliance with this part does not put this state in violation of federal law.

(2) The Tenth Amendment of the United States Constitution provides that powers not delegated to the federal government by the federal constitution, nor prohibited to the states, are reserved to the states or the people. The Legislature may, therefore, enact this part pursuant to its police power to enact legislation for the protection of the health of its residents.

(3) The provisions of this part are cumulative and do not repeal or affect any powers, duties, or authority of the department under any other law of this state, except with respect to the regulation of medical cannabis as provided in this part. If the provisions of this part conflict with any other such law, the provisions of this part shall control.

468.903 Definitions.—As used in this part, unless the

context clearly indicates otherwise, the term:

(1) "Cannabis" has the same meaning as provided in s. 893.02.

(2) "Department" means the Department of Business and Professional Regulation.

(3) "Dispensary" means a facility operated by an organization or business that is licensed under the Department of Business and Professional Regulation pursuant to ss. 499.808 and 499.809 from or at which medical cannabis is possessed and dispensed and paraphernalia is possessed and distributed to a qualifying patient or the patient's caregiver.

(4) "Dispense" means to distribute medical cannabis to a qualifying patient or the patient's caregiver in accordance with this part and department rule.

(5) "Distribute" means the actual, constructive, or attempted transfer from one person to another.

(6) "Manufacture" means the production, preparation, propagation, compounding, conversion, or processing of cannabis and marijuana, directly or indirectly, by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes the packaging or repackaging of the substance and the labeling or relabeling of its container.

(7) "Marijuana" means a pistillate hemp plant with the scientific name of *Cannabis sativa* whose dried leaves and flowering tops yield the psychoactive ingredient tetrahydrocannabinol (THC), which can be ingested, vaporized, smoked, sprayed, applied topically, or manufactured as a component ingredient in food, drink, or pill, or in hemp oil

form, to produce an intoxicating or physiological healing effect.

(8) "Marijuana plant" means a marijuana plant at any stage of its growth, including seedling and seed.

(9) "Medical cannabis" means any part of the cannabis plant used as a physician-recommended form of medical or herbal therapy, or a synthetic form of specific cannabinoids such as tetrahydrocannabinol, which is used as a physician-recommended form of medicine and is cultivated, manufactured, possessed, distributed, dispensed, obtained, consumed, smoked, eaten, digested, vaporized, or otherwise administered in accordance with part III of chapter 499 and the rules adopted pursuant to s. 499.814. The term does not include a controlled substance listed in Schedule II, Schedule III, Schedule IV, or Schedule V of s. 893.03.

(10) "Medical cannabis farm" means land that:

(a) Has received a current agricultural classification pursuant to s. 193.461 by the county property appraiser, a value adjustment board, a court of competent jurisdiction, or the board of county commissioners of the county in which the land is situated, before application for a permit to use the land to cultivate marijuana is granted, as defined in this section; and

(b) Is or will be used primarily for bona fide agricultural purposes.

(11) "Medical use" means the acquisition, possession, cultivation, manufacture, use, delivery, transfer, or transportation of cannabis or paraphernalia relating to the consumption of cannabis to treat a qualifying medical condition and the symptoms associated with that condition or to alleviate

the side effects of a qualifying medical treatment.

(12) "Paraphernalia" means:

(a) Objects and electronic devices, including vaporizers, which are used, intended for use, or designed for use in preparing, storing, ingesting, inhaling, spraying, applying, or otherwise introducing medical cannabis into the human body; and

(b) Kits, objects, devices, or equipment used, intended for use, or designed for use in planting, propagating, manufacturing, cultivating, growing, harvesting, processing, or preparing medical cannabis.

(13) "Patient's caregiver" or "caregiver" means a person who:

(a) Is designated by a qualifying patient and registered with the Department of Health as the person authorized, on the qualifying patient's behalf, to possess, obtain from a dispensary, dispense, and assist in the administration of medical cannabis; and

(b) Is at least 18 years of age.

(14) "Qualifying patient" means a person who is a resident of this state and registered with the Department of Health as a person who has been diagnosed by a physician as having a qualifying medical condition or undergoing a qualifying medical treatment.

(15) "Registry identification card" means a nontransferable document issued by the Department of Health which identifies a person as a qualifying patient or the patient's caregiver.

468.904 The medical cannabis section of the department.—

(1) The department shall adopt rules necessary to the administer this section. The department shall establish rules

that are reasonably necessary to protect the health, welfare, and safety of the public and persons who possess, cultivate, manufacture, wholesale, and retail medical cannabis, medical cannabis-based products, marijuana plants, and medical cannabis-related paraphernalia, and shall provide application forms and procedures, recordkeeping requirements, and security requirements. The rules must be in substantial conformity with generally accepted standards of safety concerning such subject matter.

(2) There is established the medical cannabis section of the department which regulates the manufacture, cultivation, distribution, dispensing, purchase, delivery, sale, and possession of medical cannabis and the manufacture, possession, purchase, sale, and use of paraphernalia related to medical cannabis. The medical cannabis section of the department is responsible for the licensure and permitting of each medical cannabis farm and dispensary in the state. The medical cannabis section of the department shall require the registration and approval of registration of each director, officer, and agent of each medical cannabis farm or dispensary in this state.

(3) The medical cannabis section of the department shall, subject to department rule, require each medical cannabis farm and dispensary to maintain true, complete, and current records of the name, address, home telephone number, and date of birth of each director, officer, and agent.

(4) The medical cannabis section of the department shall, subject to department rule, require each medical cannabis farm and dispensary to maintain true, complete, and current records of each transaction at a medical cannabis farm or dispensary,

including:

(a) The quantity of medical cannabis distributed or dispensed for each transaction;

(b) A continuous inventory of the quantity of medical cannabis, medical cannabis-based products, and marijuana plants at the medical cannabis farm or dispensary;

(c) Records of the disposal and disposal method used for any medical cannabis, medical cannabis-based product, marijuana plant's active ingredient or product, or marijuana plant that was manufactured, cultivated, or acquired but not sold or inventoried; and

(d) Any other information required by the department.

(5) The medical cannabis section of the department shall, subject to department rule:

(a) Develop and make available to each medical cannabis farm, dispensary, and the general public, educational materials about potential harmful drug interactions that could occur from using medical cannabis concurrently with other medical treatments, and the importance of informing public and private hospitals, health care providers, pharmacists, and duly licensed dispensaries in this state of the use of medical cannabis to help avoid harmful drug interactions;

(b) Conduct announced and unannounced inspections of medical cannabis farms and dispensaries; and

(c) Revoke or suspend the registration, license, or permit of a person if the department determines that the person has violated department rule, this part, or part III of chapter 499.

468.905 Medical cannabis farms.—

(1) Notwithstanding any other provision of law, a medical

cannabis farm may possess, cultivate, and manufacture medical cannabis, medical cannabis-based products, and marijuana plants for wholesale in this state for the purpose of distribution to duly licensed medical cannabis dispensaries in the state in accordance with the department rule and part III of chapter 499.

(2) Each medical cannabis farm must be registered with the department before possessing, manufacturing, cultivating, and wholesaling medical cannabis, medical cannabis-based products, or marijuana plants.

(3) A person who applies to the department for a permit to operate a medical cannabis farm must primarily use the land in which the farm will be located for bona fide agricultural purposes and obtain the agricultural classification pursuant to s. 193.461 from the county property appraiser, a value adjustment board, a court of competent jurisdiction, or the board of county commissioners of the county in which the land is situated, before applying for a medical cannabis farm permit.

(4) A medical cannabis farm may not conduct retail sales or transactions.

(5) Each medical cannabis farm shall implement a security plan to prevent the theft or diversion of all medical cannabis-based products and raw ingredients, including all marijuana plants; derivatives of marijuana plants; seedlings and seeds, whether in ground or not in ground, whether visible or not visible to the public.

(6) Each medical cannabis farm shall maintain procedures under which all medical cannabis-based products and raw ingredients, including all marijuana plants; derivatives of marijuana plants; seedlings and seeds, whether in ground or not

in ground, whether visible or not visible to the public, are accessible only to authorized personnel.

(7) The active ingredient in all medical cannabis-based products cultivated, manufactured, and wholesaled to a licensed dispensary in this state must be wholly derived from marijuana plants cultivated and grown in this state, except for marijuana seeds and seedlings.

(8) A medical cannabis farm is subject to the protections of s. 823.14 and is not deemed a public nuisance solely because its farm product includes the production of marijuana or any product derived from the marijuana plant.

468.906 Medical cannabis dispensaries.—

(1) Notwithstanding any other law of this state, a dispensary may dispense and sell to a qualifying patient or the patient's caregiver medical cannabis, medical cannabis-based products, marijuana plants, and medical cannabis-related paraphernalia and may manufacture, purchase, possess, and distribute medical cannabis-related paraphernalia in accordance with department rule and part III of chapter 499.

(2) Each dispensary must be registered with the department before possessing, purchasing, or retailing medical cannabis, medical cannabis-based products, marijuana plants, or medical cannabis related paraphernalia.

(3) A dispensary may not conduct wholesale sales or transactions.

(4) A dispensary may retail to a qualifying patient or patient's caregiver medical cannabis, medical cannabis-based products, marijuana plants, or medical cannabis-related paraphernalia if the qualifying patient or patient's caregiver:

(a) Has been issued a valid registry identification card from the Department of Health; and

(b) Is in possession of the registry identification card at the time and place of purchase.

(5) All medical cannabis-based products sold by, at, or through a licensed dispensary shall be purchased from a medical cannabis farm that has a valid, department-issued permit.

(6) A dispensary may not directly dispense within a 30-day period:

(a) More than 4 ounces of dried medical cannabis to a qualifying patient or through the patient's caregiver.

(b) More than 6 marijuana plant seedlings to a qualifying patient or 18 marijuana plant seedlings to the patient's caregiver.

(7) A dispensary shall maintain true, complete, and current records of the name and registry card identification number of each qualifying patient and patient's caregiver who purchases a medical cannabis-related product, except for medical cannabis-related paraphernalia, subject to the confidentiality limitations in part III of chapter 499. The records maintained under this paragraph shall be retained for 3 years and must include:

(a) The amount paid for the medical cannabis, medical cannabis-based product, or marijuana plant transaction; and

(b) The registry identification card number of each recipient of each medical cannabis, medical cannabis-based product, or marijuana plant transaction, subject to the confidentiality limitations in part III of chapter 499.

(8) Each dispensary shall make available to each qualifying

patient and patient's caregiver educational materials regarding potential harmful drug interactions which were developed and provided by the medical cannabis section of the department.

(9) Each dispensary shall strictly prohibit a qualifying patient or patient's caregiver from using or administering any form of medical cannabis while on the property of the dispensary. A person who violates this subsection subjects the dispensary to penalties prescribed by department rule and part III of chapter 499.

468.907 Medical cannabis farm permit.—

(1) A person may not engage in business as a medical cannabis farm in this state except in conformity with this part.

(2) Permit qualification standards by which a person who applies for a permit to operate a medical cannabis farm will be evaluated to determine acceptance of the person's application for registration and permitting and renewal of registration and permitting, must include the following factors:

(a) Knowledge of state and federal law relating to medical cannabis.

(b) Suitability of the proposed facility.

(c) Proposed staffing plan.

(d) Proposed security plan that has been assessed by the local law enforcement agency of the county or municipality in which the medical cannabis farm is located.

(e) Proposed cultivation plan.

(f) Proposed manufacturing plan.

(g) Proposed storage and inventory control plan.

(h) Proposed labeling plan.

(i) Proposed product safety plan.

(3) The department shall establish by rule the annual fees for a medical cannabis farm permit. The fees may not exceed the following amounts:

(a) Medical cannabis farm application fee, $2,500.

(b) Medical cannabis farm initial permit fee, $20,000.

(c) Medical cannabis farm application fee for renewing a permit, $1,000.

(d) Medical cannabis farm renewal permit fee, $15,000.

(4) A person who cultivates, manufactures, or wholesales medical cannabis, medical cannabis-based products, or marijuana plant products at one or more locations must possess a current valid permit for each location.

(5) If the department fails to adopt rules to administer this section before November 1, 2013, a medical cannabis farm applicant may commence an action in a court of competent jurisdiction to compel the department to perform the actions mandated pursuant to this section.

468.908 Dispensary license.—

(1) A person or entity may not operate a dispensary in this state except in conformity with the provisions of this part.

(2) License qualification standards by which a person who applies for a license to operate a dispensary will be evaluated to determine acceptance of the person’s application for registration and licensing and renewal of registration and licensing, must include the following factors:

(a) Knowledge of state and federal law relating to medical cannabis.

(b) Suitability of the proposed facility.

(c) Proposed staffing plan.

(d) Proposed security plan that has been assessed by the dispensary's municipal police department.

(e) Proposed retail plan.

(f) Proposed marketing plan.

(g) Proposed storage and inventory control plan.

(h) Proposed labeling plan.

(i) Proposed product safety plan.

(3) The department shall establish by rule the annual fees for a dispensary license. The fees may not exceed the following amounts:

(a) Dispensary application fee, $1,000.

(b) Dispensary initial license fee, $10,000.

(c) Dispensary renewal license application fee, $500.

(d) Dispensary renewal license fee, $7,500.

(4) A person who conducts the wholesale purchase or retail sale of any form of medical cannabis products at or from more than one location must possess a current valid license for each location.

(5) If the department fails to adopt rules to administer this section by November 1, 2013, an applicant to operate a dispensary may commence an action in a court of competent jurisdiction to compel the department to perform the actions mandated pursuant to this section.

468.909 Forms for applications for licenses and permits.—

(1) The department shall prescribe the application forms for obtaining a permit to operate a medical cannabis farm and a license to operate a dispensary.

(2) Each application for a license or permit required by this part must be filed in writing with the department. Each

application must require, as a minimum, the full name, date of birth, place of birth, social security number, physical description of the applicant, residence address and telephone number, and business address and telephone number of the applicant. Each application must be accompanied by an accurate and current photograph of the applicant and a complete set of fingerprints of the applicant taken by an authorized law enforcement agency; however, a set of fingerprints is not required if the applicant has possessed a valid license or permit under this part during the previous licensing or permitting year and such license or permit has not lapsed or been suspended or revoked. If fingerprints are required, the department shall submit the set of fingerprints to the Department of Law Enforcement for state processing. If the application does not require a set of fingerprints, the department shall submit the name and other identifying data to the Department of Law Enforcement for processing. Each application must be in a form to provide the data and other information set forth in this subsection, must be sworn to by the applicant or, if the applicant is a corporation, by each officer and director of the corporation. The officers and directors applying on behalf of a corporation shall provide all the data and other information required. This section does not exclude electronic filing of the application.

(3) The department may require an applicant to furnish other information or data not required by this section if the information or data is deemed necessary by the department.

468.910 Issuance of licenses and permits; prohibitions.—

(1) Each license and permit issued by the department in

accordance with this part must set forth, at a minimum, the full name, date of birth, and physical description of the licensee or permittee and have permanently affixed an accurate and current photograph of the licensee or permittee. A license or permit issued to a corporation must set forth the full name, date of birth, and physical description of the chief executive officer and have permanently affixed an accurate and current photograph of the chief executive officer. Each license and permit must also contain a license or permit number.

(2) The department may include other data or information on the license or permit if deemed appropriate.

(3) A license or permit may not be issued, renewed, or allowed to remain in effect for:

(a) A corporation or entity that has a corporate officer who is under 18 years of age; or

(b) A person who has been convicted in this state or any other state or federal jurisdiction for the following offenses:

1. A drug-related felony.

2. A nondrug-related felony conviction for which the person has not been pardoned or has not had his or her civil rights restored.

(4) A license or permit may not be issued, renewed, or allowed to remain in effect for a person who has been adjudicated mentally incompetent and has not had his or her civil rights restored.

(5) A person may not knowingly withhold information or present to the department a false, fictitious, or misrepresented application, identification, document, information, statement, or data intended or likely to deceive the department for

obtaining a license or permit.

(6) The department may adopt rules regarding persons who legally possess medical cannabis for the purpose of teaching, research, or testing and issue letters of exemption to facilitate the lawful possession of medical cannabis for those persons.

(7) A person who violates or has violated any provision of this part may not be a director, officer, member, incorporator, agent, or employee of a medical cannabis farm or dispensary. Any prior authorization of such person shall be immediately revoked, and the department shall suspend the license or permit of the medical cannabis farm or dispensary until the person is removed from the position of director, officer, member, incorporator, agent, or employee.

468.911 License and permit to be displayed.—

(1) A medical cannabis farm that has a department-issued permit may use the terms "medical cannabis farm" or "permitted medical cannabis farm," in connection with the permittee's name or place of business, to denote permitting under this part.

(2) A licensed dispensary may use the terms "dispensary," "licensed dispensary," or "licensed medical cannabis dispensary," in connection with the licensee's name or place of business, to denote licensure under this part.

(3) Each person who is issued a license or permit under this part must keep such license or permit conspicuously displayed in his or her office, place of business, or place of employment and, whenever required, shall exhibit such license or permit to any member or authorized representative of the department.

(4) A license or permit that is issued by the department is valid beginning on October 1 of the year for which it is issued and expires on September 30 in the following year.

(5) A medical cannabis farm that has a department-issued permit or a licensed dispensary shall renew its permit or license before its expiration date. If a renewal application and fee are not filed by the expiration date, the license or permit may be reinstated only if the licensee or permittee pays, within 30 days after the date of expiration, a delinquent fee that must not exceed $750 for a medical cannabis farm and $500 for a dispensary, plus the required renewal fee. If a licensee or permittee fails to comply with the renewal requirements of this part, the department may seize all medical cannabis products and dispose of them in any manner deemed appropriate by the department by November 1 of the year the license or permit expires. Any funds collected from the disposal shall be placed in the Professional Regulation Trust Fund.

(6) The fee structure for reactivation of an inactive license or permit, except when renewed within 30 days after the date of expiration, is the same as for an initial permit or license, including the application fee.

468.912 Reports of theft, illegal use, or illegal possession.—

(1) A licensee or permittee who incurs a loss, theft, or unexplained shortage of a medical cannabis product, or who has knowledge of a loss, theft, or unexplained shortage of a medical cannabis product, shall, within 12 hours after the discovery, report such loss, theft, or unexplained shortage to the county sheriff or police chief of the jurisdiction in which the loss,

theft, or unexplained shortage occurred. This loss, theft, or unexplained shortage shall also be reported to the department by the close of the next business day following the discovery.

(2) Any sheriff, police department, or law enforcement officer in this state shall give immediate notice to the department of any theft, illegal use, or illegal possession of medical cannabis which involves a person and forward a copy of his or her final written police report to the department.

(3) A law enforcement agency that investigates the causes and circumstances of a loss, theft, or unexplained shortage of medical cannabis shall forward a copy of its final written report to the department. The department shall retain these reports in the files of the affected licensee or permittee.

468.913 Procedure for cease and desist orders.—If the department determines that a provision of this part or applicable department rule has been violated, the department shall issue to the person charged with the violation an order requiring the person to cease and desist from such violation or shall impose an administrative fine, or both.

468.914 Administrative fines.—

(1) If a person violates this part or department rule adopted pursuant to this part or violates a cease and desist order issued by the department, the department may impose an administrative fine, not to exceed $5,000 for each violation per day, or may suspend or revoke the license or permit issued to the person, or both. Each day that the violation continues constitutes a separate violation, and each separate violation is subject to a separate fine. The department shall allow the licensee or permittee a reasonable period, not to exceed 30

days, to pay to the department the amount of the imposed fine. If the licensee or permittee fails to pay the fine in its entirety to the department at its office in Tallahassee within 30 days, the department shall revoke the person's license or permit. The issuance of administrative fines under this paragraph does not waive the state's right to pursue any additional penalties for the violation.

(2) All fines, monetary penalties, and costs received by the department in connection with this part shall be deposited in the Professional Regulation Trust Fund.

468.915 Injunctive relief.—In addition to the penalties and other enforcement provisions of this part, if a person who is engaged in any of the activities covered by this part violates a provision of this part, a department rule adopted pursuant thereto, or any cease and desist order as provided by this part, the department may seek injunctive relief in the Circuit Court of Leon County and may apply for temporary and permanent orders as the department deems necessary to restrain such person from engaging in any activities of this part until such person complies with this part, the department rules adopted pursuant thereto, and the orders of the department as authorized by this part.

468.916 Suspension or revocation of license or permit.—

(1) A licensee or permittee who knowingly makes or files a report that is false, intentionally or negligently fails to file a report or record required by state law, or willfully impedes or obstructs such filing or induces another person to do so, is subject to immediate suspension of his or her license or permit.

(2) A licensee or permittee who pays or receives, directly

or indirectly, a commission, bonus, kickback, or rebate to or from, or engages in any split-fee arrangement in any form with a physician, organization, agency, or person, for patients referred to a provider of health care goods and services, including, but not limited to, a hospital, nursing home, clinical laboratory, ambulatory surgical center, or pharmacy, is subject to immediate suspension of his or her license or permit.

(3) A violation of any provision of this part, any rule adopted pursuant thereto, or any cease and desist order issued by the department by a licensee or permittee as provided in this part is cause for revocation or suspension of all licenses or permits held by the licensee or permittee after the department has determined the licensee or permittee to be guilty of such violation.

(4) If the department finds the licensee or permittee to be guilty of such violation as provided in subsection (3), it shall enter an order suspending or revoking the license or permit of the person charged.

(a) An order of suspension must state the period of time of the suspension, which period must not exceed 1 year from the date of the order.

(b) An order of revocation may be entered for a period not to exceed 5 years. The order affects the revocation of all licenses or permits held by the person. During such period, a license or permit may not be issued to the person.

If, during the period between the beginning of a proceeding to revoke or suspend a license or permit and the entry of an order of suspension or revocation by the department, a new license or

permit has been issued to the person, any order of suspension or revocation shall operate effectively with respect to the new license or permit held by such person.

(5) A person whose permit or license has been suspended or revoked may not be issued a new permit or license under any other name or company name until the expiration of the suspension or revocation.

(6) The provisions of this section are cumulative and do not affect any other lawful remedy available to the state, including administrative fines and injunction relief.

468.917 Conduct of hearings; review of orders of the department.—All hearings shall be conducted in accordance with chapter 120. All review of orders of the department shall be in accordance with chapter 120.

468.918 Penalties.—

(1) A person who knowingly withholds information or presents to the department a false, fictitious, or misrepresented application, identification, document, information, statement, or data intended or likely to deceive the department for the purpose of obtaining a license or permit commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(2) A person who knowingly withholds information or makes a false or fictitious entry or misrepresentation upon any invoice, receipt, sales ticket, sales slip, or account of inventories commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(3) A licensee who knowingly fails to maintain written accounts of inventories or records of sales or transfers commits

a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(4) A permittee who knowingly fails to maintain written inventories and records commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(5) A licensee or permittee who fails to report the loss, theft, or unexplained shortage of medical cannabis commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

468.919 County and municipal ordinances.—A county or municipality in this state may not create or impose an ordinance or rule pertaining to medical cannabis which is more restrictive than the provisions contained in this part and the applicable department rules.

468.920 Deposit of fees.—All fees collected for licenses and permits required by this part shall be deposited in the Professional Regulation Trust Fund, and all moneys collected under this part and deposited in the Professional Regulation Trust Fund shall be used by the department in the administration of this part. The department shall maintain a separate account in the Professional Regulation Trust Fund for the Drugs, Devices, and Cosmetics program.

Section 3. Subsection (6) of section 812.14, Florida Statutes, is amended to read:

812.14 Trespass and larceny with relation to utility fixtures; theft of utility services.—

(6) It is prima facie evidence of a person’s intent to violate subsection (5) if:

(a) A controlled substance and materials for manufacturing

the controlled substance intended for sale or distribution to another were found in a dwelling or structure;

(b) Except as provided in this chapter, chapter 468, or chapter 499, and notwithstanding s. 893.13, the dwelling or structure has been visibly modified to accommodate the use of equipment to grow marijuana indoors, including, but not limited to, the installation of equipment to provide additional air conditioning, equipment to provide high-wattage lighting, or equipment for hydroponic cultivation; and

(c) The person or entity that owned, leased, or subleased the dwelling or structure knew of, or did so under such circumstances as would induce a reasonable person to believe in, the presence of a controlled substance and materials for manufacturing a controlled substance in the dwelling or structure, regardless of whether the person or entity was involved in the manufacture or sale of a controlled substance or was in actual possession of the dwelling or structure.

Section 4. Paragraph (c) of subsection (1) of section 893.03, Florida Statutes, is amended to read:

893.03 Standards and schedules.—The substances enumerated in this section are controlled by this chapter. The controlled substances listed or to be listed in Schedules I, II, III, IV, and V are included by whatever official, common, usual, chemical, or trade name designated. The provisions of this section shall not be construed to include within any of the schedules contained in this section any excluded drugs listed within the purview of 21 C.F.R. s. 1308.22, styled "Excluded Substances"; 21 C.F.R. s. 1308.24, styled "Exempt Chemical Preparations"; 21 C.F.R. s. 1308.32, styled "Exempted

Prescription Products"; or 21 C.F.R. s. 1308.34, styled "Exempt Anabolic Steroid Products."

(1) SCHEDULE I.—A substance in Schedule I has a high potential for abuse and has no currently accepted medical use in treatment in the United States and in its use under medical supervision does not meet accepted safety standards. The following substances are controlled in Schedule I:

(c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation that contains any quantity of the following hallucinogenic substances or that contains any of their salts, isomers, and salts of isomers, if the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

1. Alpha-ethyltryptamine.

2. 2-Amino-4-methyl-5-phenyl-2-oxazoline (4-methylaminorex).

3. 2-Amino-5-phenyl-2-oxazoline (Aminorex).

4. 4-Bromo-2,5-dimethoxyamphetamine.

5. 4-Bromo-2,5-dimethoxyphenethylamine.

6. Bufotenine.

7. Cannabis<u>, except as exempted in chapters 468 and 499</u>.

8. Cathinone.

9. Diethyltryptamine.

10. 2,5-Dimethoxyamphetamine.

11. 2,5-Dimethoxy-4-ethylamphetamine (DOET).

12. Dimethyltryptamine.

13. N-Ethyl-1-phenylcyclohexylamine (PCE) (Ethylamine analog of phencyclidine).

14. N-Ethyl-3-piperidyl benzilate.

15. N-ethylamphetamine.

16. Fenethylline.

17. N-Hydroxy-3,4-methylenedioxyamphetamine.

18. Ibogaine.

19. Lysergic acid diethylamide (LSD).

20. Mescaline.

21. Methcathinone.

22. 5-Methoxy-3,4-methylenedioxyamphetamine.

23. 4-methoxyamphetamine.

24. 4-methoxymethamphetamine.

25. 4-Methyl-2,5-dimethoxyamphetamine.

26. 3,4-Methylenedioxy-N-ethylamphetamine.

27. 3,4-Methylenedioxyamphetamine.

28. N-Methyl-3-piperidyl benzilate.

29. N,N-dimethylamphetamine.

30. Parahexyl.

31. Peyote.

32. N-(1-Phenylcyclohexyl)-pyrrolidine (PCPY) (Pyrrolidine analog of phencyclidine).

33. Psilocybin.

34. Psilocyn.

35. *Salvia divinorum*, except for any drug product approved by the United States Food and Drug Administration which contains *Salvia divinorum* or its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, if the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation.

36. Salvinorin A, except for any drug product approved by

the United States Food and Drug Administration which contains Salvinorin A or its isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, if the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation.

37. Tetrahydrocannabinols, except as exempted in chapters 468 and 499.

38. 1-[1-(2-Thienyl)-cyclohexyl]-piperidine (TCP) (Thiophene analog of phencyclidine).

39. 3,4,5-Trimethoxyamphetamine.

40. 3,4-Methylenedioxymethcathinone.

41. 3,4-Methylenedioxypyrovalerone (MDPV).

42. Methylmethcathinone.

43. Methoxymethcathinone.

44. Fluoromethcathinone.

45. Methylethcathinone.

46. 2-[(1R,3S)-3-hydroxycyclohexyl]-5-(2-methyloctan-2-yl)phenol, also known as CP 47,497 and its dimethyloctyl (C8) homologue.

47. (6aR,10aR)-9-(hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo [c]chromen-1-ol, also known as HU-210.

48. 1-Pentyl-3-(1-naphthoyl)indole, also known as JWH-018.

49. 1-Butyl-3-(1-naphthoyl)indole, also known as JWH-073.

50. 1-[2-(4-morpholinyl)ethyl]-3-(1-naphthoyl) indole, also known as JWH-200.

51. BZP (Benzylpiperazine).

52. Fluorophenylpiperazine.

53. Methylphenylpiperazine.

54. Chlorophenylpiperazine.
55. Methoxyphenylpiperazine.
56. DBZP (1,4-dibenzylpiperazine).
57. TFMPP (3-Trifluoromethylphenylpiperazine).
58. MBDB (Methylbenzodioxolylbutanamine).
59. 5-Hydroxy-alpha-methyltryptamine.
60. 5-Hydroxy-N-methyltryptamine.
61. 5-Methoxy-N-methyl-N-isopropyltryptamine.
62. 5-Methoxy-alpha-methyltryptamine.
63. Methyltryptamine.
64. 5-Methoxy-N,N-dimethyltryptamine.
65. 5-Methyl-N,N-dimethyltryptamine.
66. Tyramine (4-Hydroxyphenethylamine).
67. 5-Methoxy-N,N-Diisopropyltryptamine.
68. DiPT (N,N-Diisopropyltryptamine).
69. DPT (N,N-Dipropyltryptamine).
70. 4-Hydroxy-N,N-diisopropyltryptamine.
71. N,N-Diallyl-5-Methoxytryptamine.
72. DOI (4-Iodo-2,5-dimethoxyamphetamine).
73. DOC (4-Chloro-2,5-dimethoxyamphetamine).
74. 2C-E (4-Ethyl-2,5-dimethoxyphenethylamine).
75. 2C-T-4 (2,5-Dimethoxy-4-isopropylthiophenethylamine).
76. 2C-C (4-Chloro-2,5-dimethoxyphenethylamine).
77. 2C-T (2,5-Dimethoxy-4-methylthiophenethylamine).
78. 2C-T-2 (2,5-Dimethoxy-4-ethylthiophenethylamine).
79. 2C-T-7 (2,5-Dimethoxy-4-(n)-propylthiophenethylamine).
80. 2C-I (4-Iodo-2,5-dimethoxyphenethylamine).
81. Butylone (beta-keto-N-methylbenzodioxolylpropylamine).
82. Ethcathinone.

83. Ethylone (3,4-methylenedioxy-N-ethylcathinone).
84. Naphyrone (naphthylpyrovalerone).
85. N-N-Dimethyl-3,4-methylenedioxycathinone.
86. N-N-Diethyl-3,4-methylenedioxycathinone.
87. 3,4-methylenedioxy-propiophenone.
88. 2-Bromo-3,4-Methylenedioxypropiophenone.
89. 3,4-methylenedioxy-propiophenone-2-oxime.
90. N-Acetyl-3,4-methylenedioxycathinone.
91. N-Acetyl-N-Methyl-3,4-Methylenedioxycathinone.
92. N-Acetyl-N-Ethyl-3,4-Methylenedioxycathinone.
93. Bromomethcathinone.
94. Buphedrone (alpha-methylamino-butyrophenone).
95. Eutylone (beta-Keto-Ethylbenzodioxolylbutanamine).
96. Dimethylcathinone.
97. Dimethylmethcathinone.
98. Pentylone (beta-Keto-Methylbenzodioxolylpentanamine).
99. (MDPPP) 3,4-Methylenedioxy-alpha-pyrrolidinopropiophenone.
100. (MDPBP) 3,4-Methylenedioxy-alpha-pyrrolidinobutiophenone.
101. Methoxy-alpha-pyrrolidinopropiophenone (MOPPP).
102. Methyl-alpha-pyrrolidinohexiophenone (MPHP).
103. Benocyclidine (BCP) or benzothiophenylcyclohexylpiperidine (BTCP).
104. Fluoromethylaminobutyrophenone (F-MABP).
105. Methoxypyrrolidinobutyrophenone (MeO-PBP).
106. Ethyl-pyrrolidinobutyrophenone (Et-PBP).
107. 3-Methyl-4-Methoxymethcathinone (3-Me-4-MeO-MCAT).
108. Methylethylaminobutyrophenone (Me-EABP).

109. Methylamino-butyrophenone (MABP).

110. Pyrrolidinopropiophenone (PPP).

111. Pyrrolidinobutiophenone (PBP).

112. Pyrrolidinovalerophenone (PVP).

113. Methyl-alpha-pyrrolidinopropiophenone (MPPP).

114. JWH-007 (1-pentyl-2-methyl-3-(1-naphthoyl)indole).

115. JWH-015 (2-Methyl-1-propyl-1H-indol-3-yl)-1-naphthalenylmethanone).

116. JWH-019 (Naphthalen-1-yl-(1-hexylindol-3-yl)methanone).

117. JWH-020 (1-heptyl-3-(1-naphthoyl)indole).

118. JWH-072 (Naphthalen-1-yl-(1-propyl-1H-indol-3-yl)methanone).

119. JWH-081 (4-methoxynaphthalen-1-yl-(1-pentylindol-3-yl)methanone).

120. JWH-122 (1-Pentyl-3-(4-methyl-1-naphthoyl)indole).

121. JWH-133 ((6aR,10aR)-3-(1,1-Dimethylbutyl)-6a,7,10,10a-tetrahydro-6,6,9-trimethyl-6H-dibenzo[b,d]pyran)).

122. JWH-175 (3-(naphthalen-1-ylmethyl)-1-pentyl-1H-indole).

123. JWH-201 (1-pentyl-3-(4-methoxyphenylacetyl)indole).

124. JWH-203 (2-(2-chlorophenyl)-1-(1-pentylindol-3-yl)ethanone).

125. JWH-210 (4-ethylnaphthalen-1-yl-(1-pentylindol-3-yl)methanone).

126. JWH-250 (2-(2-methoxyphenyl)-1-(1-pentylindol-3-yl)ethanone).

127. JWH-251 (2-(2-methylphenyl)-1-(1-pentyl-1H-indol-3-yl)ethanone).

128. JWH-302 (1-pentyl-3-(3-methoxyphenylacetyl)indole).

129. JWH-398 (1-pentyl-3-(4-chloro-1-naphthoyl)indole).

130. HU-211 ((6aS,10aS)-9-(Hydroxymethyl)-6,6-dimethyl-3-(2-methyloctan-2-yl)-6a,7,10,10a-tetrahydrobenzo[c]chromen-1-ol).

131. HU-308 ([(1R,2R,5R)-2-[2,6-dimethoxy-4-(2-methyloctan-2-yl)phenyl]-7,7-dimethyl-4-bicyclo[3.1.1]hept-3-enyl] methanol).

132. HU-331 (3-hydroxy-2-[(1R,6R)-3-methyl-6-(1-methylethenyl)-2-cyclohexen-1-yl]-5-pentyl-2,5-cyclohexadiene-1,4-dione).

133. CB-13 (Naphthalen-1-yl-(4-pentyloxynaphthalen-1-yl)methanone).

134. CB-25 (N-cyclopropyl-11-(3-hydroxy-5-pentylphenoxy)-undecanamide).

135. CB-52 (N-cyclopropyl-11-(2-hexyl-5-hydroxyphenoxy)-undecanamide).

136. CP 55,940 (2-[(1R,2R,5R)-5-hydroxy-2-(3-hydroxypropyl)cyclohexyl]-5-(2-methyloctan-2-yl)phenol).

137. AM-694 (1-[(5-fluoropentyl)-1H-indol-3-yl]-(2-iodophenyl)methanone).

138. AM-2201 (1-[(5-fluoropentyl)-1H-indol-3-yl]-(naphthalen-1-yl)methanone).

139. RCS-4 ((4-methoxyphenyl) (1-pentyl-1H-indol-3-yl)methanone).

140. RCS-8 (1-(1-(2-cyclohexylethyl)-1H-indol-3-yl)-2-(2-methoxyphenylethanone).

141. WIN55,212-2 ((R)-(+)-[2,3-Dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de]-1,4-benzoxazin-6-yl]-1-

naphthalenylmethanone).

142. WIN55,212-3 ([(3S)-2,3-Dihydro-5-methyl-3-(4-morpholinylmethyl)pyrrolo[1,2,3-de]-1,4-benzoxazin-6-yl]-1-naphthalenylmethanone).

Section 5. Subsections (1) through (6) of section 893.13, Florida Statutes, are amended to read:

893.13 Prohibited acts; penalties.—

(1)(a) Except as authorized by this chapter and chapter 499, it is unlawful for any person to sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance. Any person who violates this provision with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. Except as provided in this chapter, chapter 468, and chapter 499, a controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. A controlled substance named or described in s. 893.03(5) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(b) Except as provided in this chapter, chapter 468, and chapter 499, it is unlawful to sell or deliver in excess of 10 grams of any substance named or described in s. 893.03(1)(a) or (1)(b), or any combination thereof, or any mixture containing

any such substance. Any person who violates this paragraph commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Except as authorized by this chapter, chapter 468, and chapter 499, it is unlawful for any person to sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising a child care facility as defined in s. 402.302 or a public or private elementary, middle, or secondary school between the hours of 6 a.m. and 12 midnight, or at any time in, on, or within 1,000 feet of real property comprising a state, county, or municipal park, a community center, or a publicly owned recreational facility. For the purposes of this paragraph, the term "community center" means a facility operated by a nonprofit community-based organization for the provision of recreational, social, or educational services to the public. Any person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The defendant must be sentenced to a minimum term of imprisonment of 3 calendar years unless the offense was committed within 1,000 feet of the real property comprising a child care facility as defined in s. 402.302.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) commits a felony of

the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

This paragraph does not apply to a child care facility unless the owner or operator of the facility posts a sign that is not less than 2 square feet in size with a word legend identifying the facility as a licensed child care facility and that is posted on the property of the child care facility in a conspicuous place where the sign is reasonably visible to the public.

(d) Except as authorized by this chapter, chapter 468, and chapter 499, it is unlawful for any person to sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising a public or private college, university, or other postsecondary educational institution. Any person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s.

775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(e) Except as authorized by this chapter, chapter 468, and chapter 499, it is unlawful for any person to sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance not authorized by law in, on, or within 1,000 feet of a physical place for worship at which a church or religious organization regularly conducts religious services or within 1,000 feet of a convenience business as defined in s. 812.171. Any person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(f) Except as authorized by this chapter, chapter 468, and chapter 499, it is unlawful for any person to sell, manufacture,

or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising a public housing facility at any time. For purposes of this section, the term "real property comprising a public housing facility" means real property, as defined in s. 421.03(12), of a public corporation created as a housing authority pursuant to part I of chapter 421. Any person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(g) Except as authorized by this chapter, chapter 468, and chapter 499, it is unlawful for any person to manufacture methamphetamine or phencyclidine, or possess any listed chemical as defined in s. 893.033 in violation of s. 893.149 and with intent to manufacture methamphetamine or phencyclidine. If any person violates this paragraph and:

1. The commission or attempted commission of the crime occurs in a structure or conveyance where any child under 16

years of age is present, the person commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. In addition, the defendant must be sentenced to a minimum term of imprisonment of 5 calendar years.

2. The commission of the crime causes any child under 16 years of age to suffer great bodily harm, the person commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. In addition, the defendant must be sentenced to a minimum term of imprisonment of 10 calendar years.

(h) Except as authorized by this chapter, chapter 468, and chapter 499, it is unlawful for any person to sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising an assisted living facility, as that term is used in chapter 429. Any person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(2)(a) Except as authorized by this chapter, chapter 468, and chapter 499, it is unlawful for any person to purchase, or possess with intent to purchase, a controlled substance. Any

person who violates this provision with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. A controlled substance named or described in s. 893.03(5) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(b) Except as provided in this chapter, chapter 468, and chapter 499, it is unlawful to purchase in excess of 10 grams of any substance named or described in s. 893.03(1)(a) or (1)(b), or any combination thereof, or any mixture containing any such substance. Any person who violates this paragraph commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(3) Except as provided in this chapter, chapter 468, and chapter 499, any person who delivers, without consideration, not more than 20 grams of cannabis, as defined in this chapter, commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. For the purposes of this paragraph, "cannabis" does not include the resin extracted from the plants of the genus *Cannabis* or any compound manufacture, salt, derivative, mixture, or preparation of such resin.

(4) Except as authorized by this chapter, chapter 468, and

chapter 499, it is unlawful for any person 18 years of age or older to deliver any controlled substance to a person under the age of 18 years, except for an emancipated minor, or to use or hire a person under the age of 18 years as an agent or employee in the sale or delivery of such a substance, or to use such person to assist in avoiding detection or apprehension for a violation of this chapter. Any person who violates this provision with respect to:

(a) A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Imposition of sentence may not be suspended or deferred, nor shall the person so convicted be placed on probation.

(5) It is unlawful for any person to bring into this state any controlled substance unless the possession of such controlled substance is authorized by this chapter or chapter 499 or unless such person is licensed to do so by the appropriate federal agency. Any person who violates this provision with respect to:

(a) A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., commits a felony of the second degree, punishable as provided in

s. 775.082, s. 775.083, or s. 775.084.

(b) A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) A controlled substance named or described in s. 893.03(5) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(6)(a) It is unlawful for any person to be in actual or constructive possession of a controlled substance unless such controlled substance was lawfully obtained from a practitioner or pursuant to a valid prescription or order of a practitioner while acting in the course of his or her professional practice or to be in actual or constructive possession of a controlled substance except as otherwise authorized by this chapter, chapter 468, and chapter 499. Any person who violates this provision commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Except as provided in this chapter, chapter 468, and chapter 499, if the offense is the possession of not more than 20 grams of cannabis, as defined in this chapter, or 3 grams or less of a controlled substance described in s. 893.03(1)(c)46.-50. and 114.-142., the person commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083. For the purposes of this subsection, "cannabis" does not include the resin extracted from the plants of the genus *Cannabis*, or any compound manufacture, salt, derivative, mixture, or preparation of such resin, and a controlled substance described in s.

893.03(1)(c)46.-50. and 114.-142. does not include the substance in a powdered form.

(c) Except as provided in this chapter, chapter 468, and chapter 499, it is unlawful to possess in excess of 10 grams of any substance named or described in s. 893.03(1)(a) or (1)(b), or any combination thereof, or any mixture containing any such substance. Any person who violates this paragraph commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(d) Notwithstanding any provision to the contrary of the laws of this state relating to arrest, a law enforcement officer may arrest without warrant any person who the officer has probable cause to believe is violating the provisions of this chapter and chapter 499 relating to possession of cannabis.

Section 6. Section 893.1351, Florida Statutes, is amended to read:

893.1351 Ownership, lease, rental, or possession for trafficking in or manufacturing a controlled substance.—

(1) Except as provided by this chapter, chapter 468, and chapter 499, a person may not own, lease, or rent any place, structure, or part thereof, trailer, or other conveyance with the knowledge that the place, structure, trailer, or conveyance will be used for the purpose of trafficking in a controlled substance, as provided in s. 893.135; for the sale of a controlled substance, as provided in s. 893.13; or for the manufacture of a controlled substance intended for sale or distribution to another. A person who violates this subsection commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(2) Except as provided by this chapter, chapter 468, and chapter 499, a person may not knowingly be in actual or constructive possession of any place, structure, or part thereof, trailer, or other conveyance with the knowledge that the place, structure, or part thereof, trailer, or conveyance will be used for the purpose of trafficking in a controlled substance, as provided in s. 893.135; for the sale of a controlled substance, as provided in s. 893.13; or for the manufacture of a controlled substance intended for sale or distribution to another. A person who violates this subsection commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(3) Except as provided by this chapter, chapter 468, and chapter 499, a person who is in actual or constructive possession of a place, structure, trailer, or conveyance with the knowledge that the place, structure, trailer, or conveyance is being used to manufacture a controlled substance intended for sale or distribution to another and who knew or should have known that a minor is present or resides in the place, structure, trailer, or conveyance commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(4) Except as provided by this chapter, chapter 468, and chapter 499, for the purposes of this section, proof of the possession of 25 or more cannabis plants constitutes prima facie evidence that the cannabis is intended for sale or distribution.

Section 7. Section 893.145, Florida Statutes, is amended to read:

893.145 "Drug paraphernalia" defined.—Except as provided in

this chapter, chapter 468, and chapter 499, the term "drug paraphernalia" means all equipment, products, and materials of any kind which are used, intended for use, or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, transporting, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of this chapter or s. 877.111. Drug paraphernalia is deemed to be contraband which shall be subject to civil forfeiture. The term includes, but is not limited to:

(1) Kits used, intended for use, or designed for use in the planting, propagating, cultivating, growing, or harvesting of any species of plant which is a controlled substance or from which a controlled substance can be derived.

(2) Kits used, intended for use, or designed for use in manufacturing, compounding, converting, producing, processing, or preparing controlled substances.

(3) Isomerization devices used, intended for use, or designed for use in increasing the potency of any species of plant which is a controlled substance.

(4) Testing equipment used, intended for use, or designed for use in identifying, or in analyzing the strength, effectiveness, or purity of, controlled substances.

(5) Scales and balances used, intended for use, or designed for use in weighing or measuring controlled substances.

(6) Diluents and adulterants, such as quinine hydrochloride, mannitol, mannite, dextrose, and lactose, used,

intended for use, or designed for use in cutting controlled substances.

(7) Separation gins and sifters used, intended for use, or designed for use in removing twigs and seeds from, or in otherwise cleaning or refining, cannabis.

(8) Blenders, bowls, containers, spoons, and mixing devices used, intended for use, or designed for use in compounding controlled substances.

(9) Capsules, balloons, envelopes, and other containers used, intended for use, or designed for use in packaging small quantities of controlled substances.

(10) Containers and other objects used, intended for use, or designed for use in storing, concealing, or transporting controlled substances.

(11) Hypodermic syringes, needles, and other objects used, intended for use, or designed for use in parenterally injecting controlled substances into the human body.

(12) Objects used, intended for use, or designed for use in ingesting, inhaling, or otherwise introducing cannabis, cocaine, hashish, hashish oil, or nitrous oxide into the human body, such as:

(a) Metal, wooden, acrylic, glass, stone, plastic, or ceramic pipes, with or without screens, permanent screens, hashish heads, or punctured metal bowls.

(b) Water pipes.

(c) Carburetion tubes and devices.

(d) Smoking and carburetion masks.

(e) Roach clips: meaning objects used to hold burning material, such as a cannabis cigarette, that has become too

small or too short to be held in the hand.

(f) Miniature cocaine spoons, and cocaine vials.

(g) Chamber pipes.

(h) Carburetor pipes.

(i) Electric pipes.

(j) Air-driven pipes.

(k) Chillums.

(l) Bongs.

(m) Ice pipes or chillers.

(n) A cartridge or canister, which means a small metal device used to contain nitrous oxide.

(o) A charger, sometimes referred to as a "cracker," which means a small metal or plastic device that contains an interior pin that may be used to expel nitrous oxide from a cartridge or container.

(p) A charging bottle, which means a device that may be used to expel nitrous oxide from a cartridge or canister.

(q) A whip-it, which means a device that may be used to expel nitrous oxide.

(r) A tank.

(s) A balloon.

(t) A hose or tube.

(u) A 2-liter-type soda bottle.

(v) Duct tape.

Section 8. Present subsection (3) of section 921.0022, Florida Statutes, is redesignated as subsection (4), a new subsection (3) is added to that section, and paragraphs (a), (b), (c), (e), (g), (h), and (i) of present subsection (3) of that section are amended, to read:

921.0022 Criminal Punishment Code; offense severity ranking chart.—

(3) For the purpose of this section, the term "cannabis" does not include any form of cannabis which is cultivated, manufactured, possessed, and distributed in the form of medical cannabis in compliance with chapter 499.

(4)~~(3)~~ OFFENSE SEVERITY RANKING CHART

(a) LEVEL 1

Florida Statute	Felony Degree	Description
24.118(3)(a)	3rd	Counterfeit or altered state lottery ticket.
212.054(2)(b)	3rd	Discretionary sales surtax; limitations, administration, and collection.
212.15(2)(b)	3rd	Failure to remit sales taxes, amount greater than $300 but less than $20,000.
316.1935(1)	3rd	Fleeing or attempting to elude law enforcement officer.
319.30(5)	3rd	Sell, exchange, give away certificate of title or identification number plate.
319.35(1)(a)	3rd	Tamper, adjust, change, etc., an odometer.

320.26(1)(a)	3rd	Counterfeit, manufacture, or sell registration license plates or validation stickers.
322.212 (1)(a)-(c)	3rd	Possession of forged, stolen, counterfeit, or unlawfully issued driver's license; possession of simulated identification.
322.212(4)	3rd	Supply or aid in supplying unauthorized driver's license or identification card.
322.212(5)(a)	3rd	False application for driver's license or identification card.
414.39(2)	3rd	Unauthorized use, possession, forgery, or alteration of food assistance program, Medicaid ID, value greater than $200.
414.39(3)(a)	3rd	Fraudulent misappropriation of public assistance funds by employee/official, value more than $200.
443.071(1)	3rd	False statement or representation to obtain or increase reemployment assistance benefits.
509.151(1)	3rd	Defraud an innkeeper, food or lodging

		value greater than $300.
517.302(1)	3rd	Violation of the Florida Securities and Investor Protection Act.
562.27(1)	3rd	Possess still or still apparatus.
713.69	3rd	Tenant removes property upon which lien has accrued, value more than $50.
812.014(3)(c)	3rd	Petit theft (3rd conviction); theft of any property not specified in subsection (2).
812.081(2)	3rd	Unlawfully makes or causes to be made a reproduction of a trade secret.
815.04(4)(a)	3rd	Offense against intellectual property (i.e., computer programs, data).
817.52(2)	3rd	Hiring with intent to defraud, motor vehicle services.
817.569(2)	3rd	Use of public record or public records information to facilitate commission of a felony.
826.01	3rd	Bigamy.

828.122(3)	3rd	Fighting or baiting animals.
831.04(1)	3rd	Any erasure, alteration, etc., of any replacement deed, map, plat, or other document listed in s. 92.28.
831.31(1)(a)	3rd	Sell, deliver, or possess counterfeit controlled substances, all but s. 893.03(5) drugs.
832.041(1)	3rd	Stopping payment with intent to defraud $150 or more.
832.05(2)(b) & (4)(c)	3rd	Knowing, making, issuing worthless checks $150 or more or obtaining property in return for worthless check $150 or more.
838.15(2)	3rd	Commercial bribe receiving.
838.16	3rd	Commercial bribery.
843.18	3rd	Fleeing by boat to elude a law enforcement officer.
847.011(1)(a)	3rd	Sell, distribute, etc., obscene, lewd, etc., material (2nd conviction).
849.01	3rd	Keeping gambling house.

849.09(1)(a)-(d)	3rd	Lottery; set up, promote, etc., or assist therein, conduct or advertise drawing for prizes, or dispose of property or money by means of lottery.
849.23	3rd	Gambling-related machines; "common offender" as to property rights.
849.25(2)	3rd	Engaging in bookmaking.
860.08	3rd	Interfere with a railroad signal.
860.13(1)(a)	3rd	Operate aircraft while under the influence.
893.13(2)(a)2.	3rd	Purchase of cannabis, except as authorized by this chapter, chapter 468, and chapter 499.
893.13(6)(a)	3rd	Possession of cannabis (more than 20 grams), except as authorized by this chapter, chapter 468, and chapter 499.
934.03(1)(a)	3rd	Intercepts, or procures any other person to intercept, any wire or oral communication.

(b) LEVEL 2

Florida Statute	Felony Degree	Description
379.2431 (1)(e)3.	3rd	Possession of 11 or fewer marine turtle eggs in violation of the Marine Turtle Protection Act.
379.2431 (1)(e)4.	3rd	Possession of more than 11 marine turtle eggs in violation of the Marine Turtle Protection Act.
403.413(5)(c)	3rd	Dumps waste litter exceeding 500 lbs. in weight or 100 cubic feet in volume or any quantity for commercial purposes, or hazardous waste.
517.07(2)	3rd	Failure to furnish a prospectus meeting requirements.
590.28(1)	3rd	Intentional burning of lands.
784.05(3)	3rd	Storing or leaving a loaded firearm within reach of minor who uses it to inflict injury or death.
787.04(1)	3rd	In violation of court order, take, entice, etc., minor beyond state limits.
806.13(1)(b)3.	3rd	Criminal mischief; damage $1,000 or more

		to public communication or any other public service.
810.061(2)	3rd	Impairing or impeding telephone or power to a dwelling; facilitating or furthering burglary.
810.09(2)(e)	3rd	Trespassing on posted commercial horticulture property.
812.014(2)(c)1.	3rd	Grand theft, 3rd degree; $300 or more but less than $5,000.
812.014(2)(d)	3rd	Grand theft, 3rd degree; $100 or more but less than $300, taken from unenclosed curtilage of dwelling.
812.015(7)	3rd	Possession, use, or attempted use of an antishoplifting or inventory control device countermeasure.
817.234(1)(a)2.	3rd	False statement in support of insurance claim.
817.481(3)(a)	3rd	Obtain credit or purchase with false, expired, counterfeit, etc., credit card, value over $300.
817.52(3)	3rd	Failure to redeliver hired vehicle.

817.54	3rd	With intent to defraud, obtain mortgage note, etc., by false representation.
817.60(5)	3rd	Dealing in credit cards of another.
817.60(6)(a)	3rd	Forgery; purchase goods, services with false card.
817.61	3rd	Fraudulent use of credit cards over $100 or more within 6 months.
826.04	3rd	Knowingly marries or has sexual intercourse with person to whom related.
831.01	3rd	Forgery.
831.02	3rd	Uttering forged instrument; utters or publishes alteration with intent to defraud.
831.07	3rd	Forging bank bills, checks, drafts, or promissory notes.
831.08	3rd	Possessing 10 or more forged notes, bills, checks, or drafts.
831.09	3rd	Uttering forged notes, bills, checks, drafts, or promissory notes.

831.11	3rd	Bringing into the state forged bank bills, checks, drafts, or notes.
832.05(3)(a)	3rd	Cashing or depositing item with intent to defraud.
843.08	3rd	Falsely impersonating an officer.
893.13(2)(a)2.	3rd	Purchase of any s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs other than cannabis.
893.147(2)	3rd	Manufacture or delivery of drug paraphernalia, except as authorized by this chapter, chapter 468, and chapter 499.

(c) LEVEL 3

Florida Statute	Felony Degree	Description
119.10(2)(b)	3rd	Unlawful use of confidential information from police reports.
316.066 (3)(b)-(d)	3rd	Unlawfully obtaining or using confidential crash reports.

316.193(2)(b)	3rd	Felony DUI, 3rd conviction.
316.1935(2)	3rd	Fleeing or attempting to elude law enforcement officer in patrol vehicle with siren and lights activated.
319.30(4)	3rd	Possession by junkyard of motor vehicle with identification number plate removed.
319.33(1)(a)	3rd	Alter or forge any certificate of title to a motor vehicle or mobile home.
319.33(1)(c)	3rd	Procure or pass title on stolen vehicle.
319.33(4)	3rd	With intent to defraud, possess, sell, etc., a blank, forged, or unlawfully obtained title or registration.
327.35(2)(b)	3rd	Felony BUI.
328.05(2)	3rd	Possess, sell, or counterfeit fictitious, stolen, or fraudulent titles or bills of sale of vessels.
328.07(4)	3rd	Manufacture, exchange, or possess vessel with counterfeit or wrong ID number.

376.302(5)	3rd	Fraud related to reimbursement for cleanup expenses under the Inland Protection Trust Fund.
379.2431 (1)(e)5.	3rd	Taking, disturbing, mutilating, destroying, causing to be destroyed, transferring, selling, offering to sell, molesting, or harassing marine turtles, marine turtle eggs, or marine turtle nests in violation of the Marine Turtle Protection Act.
379.2431 (1)(e)6.	3rd	Soliciting to commit or conspiring to commit a violation of the Marine Turtle Protection Act.
400.9935(4)	3rd	Operating a clinic without a license or filing false license application or other required information.
440.1051(3)	3rd	False report of workers' compensation fraud or retaliation for making such a report.
501.001(2)(b)	2nd	Tampers with a consumer product or the container using materially false/misleading information.
624.401(4)(a)	3rd	Transacting insurance without a

		certificate of authority.
624.401(4)(b)1.	3rd	Transacting insurance without a certificate of authority; premium collected less than $20,000.
626.902(1)(a) & (b)	3rd	Representing an unauthorized insurer.
697.08	3rd	Equity skimming.
790.15(3)	3rd	Person directs another to discharge firearm from a vehicle.
796.05(1)	3rd	Live on earnings of a prostitute.
806.10(1)	3rd	Maliciously injure, destroy, or interfere with vehicles or equipment used in firefighting.
806.10(2)	3rd	Interferes with or assaults firefighter in performance of duty.
810.09(2)(c)	3rd	Trespass on property other than structure or conveyance armed with firearm or dangerous weapon.
812.014(2)(c)2.	3rd	Grand theft; $5,000 or more but less than $10,000.

812.0145(2)(c)	3rd	Theft from person 65 years of age or older; $300 or more but less than $10,000.
815.04(4)(b)	2nd	Computer offense devised to defraud or obtain property.
817.034(4)(a)3.	3rd	Engages in scheme to defraud (Florida Communications Fraud Act), property valued at less than $20,000.
817.233	3rd	Burning to defraud insurer.
817.234 (8)(b)-(c)	3rd	Unlawful solicitation of persons involved in motor vehicle accidents.
817.234(11)(a)	3rd	Insurance fraud; property value less than $20,000.
817.236	3rd	Filing a false motor vehicle insurance application.
817.2361	3rd	Creating, marketing, or presenting a false or fraudulent motor vehicle insurance card.
817.413(2)	3rd	Sale of used goods as new.

817.505(4)	3rd	Patient brokering.
828.12(2)	3rd	Tortures any animal with intent to inflict intense pain, serious physical injury, or death.
831.28(2)(a)	3rd	Counterfeiting a payment instrument with intent to defraud or possessing a counterfeit payment instrument.
831.29	2nd	Possession of instruments for counterfeiting drivers' licenses or identification cards.
838.021(3)(b)	3rd	Threatens unlawful harm to public servant.
843.19	3rd	Injure, disable, or kill police dog or horse.
860.15(3)	3rd	Overcharging for repairs and parts.
870.01(2)	3rd	Riot; inciting or encouraging.
893.13(1)(a)2.	3rd	Sell, manufacture, or deliver cannabis, except as authorized by this chapter, chapter 468, and chapter 499 (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7.,

		(2)(c)8., (2)(c)9., (3), or (4) drugs).
893.13(1)(d)2.	2nd	Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs, except as authorized by this chapter, chapter 468, and chapter 499, within 1,000 feet of university.
893.13(1)(f)2.	2nd	Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs within 1,000 feet of public housing facility.
893.13(6)(a)	3rd	Possession of any controlled substance other than felony possession of cannabis and possession of cannabis as authorized by this chapter and chapter 499.
893.13(7)(a)8.	3rd	Withhold information from practitioner regarding previous receipt of or prescription for a controlled substance.
893.13(7)(a)9.	3rd	Obtain or attempt to obtain controlled substance by fraud, forgery, misrepresentation, etc.

893.13(7)(a)10.	3rd	Affix false or forged label to package of controlled substance.
893.13(7)(a)11.	3rd	Furnish false or fraudulent material information on any document or record required by chapter 893.
893.13(8)(a)1.	3rd	Knowingly assist a patient, other person, or owner of an animal in obtaining a controlled substance through deceptive, untrue, or fraudulent representations in or related to the practitioner’s practice.
893.13(8)(a)2.	3rd	Employ a trick or scheme in the practitioner’s practice to assist a patient, other person, or owner of an animal in obtaining a controlled substance.
893.13(8)(a)3.	3rd	Knowingly write a prescription for a controlled substance for a fictitious person.
893.13(8)(a)4.	3rd	Write a prescription for a controlled substance for a patient, other person, or an animal if the sole purpose of writing the prescription is a monetary

		benefit for the practitioner.
918.13(1)(a)	3rd	Alter, destroy, or conceal investigation evidence.
944.47 (1)(a)1.-2.	3rd	Introduce contraband to correctional facility.
944.47(1)(c)	2nd	Possess contraband while upon the grounds of a correctional institution.
985.721	3rd	Escapes from a juvenile facility (secure detention or residential commitment facility).

(e) LEVEL 5

Florida Statute	Felony Degree	Description
316.027(1)(a)	3rd	Accidents involving personal injuries, failure to stop; leaving scene.
316.1935(4)(a)	2nd	Aggravated fleeing or eluding.
322.34(6)	3rd	Careless operation of motor vehicle with suspended license, resulting in death or serious bodily injury.

327.30(5)	3rd	Vessel accidents involving personal injury; leaving scene.
379.367(4)	3rd	Willful molestation of a commercial harvester's spiny lobster trap, line, or buoy.
379.3671(2)(c)3.	3rd	Willful molestation, possession, or removal of a commercial harvester's trap contents or trap gear by another harvester.
381.0041(11)(b)	3rd	Donate blood, plasma, or organs knowing HIV positive.
440.10(1)(g)	2nd	Failure to obtain workers' compensation coverage.
440.105(5)	2nd	Unlawful solicitation for the purpose of making workers' compensation claims.
440.381(2)	2nd	Submission of false, misleading, or incomplete information with the purpose of avoiding or reducing workers' compensation premiums.
624.401(4)(b)2.	2nd	Transacting insurance without a certificate or authority; premium collected $20,000 or more but less than

		$100,000.
626.902(1)(c)	2nd	Representing an unauthorized insurer; repeat offender.
790.01(2)	3rd	Carrying a concealed firearm.
790.162	2nd	Threat to throw or discharge destructive device.
790.163(1)	2nd	False report of deadly explosive or weapon of mass destruction.
790.221(1)	2nd	Possession of short-barreled shotgun or machine gun.
790.23	2nd	Felons in possession of firearms, ammunition, or electronic weapons or devices.
800.04(6)(c)	3rd	Lewd or lascivious conduct; offender less than 18 years.
800.04(7)(b)	2nd	Lewd or lascivious exhibition; offender 18 years or older.
806.111(1)	3rd	Possess, manufacture, or dispense fire bomb with intent to damage any structure or property.

812.0145(2)(b)	2nd	Theft from person 65 years of age or older; $10,000 or more but less than $50,000.
812.015(8)	3rd	Retail theft; property stolen is valued at $300 or more and one or more specified acts.
812.019(1)	2nd	Stolen property; dealing in or trafficking in.
812.131(2)(b)	3rd	Robbery by sudden snatching.
812.16(2)	3rd	Owning, operating, or conducting a chop shop.
817.034(4)(a)2.	2nd	Communications fraud, value $20,000 to $50,000.
817.234(11)(b)	2nd	Insurance fraud; property value $20,000 or more but less than $100,000.
817.2341(1), (2)(a) & (3)(a)	3rd	Filing false financial statements, making false entries of material fact or false statements regarding property values relating to the solvency of an insuring entity.

817.568(2)(b)	2nd	Fraudulent use of personal identification information; value of benefit, services received, payment avoided, or amount of injury or fraud, $5,000 or more or use of personal identification information of 10 or more individuals.
817.625(2)(b)	2nd	Second or subsequent fraudulent use of scanning device or reencoder.
825.1025(4)	3rd	Lewd or lascivious exhibition in the presence of an elderly person or disabled adult.
827.071(4)	2nd	Possess with intent to promote any photographic material, motion picture, etc., which includes sexual conduct by a child.
827.071(5)	3rd	Possess, control, or intentionally view any photographic material, motion picture, etc., which includes sexual conduct by a child.
839.13(2)(b)	2nd	Falsifying records of an individual in the care and custody of a state agency involving great bodily harm or death.

843.01	3rd	Resist officer with violence to person; resist arrest with violence.
847.0135(5)(b)	2nd	Lewd or lascivious exhibition using computer; offender 18 years or older.
847.0137 (2) & (3)	3rd	Transmission of pornography by electronic device or equipment.
847.0138 (2) & (3)	3rd	Transmission of material harmful to minors to a minor by electronic device or equipment.
874.05(2)	2nd	Encouraging or recruiting another to join a criminal gang; second or subsequent offense.
893.13(1)(a)1.	2nd	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs).
893.13(1)(c)2.	2nd	Sell, manufacture, or deliver cannabis, except as authorized by this chapter, chapter 468, and chapter 499, (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs) within 1,000 feet of a child care

		facility, school, or state, county, or municipal park or publicly owned recreational facility or community center.
893.13(1)(d)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs) within 1,000 feet of university.
893.13(1)(e)2.	2nd	Sell, manufacture, or deliver cannabis, except as authorized by this chapter, chapter 468, and chapter 499, or other drug prohibited under s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) within 1,000 feet of property used for religious services or a specified business site.
893.13(1)(f)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), or (2)(a), (2)(b), or (2)(c)4. drugs) within 1,000 feet of public housing facility.
893.13(4)(b)	2nd	Deliver to minor cannabis, except as authorized by this chapter, chapter 468, and chapter 499 (or other s.

		893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., (2)(c)5., (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (3), or (4) drugs).
893.1351(1)	3rd	Ownership, lease, or rental for trafficking in or manufacturing of controlled substance.

(g) LEVEL 7

Florida Statute	Felony Degree	Description
316.027(1)(b)	1st	Accident involving death, failure to stop; leaving scene.
316.193(3)(c)2.	3rd	DUI resulting in serious bodily injury.
316.1935(3)(b)	1st	Causing serious bodily injury or death to another person; driving at high speed or with wanton disregard for safety while fleeing or attempting to elude law enforcement officer who is in a patrol vehicle with siren and lights activated.
327.35(3)(c)2.	3rd	Vessel BUI resulting in serious bodily injury.

402.319(2)	2nd	Misrepresentation and negligence or intentional act resulting in great bodily harm, permanent disfiguration, permanent disability, or death.
409.920 (2)(b)1.a.	3rd	Medicaid provider fraud; $10,000 or less.
409.920 (2)(b)1.b.	2nd	Medicaid provider fraud; more than $10,000, but less than $50,000.
456.065(2)	3rd	Practicing a health care profession without a license.
456.065(2)	2nd	Practicing a health care profession without a license which results in serious bodily injury.
458.327(1)	3rd	Practicing medicine without a license.
459.013(1)	3rd	Practicing osteopathic medicine without a license.
460.411(1)	3rd	Practicing chiropractic medicine without a license.
461.012(1)	3rd	Practicing podiatric medicine without a license.

462.17	3rd	Practicing naturopathy without a license.
463.015(1)	3rd	Practicing optometry without a license.
464.016(1)	3rd	Practicing nursing without a license.
465.015(2)	3rd	Practicing pharmacy without a license.
466.026(1)	3rd	Practicing dentistry or dental hygiene without a license.
467.201	3rd	Practicing midwifery without a license.
468.366	3rd	Delivering respiratory care services without a license.
483.828(1)	3rd	Practicing as clinical laboratory personnel without a license.
483.901(9)	3rd	Practicing medical physics without a license.
484.013(1)(c)	3rd	Preparing or dispensing optical devices without a prescription.
484.053	3rd	Dispensing hearing aids without a license.

494.0018(2)	1st	Conviction of any violation of ss. 494.001-494.0077 in which the total money and property unlawfully obtained exceeded $50,000 and there were five or more victims.
560.123(8)(b)1.	3rd	Failure to report currency or payment instruments exceeding $300 but less than $20,000 by a money services business.
560.125(5)(a)	3rd	Money services business by unauthorized person, currency or payment instruments exceeding $300 but less than $20,000.
655.50(10)(b)1.	3rd	Failure to report financial transactions exceeding $300 but less than $20,000 by financial institution.
775.21(10)(a)	3rd	Sexual predator; failure to register; failure to renew driver's license or identification card; other registration violations.
775.21(10)(b)	3rd	Sexual predator working where children regularly congregate.
775.21(10)(g)	3rd	Failure to report or providing false information about a sexual predator;

		harbor or conceal a sexual predator.
782.051(3)	2nd	Attempted felony murder of a person by a person other than the perpetrator or the perpetrator of an attempted felony.
782.07(1)	2nd	Killing of a human being by the act, procurement, or culpable negligence of another (manslaughter).
782.071	2nd	Killing of a human being or viable fetus by the operation of a motor vehicle in a reckless manner (vehicular homicide).
782.072	2nd	Killing of a human being by the operation of a vessel in a reckless manner (vessel homicide).
784.045(1)(a)1.	2nd	Aggravated battery; intentionally causing great bodily harm or disfigurement.
784.045(1)(a)2.	2nd	Aggravated battery; using deadly weapon.
784.045(1)(b)	2nd	Aggravated battery; perpetrator aware victim pregnant.

784.048(4)	3rd	Aggravated stalking; violation of injunction or court order.
784.048(7)	3rd	Aggravated stalking; violation of court order.
784.07(2)(d)	1st	Aggravated battery on law enforcement officer.
784.074(1)(a)	1st	Aggravated battery on sexually violent predators facility staff.
784.08(2)(a)	1st	Aggravated battery on a person 65 years of age or older.
784.081(1)	1st	Aggravated battery on specified official or employee.
784.082(1)	1st	Aggravated battery by detained person on visitor or other detainee.
784.083(1)	1st	Aggravated battery on code inspector.
787.06(3)(a)	1st	Human trafficking using coercion for labor and services.
787.06(3)(e)	1st	Human trafficking using coercion for labor and services by the transfer or transport of any individual from

		outside Florida to within the state.
790.07(4)	1st	Specified weapons violation subsequent to previous conviction of s. 790.07(1) or (2).
790.16(1)	1st	Discharge of a machine gun under specified circumstances.
790.165(2)	2nd	Manufacture, sell, possess, or deliver hoax bomb.
790.165(3)	2nd	Possessing, displaying, or threatening to use any hoax bomb while committing or attempting to commit a felony.
790.166(3)	2nd	Possessing, selling, using, or attempting to use a hoax weapon of mass destruction.
790.166(4)	2nd	Possessing, displaying, or threatening to use a hoax weapon of mass destruction while committing or attempting to commit a felony.
790.23	1st,PBL	Possession of a firearm by a person who qualifies for the penalty enhancements provided for in s. 874.04.

794.08(4)	3rd	Female genital mutilation; consent by a parent, guardian, or a person in custodial authority to a victim younger than 18 years of age.
796.03	2nd	Procuring any person under 16 years for prostitution.
800.04(5)(c)1.	2nd	Lewd or lascivious molestation; victim less than 12 years of age; offender less than 18 years.
800.04(5)(c)2.	2nd	Lewd or lascivious molestation; victim 12 years of age or older but less than 16 years; offender 18 years or older.
806.01(2)	2nd	Maliciously damage structure by fire or explosive.
810.02(3)(a)	2nd	Burglary of occupied dwelling; unarmed; no assault or battery.
810.02(3)(b)	2nd	Burglary of unoccupied dwelling; unarmed; no assault or battery.
810.02(3)(d)	2nd	Burglary of occupied conveyance; unarmed; no assault or battery.
810.02(3)(e)	2nd	Burglary of authorized emergency

			vehicle.
2613			
	812.014(2)(a)1.	1st	Property stolen, valued at $100,000 or more or a semitrailer deployed by a law enforcement officer; property stolen while causing other property damage; 1st degree grand theft.
2614			
	812.014(2)(b)2.	2nd	Property stolen, cargo valued at less than $50,000, grand theft in 2nd degree.
2615			
	812.014(2)(b)3.	2nd	Property stolen, emergency medical equipment; 2nd degree grand theft.
2616			
	812.014(2)(b)4.	2nd	Property stolen, law enforcement equipment from authorized emergency vehicle.
2617			
	812.0145(2)(a)	1st	Theft from person 65 years of age or older; $50,000 or more.
2618			
	812.019(2)	1st	Stolen property; initiates, organizes, plans, etc., the theft of property and traffics in stolen property.
2619			
	812.131(2)(a)	2nd	Robbery by sudden snatching.
2620			
	812.133(2)(b)	1st	Carjacking; no firearm, deadly weapon,

		or other weapon.
817.234(8)(a)	2nd	Solicitation of motor vehicle accident victims with intent to defraud.
817.234(9)	2nd	Organizing, planning, or participating in an intentional motor vehicle collision.
817.234(11)(c)	1st	Insurance fraud; property value $100,000 or more.
817.2341 (2)(b) & (3)(b)	1st	Making false entries of material fact or false statements regarding property values relating to the solvency of an insuring entity which are a significant cause of the insolvency of that entity.
825.102(3)(b)	2nd	Neglecting an elderly person or disabled adult causing great bodily harm, disability, or disfigurement.
825.103(2)(b)	2nd	Exploiting an elderly person or disabled adult and property is valued at $20,000 or more, but less than $100,000.
827.03(2)(b)	2nd	Neglect of a child causing great bodily harm, disability, or disfigurement.

827.04(3)	3rd	Impregnation of a child under 16 years of age by person 21 years of age or older.
837.05(2)	3rd	Giving false information about alleged capital felony to a law enforcement officer.
838.015	2nd	Bribery.
838.016	2nd	Unlawful compensation or reward for official behavior.
838.021(3)(a)	2nd	Unlawful harm to a public servant.
838.22	2nd	Bid tampering.
847.0135(3)	3rd	Solicitation of a child, via a computer service, to commit an unlawful sex act.
847.0135(4)	2nd	Traveling to meet a minor to commit an unlawful sex act.
872.06	2nd	Abuse of a dead human body.
874.10	1st,PBL	Knowingly initiates, organizes, plans, finances, directs, manages, or supervises criminal gang-related

		activity.
893.13(1)(c)1.	1st	Sell, manufacture, or deliver cocaine (or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4.) within 1,000 feet of a child care facility, school, or state, county, or municipal park or publicly owned recreational facility or community center.
893.13(1)(e)1.	1st	Sell, manufacture, or deliver cocaine or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., within 1,000 feet of property used for religious services or a specified business site.
893.13(4)(a)	1st	Deliver to minor cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs).
893.135(1)(a)1.	1st	Trafficking in cannabis, except as authorized by this chapter, chapter 468, and chapter 499, more than 25 lbs., less than 2,000 lbs.
893.135 (1)(b)1.a.	1st	Trafficking in cocaine, more than 28 grams, less than 200 grams.

893.135(1)(c)1.a.	1st	Trafficking in illegal drugs, more than 4 grams, less than 14 grams<u>, excluding cannabis and tetrahydrocannabinols, when excepted by this chapter or chapter 499</u>.
893.135(1)(d)1.	1st	Trafficking in phencyclidine, more than 28 grams, less than 200 grams.
893.135(1)(e)1.	1st	Trafficking in methaqualone, more than 200 grams, less than 5 kilograms.
893.135(1)(f)1.	1st	Trafficking in amphetamine, more than 14 grams, less than 28 grams.
893.135 (1)(g)1.a.	1st	Trafficking in flunitrazepam, 4 grams or more, less than 14 grams.
893.135 (1)(h)1.a.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 1 kilogram or more, less than 5 kilograms.
893.135 (1)(j)1.a.	1st	Trafficking in 1,4-Butanediol, 1 kilogram or more, less than 5 kilograms.
893.135 (1)(k)2.a.	1st	Trafficking in Phenethylamines, 10 grams or more, less than 200 grams.

893.1351(2)	2nd	Possession of place for trafficking in or manufacturing of controlled substance.
896.101(5)(a)	3rd	Money laundering, financial transactions exceeding $300 but less than $20,000.
896.104(4)(a)1.	3rd	Structuring transactions to evade reporting or registration requirements, financial transactions exceeding $300 but less than $20,000.
943.0435(4)(c)	2nd	Sexual offender vacating permanent residence; failure to comply with reporting requirements.
943.0435(8)	2nd	Sexual offender; remains in state after indicating intent to leave; failure to comply with reporting requirements.
943.0435(9)(a)	3rd	Sexual offender; failure to comply with reporting requirements.
943.0435(13)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.

943.0435(14)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
944.607(9)	3rd	Sexual offender; failure to comply with reporting requirements.
944.607(10)(a)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
944.607(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
944.607(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
985.4815(10)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
985.4815(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
985.4815(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.

(h) LEVEL 8

Florida Statute	Felony Degree	Description
316.193 (3)(c)3.a.	2nd	DUI manslaughter.
316.1935(4)(b)	1st	Aggravated fleeing or attempted eluding with serious bodily injury or death.
327.35(3)(c)3.	2nd	Vessel BUI manslaughter.
499.0051(7)	1st	Knowing trafficking in contraband prescription drugs.
499.0051(8)	1st	Knowing forgery of prescription labels or prescription drug labels.
560.123(8)(b)2.	2nd	Failure to report currency or payment instruments totaling or exceeding $20,000, but less than $100,000 by money transmitter.
560.125(5)(b)	2nd	Money transmitter business by unauthorized person, currency or payment instruments totaling or exceeding $20,000, but less than $100,000.

655.50(10)(b)2.	2nd	Failure to report financial transactions totaling or exceeding $20,000, but less than $100,000 by financial institutions.
777.03(2)(a)	1st	Accessory after the fact, capital felony.
782.04(4)	2nd	Killing of human without design when engaged in act or attempt of any felony other than arson, sexual battery, robbery, burglary, kidnapping, aggravated fleeing or eluding with serious bodily injury or death, aircraft piracy, or unlawfully discharging bomb.
782.051(2)	1st	Attempted felony murder while perpetrating or attempting to perpetrate a felony not enumerated in s. 782.04(3).
782.071(1)(b)	1st	Committing vehicular homicide and failing to render aid or give information.
782.072(2)	1st	Committing vessel homicide and failing to render aid or give information.

787.06(3)(b)	1st	Human trafficking using coercion for commercial sexual activity.
787.06(3)(c)	1st	Human trafficking using coercion for labor and services of an unauthorized alien.
787.06(3)(f)	1st	Human trafficking using coercion for commercial sexual activity by the transfer or transport of any individual from outside Florida to within the state.
790.161(3)	1st	Discharging a destructive device which results in bodily harm or property damage.
794.011(5)	2nd	Sexual battery, victim 12 years or over, offender does not use physical force likely to cause serious injury.
794.08(3)	2nd	Female genital mutilation, removal of a victim younger than 18 years of age from this state.
800.04(4)	2nd	Lewd or lascivious battery.
806.01(1)	1st	Maliciously damage dwelling or

		structure by fire or explosive, believing person in structure.
810.02(2)(a)	1st,PBL	Burglary with assault or battery.
810.02(2)(b)	1st,PBL	Burglary; armed with explosives or dangerous weapon.
810.02(2)(c)	1st	Burglary of a dwelling or structure causing structural damage or $1,000 or more property damage.
812.014(2)(a)2.	1st	Property stolen; cargo valued at $50,000 or more, grand theft in 1st degree.
812.13(2)(b)	1st	Robbery with a weapon.
812.135(2)(c)	1st	Home-invasion robbery, no firearm, deadly weapon, or other weapon.
817.568(6)	2nd	Fraudulent use of personal identification information of an individual under the age of 18.
825.102(2)	1st	Aggravated abuse of an elderly person or disabled adult.
825.1025(2)	2nd	Lewd or lascivious battery upon an

		elderly person or disabled adult.
825.103(2)(a)	1st	Exploiting an elderly person or disabled adult and property is valued at $100,000 or more.
837.02(2)	2nd	Perjury in official proceedings relating to prosecution of a capital felony.
837.021(2)	2nd	Making contradictory statements in official proceedings relating to prosecution of a capital felony.
860.121(2)(c)	1st	Shooting at or throwing any object in path of railroad vehicle resulting in great bodily harm.
860.16	1st	Aircraft piracy.
893.13(1)(b)	1st	Sell or deliver in excess of 10 grams of any substance specified in s. 893.03(1)(a) or (b).
893.13(2)(b)	1st	Purchase in excess of 10 grams of any substance specified in s. 893.03(1)(a) or (b).
893.13(6)(c)	1st	Possess in excess of 10 grams of any

		substance specified in s. 893.03(1)(a) or (b).
893.135(1)(a)2.	1st	Trafficking in cannabis, except as authorized by this chapter, chapter 468, and chapter 499, more than 2,000 lbs., less than 10,000 lbs.
893.135 (1)(b)1.b.	1st	Trafficking in cocaine, more than 200 grams, less than 400 grams.
893.135 (1)(c)1.b.	1st	Trafficking in illegal drugs, more than 14 grams, less than 28 grams, excluding cannabis and tetrahydocannabinols, when excepted by this chapter or chapter 499.
893.135 (1)(d)1.b.	1st	Trafficking in phencyclidine, more than 200 grams, less than 400 grams.
893.135 (1)(e)1.b.	1st	Trafficking in methaqualone, more than 5 kilograms, less than 25 kilograms.
893.135 (1)(f)1.b.	1st	Trafficking in amphetamine, more than 28 grams, less than 200 grams.
893.135 (1)(g)1.b.	1st	Trafficking in flunitrazepam, 14 grams or more, less than 28 grams.

893.135 (1)(h)1.b.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 5 kilograms or more, less than 10 kilograms.
893.135 (1)(j)1.b.	1st	Trafficking in 1,4-Butanediol, 5 kilograms or more, less than 10 kilograms.
893.135 (1)(k)2.b.	1st	Trafficking in Phenethylamines, 200 grams or more, less than 400 grams.
893.1351(3)	1st	Possession of a place used to manufacture controlled substance when minor is present or resides there.
895.03(1)	1st	Use or invest proceeds derived from pattern of racketeering activity.
895.03(2)	1st	Acquire or maintain through racketeering activity any interest in or control of any enterprise or real property.
895.03(3)	1st	Conduct or participate in any enterprise through pattern of racketeering activity.
896.101(5)(b)	2nd	Money laundering, financial transactions totaling or exceeding

		$20,000, but less than $100,000.
896.104(4)(a)2.	2nd	Structuring transactions to evade reporting or registration requirements, financial transactions totaling or exceeding $20,000 but less than $100,000.

(i) LEVEL 9

Florida Statute	Felony Degree	Description
316.193 (3)(c)3.b.	1st	DUI manslaughter; failing to render aid or give information.
327.35(3)(c)3.b.	1st	BUI manslaughter; failing to render aid or give information.
409.920 (2)(b)1.c.	1st	Medicaid provider fraud; $50,000 or more.
499.0051(9)	1st	Knowing sale or purchase of contraband prescription drugs resulting in great bodily harm.
560.123(8)(b)3.	1st	Failure to report currency or payment instruments totaling or exceeding $100,000 by money transmitter.

560.125(5)(c)	1st	Money transmitter business by unauthorized person, currency, or payment instruments totaling or exceeding $100,000.
655.50(10)(b)3.	1st	Failure to report financial transactions totaling or exceeding $100,000 by financial institution.
775.0844	1st	Aggravated white collar crime.
782.04(1)	1st	Attempt, conspire, or solicit to commit premeditated murder.
782.04(3)	1st,PBL	Accomplice to murder in connection with arson, sexual battery, robbery, burglary, aggravated fleeing or eluding with serious bodily injury or death, and other specified felonies.
782.051(1)	1st	Attempted felony murder while perpetrating or attempting to perpetrate a felony enumerated in s. 782.04(3).
782.07(2)	1st	Aggravated manslaughter of an elderly person or disabled adult.

787.01(1)(a)1.	1st,PBL	Kidnapping; hold for ransom or reward or as a shield or hostage.
787.01(1)(a)2.	1st,PBL	Kidnapping with intent to commit or facilitate commission of any felony.
787.01(1)(a)4.	1st,PBL	Kidnapping with intent to interfere with performance of any governmental or political function.
787.02(3)(a)	1st	False imprisonment; child under age 13; perpetrator also commits aggravated child abuse, sexual battery, or lewd or lascivious battery, molestation, conduct, or exhibition.
787.06(3)(d)	1st	Human trafficking using coercion for commercial sexual activity of an unauthorized alien.
787.06(3)(g)	1st,PBL	Human trafficking for commercial sexual activity of a child under the age of 18.
787.06(4)	1st	Selling or buying of minors into human trafficking.
790.161	1st	Attempted capital destructive device

		offense.
790.166(2)	1st,PBL	Possessing, selling, using, or attempting to use a weapon of mass destruction.
794.011(2)	1st	Attempted sexual battery; victim less than 12 years of age.
794.011(2)	Life	Sexual battery; offender younger than 18 years and commits sexual battery on a person less than 12 years.
794.011(4)	1st	Sexual battery; victim 12 years or older, certain circumstances.
794.011(8)(b)	1st	Sexual battery; engage in sexual conduct with minor 12 to 18 years by person in familial or custodial authority.
794.08(2)	1st	Female genital mutilation; victim younger than 18 years of age.
796.035	1st	Selling or buying of minors into prostitution.
800.04(5)(b)	Life	Lewd or lascivious molestation; victim less than 12 years; offender 18 years

		or older.
812.13(2)(a)	1st,PBL	Robbery with firearm or other deadly weapon.
812.133(2)(a)	1st,PBL	Carjacking; firearm or other deadly weapon.
812.135(2)(b)	1st	Home-invasion robbery with weapon.
817.568(7)	2nd, PBL	Fraudulent use of personal identification information of an individual under the age of 18 by his or her parent, legal guardian, or person exercising custodial authority.
827.03(2)(a)	1st	Aggravated child abuse.
847.0145(1)	1st	Selling, or otherwise transferring custody or control, of a minor.
847.0145(2)	1st	Purchasing, or otherwise obtaining custody or control, of a minor.
859.01	1st	Poisoning or introducing bacteria, radioactive materials, viruses, or chemical compounds into food, drink, medicine, or water with intent to kill or injure another person.

893.135	1st	Attempted capital trafficking offense.
893.135(1)(a)3.	1st	Trafficking in cannabis, except as authorized by this chapter, chapter 468 and chapter 499, more than 10,000 lbs.
893.135 (1)(b)1.c.	1st	Trafficking in cocaine, more than 400 grams, less than 150 kilograms.
893.135 (1)(c)1.c.	1st	Trafficking in illegal drugs, more than 28 grams, less than 30 kilograms, excluding cannabis and tetrahydocannabinols, when excepted by this chapter, chapter 468, or chapter 499.
893.135 (1)(d)1.c.	1st	Trafficking in phencyclidine, more than 400 grams.
893.135 (1)(e)1.c.	1st	Trafficking in methaqualone, more than 25 kilograms.
893.135 (1)(f)1.c.	1st	Trafficking in amphetamine, more than 200 grams.
893.135 (1)(h)1.c.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 10 kilograms or more.

893.135 (1)(j)1.c.	1st	Trafficking in 1,4-Butanediol, 10 kilograms or more.
893.135 (1)(k)2.c.	1st	Trafficking in Phenethylamines, 400 grams or more.
896.101(5)(c)	1st	Money laundering, financial instruments totaling or exceeding $100,000.
896.104(4)(a)3.	1st	Structuring transactions to evade reporting or registration requirements, financial transactions totaling or exceeding $100,000.

Section 9. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 10. This act shall take effect July 1, 2013.

Tab 8

Florida Department of Health Preliminary Analysis

Florida Department Health Preliminary Analysis

The Florida Department of Health's preliminary analysis of the petition initiative language was prepared by the department at the request of the Legislature's Office of Economic and Demographic Research.

Florida Department of Health
"Use of Marijuana for Certain Medical Conditions"
Constitutional Amendment Analysis

I. PLANNING ASSUMPTIONS

This analysis assumes the proposed Constitutional Amendment entitled "Use of Marijuana for Certain Medical Conditions" will be approved by the Florida voters and will have an effective date of January 1, 2015. These planning assumptions are based on the best information available as of October 11, 2013 and may be amended as additional information becomes available. These assumptions are not a statement of position of the department.

1.0 General Planning Assumptions

1.1. The Constitutional Amendment will appear on the ballot in November 2014.
1.2. The Constitutional Amendment will be approved by voters and be effective January 1, 2015.
1.3. The Florida Legislature will pass laws necessary to support this Constitutional Amendment and the Governor will enact these laws.
1.4. The program will be supported by fee revenue beginning October 1, 2015 and beyond.
1.5. Definitions included in the Constitutional Amendment will not be altered, but may be clarified in Florida Statute and/or Florida Administrative Code.
1.6. Applicable definitions not included in the Constitutional Amendment will be identified in Florida Statute and/or Florida Administrative Code.
1.7. The Florida Medical Marijuana Program has four components: (1) Physician issuance of certification, (2) Patient and caregiver identification cards, (3) Medical Marijuana Treatment Center registration and regulation and (4) regulation of the adequate supply of marijuana for a qualifying patient's medical use.
1.8. The Florida Medical Marijuana Program will not provide the following:

- Physician referral list. The program will not serve as a referral source. However, any medical doctor (MD), doctor of osteopathy (DO), dentist, or podiatric physician licensed in Florida can certify a patient for the program.
- Caregiver referral. The program will not serve as a referral source for patients who are seeking caregivers.
- Medical research. The program will not provide information or address the health effects of using medical marijuana.
- Legal advice. If there are any questions concerning how to comply with the program requirements, it will be recommended that a person consult a private attorney.
- Growing process resources. The program will not provide resources for the growing process and will not have information about where to get the seeds or plants to start growing medical marijuana.

2.0 Marijuana

2.1. Marijuana (referred to as Marihuana) is a Schedule 1 Controlled Substance under the Federal Controlled Substances Act, 21CFR1308.11.
2.2. Cannabis is a Schedule 1 Controlled Substance in section 893.03(1)(c)7, Florida Statutes, meaning the drug has no current acceptable medical use in treatment in Florida.

2.3. Dronabinol is approved by the Federal Drug Administration and listed as a Schedule III Controlled Substance in section 893.03(3)(f), Florida Statutes.
2.4. The Department of Health does not have the resources or knowledge base to provide information on cultivation or transportation and would need to look to Department of Agriculture and Consumer Services for assistance in these areas.

3.0 Physicians

3.1. Florida licensed physicians authorized to provide certification of a qualified patient include medical doctors, doctor of osteopathy, dentists, and podiatric physicians. These physicians are currently authorized to prescribe controlled substances in schedules II through V as defined in Chapter 893, Florida Statutes. Currently, optometrists may diagnose glaucoma; however, no optometrists may prescribe any oral ocular pharmaceutical agent unless the drug is specifically listed in statute.
3.2. Licensed physicians in Florida cannot prescribe marijuana under Florida law, see section 893.03(1), Florida Statutes.
3.3. Licensed physicians will not be required to offer patients a certification for use of medical marijuana.
3.4. Pharmacies and dispensing physicians are not authorized to dispense Schedule 1 Controlled Substances.
3.5. Physician certification and other documentation that links the patient to their medical condition are protected health information and exempt from public records release.
3.6. Physical exam and full assessment of patient's medical history will be required prior to issuing a physician certification.
3.7. Existing physician disciplinary laws and rules are sufficient for this program.

4.0 Qualifying Patients & Personal Caregivers

4.1. Qualifying patient and personal caregiver identification cards will authorize the holder to acquire and possess medical marijuana.
4.2. All records of the qualifying patients will be exempt from public records release.
4.3. Qualifying patient and personal caregiver request for an identification card will be conducted via web-based and mail-in processes.
4.4. Qualifying patients under the age of eighteen will have custodial parent or legal guardian permission to obtain an identification card.
4.5. Personal caregivers will be at least twenty-one (21) years old and have agreed to assist a qualifying patient.

5.0 Medical Marijuana Treatment Centers

5.1. Medical Marijuana Treatment Centers will register with the Florida Department of Health (DOH) using a web-based system.
5.2. Medical Marijuana Treatment Centers will have to comply with any federal registration requirement prior to applying for registration in Florida.
5.3. Medical Marijuana Treatment Centers will be inspected quarterly by the DOH.

6.0 Department of Health

6.1. The DOH will promulgate rules by June 30, 2015 to implement the program regulation outlined in the Constitutional Amendment.

6.2. Education materials or required trainings for caregivers, patients, physicians, treatment centers and DOH staff will be available prior to the issuance of identification cards and registrations.
6.3. The DOH will begin issuance of patient and caregiver identification cards prior to October 1, 2015.
6.4. The DOH will begin registering Medical Marijuana Treatment Centers prior to October 1, 2015.

II. PROGRAM DESCRIPTION

If the proposed Constitutional Amendment is enacted, the Florida Department of Health will establish a Florida Medical Marijuana Program. The Program will have four components: (1) Physician issuance of certification, (2) Patient and caregiver identification cards, (3) Medical Marijuana Treatment Center licensure and regulation and (4) regulation of the adequate supply of marijuana for a qualifying patient's medical use. The key responsibilities for each of the Program components are outlined below.

1. Physician Certification Issuance

Definitions from Proposed Constitutional Amendment

- Debilitating Medical Condition means cancer, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis or other conditions for which a physician believes that the benefits of the medical use of marijuana would likely outweigh the potential health risks for a patient.
- Marijuana has the meaning given cannabis in Section 893.02(3), Florida Statutes (2013).
- Medical Use: means the acquisition, possession, use, delivery, transfer, or administration of marijuana or related supplies by a qualifying patient or personal caregiver for use by a qualifying patient for the treatment of a debilitating medical condition.
- Physician: A physician who is licensed in Florida
- Physician Certification: A written document signed by a physician, stating that in the physician's professional opinion, the patient suffers a debilitating medical condition, that the potential benefits of the medical use of marijuana would likely outweigh the health risks for the patient, and for how long the physician recommends the medical use of marijuana for the patient.

FDOH Responsibilities

1. Establish standards for the certification issued by physicians
2. Educate physicians on the requirements to issue certifications based on current Florida Statutes

2. Patient and Caregiver Identification Cards

Definitions from Constitutional Amendment

- Identification Card means a document issued by the Department that identifies a person who has a physician certification or a personal caregiver who is at least twenty-one (21) years old and has agreed to assist with a qualifying patient's medical use of marijuana.

- Personal Caregiver means a person who is at least twenty-one (21) years old who has agreed to assist with a qualifying patient's medical use of marijuana and has a caregiver identification card issued by the Department. A personal caregiver may assist no more than five (5) qualifying patients at one time. An employee of a hospice provider, nursing, or medical facility may serve as a personal caregiver to more than five (5) qualifying patients as permitted by the Department. Personal caregivers are prohibited from consuming marijuana obtained for the personal, medical use by the qualifying patient.
- Qualifying Patient means a person who has been diagnosed to have a debilitating medical condition, who has a physician certification and a valid qualifying patient identification card. If the Department does not begin issuing identification cards within nine (9) months after the effective date of this section, then a valid physician certification will serve as a patient identification card in order to allow a person to become a "qualifying patient" until the Department begins issuing identification cards.

FDOH Responsibilities

1. Develop and maintain administrative rules which define procedures for:
    - Issuance and renewal of qualifying patient identification cards
    - Issuance and renewal of personal caregiver identification cards
2. Develop a registry to maintain qualified patient information and personal caregiver information
3. Educate patients and caregivers on identification card issuance processes
4. Educate law enforcement partners on patient and caregiver identification cards
5. Ensure qualifying patient information is kept confidential.
6. Collect fees for identification cards
7. Issue identification cards
8. Replace lost identification cards, if necessary
9. Renew identification cards

3. Medical Marijuana Treatment Center Licensure and Regulation

Definitions from Constitutional Amendment

- Medical Marijuana Treatment Center: means an entity that acquires, cultivates, possesses, processes (including development of related products such as food, tinctures, aerosols, oils, or ointments), transfers, transports, sells, distributes, dispenses, or administers marijuana, products containing marijuana, related supplies, or educational materials to qualifying patients or their personal caregivers and is registered by the Department.

FDOH Responsibilities

1. Develop and maintain administrative rules which:
    - Define procedures for registration of Medical Marijuana Treatment Centers, including issuance, renewal, suspension and revocation of registration
    - Establish standards to ensure security, record-keeping, testing, labeling, inspection and safety
2. Develop a treatment center registry
3. Collect fees for registered treatment centers
4. Educate treatment center owners on laws, rules and procedures
5. Educate law enforcement partners on treatment centers requirements and authority
6. Issue registrations to treatment centers

7. Inspect treatment centers based on established standards
8. Investigate, suspend and revoke registrations as established procedures
9. Renew treatment center registrations

4. Regulation of the Adequate Supply for Qualifying Patients' Medical Use

Definition from Constitutional Amendment

- A regulation that defines the amount of marijuana that could reasonably be presumed to be an adequate supply for qualifying patients' medical use, based on the best available evidence. This presumption as to quantity may be overcome with evidence of a particular qualifying patient's appropriate medical use.

FDOH Responsibilities

1. Develop and maintain administrative rules which:
    - Define adequate supply for qualifying patients
    - Determine the evidence necessary to define an adequate supply.
    - Outline a threshold for a particular patient's appropriate medical use.
2. Educate physicians, caregivers, patients and law enforcement on administrative rules concerning adequate supply of qualifying patients' medical use.

III. COST ANALYSIS

Table 1
Florida Medical Marijuana Program
Qualified Patient, Caregiver & Treatment Facility Estimates

	Number	Methodology
Estimated Number of Qualified Patients	347,700	Estimate assumes mature program - 18 patients per 1,000 population, based on average actual 2012 experience of Colorado and Oregon. Florida 2012 population (19,317,568/1,000 *18), rounded to nearest 100. First year registration estimate assumes 6 per 1,000 population, based on Arizona actual 2011 experience. (19,317,568/1,000 *6, rounded to nearest 100) = 115,900. **Alternate methodology to consider** - proportion of prevalence of named debilitating diseases compared across states.
Estimated Number of Personal Caregivers	208,620	Estimate assumes mature program - 6 caregivers for every 10 patients, based on Colorado actual 2012 experience, rounded. First year registration (115,900/10*6) = 69,540
Estimated Number of Medical Marijuana Treatment Centers to be Registered	809	Estimated number of facilities based on Colorado program. Approximate Number of Facilities: • 629 dispensaries (1 dispensary/30,325 persons) • 60 commercial transporters (transporting from cultivator/processor to dispensary or dispensary to patient) • 60 processors • 60 cultivators (commercial or patient)

Florida Department of Health
"Use of Marijuana for Certain Medical Conditions"
Constitutional Amendment Analysis

Table 2
Florida Medical Marijuana Program
Cost Estimates, 2015 & 2016

Cost of Program Implementation	Year 1 2015	Year 2 2016	Description
Program Staff – State Health Office Year 1 – Program Manager Only Year 2 – Program manager, environmental consultant and senior clerk.	$96,541	$217,121	Year 1 Program Manager, $60,000 salary, fringe (35%) & expense package ($15,541). Expense = $6,211 recurring expense, $3,762 non-recurring, $5,568 limited travel. Recurring FTE. Year 2 additional 2.0 FTEs to manage established program. Environmental Consultant ($82,587) and Senior Clerk ($37,993).
Support for rule development	$59,406	$0	Contracted operations management consultant $20 hr/2080 hours plus fringe (35%) and contract overhead (4%). One-time contractual.
Develop & disseminate educational materials	$42,120	$21,060	Contracted educator $20.00 hr/1500 hours plus fringe (35%) and contract overhead (4%). One-time contractual. Year 2 includes 750 hours of contracted time to refresh training materials.
Business Analyst for data system	$88,400	$0	$85 per hour for 1040 hours. One-time contractual.
Data system for patient/caregiver registration & medical treatment center management	$150,000	$0	Cost to design, develop, and test data system based on business requirements. One-time contractual 1800 hours at $75.00 per hour and $15,000 for hardware.
Annual data system user support and maintenance	$0	$25,000	Annual cost of help desk and software maintenance 625 hours per year at $40 per hour. Recurring $25,000 after Year 1 implementation.
Treatment facility inspections, reinspections, and complaint investigations Year 1 – 3 months Year 2 – 12 months	$110,394	$444,075	Cost per service determined from biomedical waste program with similar program/inspection components. Cost for services for 12 months - 749 dispensary/ transporter/processor quarterly inspections @ $85 each= $254,660; 25% reinspections rate = $63,665; 20% complaint investigations 150 @ $85 = $12,750; 125 cultivators quarterly inspections @ $170 = $85,000; 25% reinspections rate $21,250; 20% complaint investigations 25 @ $170 = $4,250. Interagency Agreement with DOACS for inspections of cultivators/processors - $2,500 per year beginning year 2.
Regional Inspector Transportation, Computers and Connectivity	$366,440	$0	One-time cost for 10 state vehicles @ $35,000 each and 10 pentablets @ $1,500 each for regional inspectors. Routine repair and maintenance in Year 2 included in cost per service. VPN connectivity service $48 per month per inspector for 3 months in year 1 – $1,440. Year 2 costs included in cost per service.
Total Estimated Costs	**$913,301**	**$707,256**	

IV. OPEN DISCUSSION ITEMS

ATTACHMENTS

Tab 9

Draft – Summary of Initiative Financial Information Statement

Draft – Summary of Initiative Financial Information Statement

The draft elements of the "Summary of Initiative Financial Information Statement" that are included to date are:

I) Substantive Analysis

A) Proposed Amendment

- Ballot Title
- Ballot Summary
- Statement and Purpose
- Proposed Amendment to the Florida Constitution
- Effective Date

B) Effect of Proposed Amendment

- Background

INITIATIVE FINANCIAL INFORMATION STATEMENT
ALLOWING THE USE OF MARIJUANA FOR CERTAIN MEDICAL CONDITIONS

SUMMARY OF INITIATIVE FINANCIAL INFORMATION STATEMENT

I. SUBSTANTIVE ANALYSIS

A. Proposed Amendment

Ballot Title:

Use of Marijuana for Certain Medical Conditions.

Ballot Summary:

Allows the medical use of marijuana for individuals with debilitating diseases as determined by a licensed Florida physician. Allows caregivers to assist patients' medical use of marijuana. The Department of Health shall register and regulate centers that produce and distribute marijuana for medical purposes and shall issue identification cards to patients and caregivers. Applies only to Florida law. Does not authorize violations of federal law or any non-medical use, possession or production of marijuana.

Statement and Purpose:

According to the sponsors, "doctors should have the freedom to recommend the treatment they deem appropriate for their patients - including medical marijuana…[and] studies show that many patients suffering with HIV/AIDS, glaucoma, cancer and chemotherapy, multiple sclerosis, epilepsy, and other debilitating illnesses find that marijuana provides relief from their symptoms."[1]

Proposed Amendment to the Florida Constitution:

ARTICLE X, SECTION 29. Medical marijuana production, possession and use.—

(a) PUBLIC POLICY.

(1) The medical use of marijuana by a qualifying patient or personal caregiver is not subject to criminal or civil liability or sanctions under Florida law except as provided in this section.
(2) A physician licensed in Florida shall not be subject to criminal or civil liability or sanctions under Florida law for issuing a physician certification

[1] See http://www.unitedforcare.org/. (last visited on Oct. 10, 2013)

to a person diagnosed with a debilitating medical condition in a manner consistent with this section.

(3) Actions and conduct by a medical marijuana treatment center registered with the Department, or its employees, as permitted by this section and in compliance with Department regulations, shall not be subject to criminal or civil liability or sanctions under Florida law except as provided in this section.

(b) DEFINITIONS. For purposes of this section, the following words and terms shall have the following meanings:

(1) *"Debilitating Medical Condition"* means cancer, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis or other conditions for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for a patient.

(2) *"Department"* means the Department of Health or its successor agency.

(3) *"Identification card"* means a document issued by the Department that identifies a person who has a physician certification or a personal caregiver who is at least twenty-one (21) years old and has agreed to assist with a qualifying patient's medical use of marijuana.

(4) *"Marijuana"* has the meaning given cannabis in Section 893.02(3), Florida Statutes (2013).

(5) *"Medical Marijuana Treatment Center"* means an entity that acquires, cultivates, possesses, processes (including development of related products such as food, tinctures, aerosols, oils, or ointments), transfers, transports, sells, distributes, dispenses, or administers marijuana, products containing marijuana, related supplies, or educational materials to qualifying patients or their personal caregivers and is registered by the Department.

(6) *"Medical use"* means the acquisition, possession, use, delivery, transfer, or administration of marijuana or related supplies by a qualifying patient or personal caregiver for use by a qualifying patient for the treatment of a debilitating medical condition.

(7) *"Personal caregiver"* means a person who is at least twenty-one (21) years old who has agreed to assist with a qualifying patient's medical use of marijuana and has a caregiver identification card issued by the Department. A personal caregiver may assist no more than five (5) qualifying patients at one time. An employee of a hospice provider, nursing, or medical facility may serve as a personal caregiver to more than five (5) qualifying patients as permitted by the Department. Personal caregivers are prohibited from consuming marijuana obtained for the personal, medical use by the qualifying patient.

(8) *"Physician"* means a physician who is licensed in Florida.

(9) *"Physician certification"* means a written document signed by a physician, stating that in the physician's professional opinion, the patient suffers from a debilitating medical condition, that the potential benefits of the medical use of marijuana would likely outweigh the health risks for the patient, and for how long the physician recommends the medical use of marijuana for the patient. A physician certification may only be provided after the physician has conducted a physical examination of the patient and a full assessment of the patient's medical history.

(10) *"Qualifying patient"* means a person who has been diagnosed to have a debilitating medical condition, who has a physician certification and a valid qualifying patient identification card. If the Department does not begin issuing identification cards within nine (9) months after the effective date of this section, then a valid physician certification will serve as a patient identification card in order to allow a person to become a "qualifying patient" until the Department begins issuing identification cards.

(c) LIMITATIONS.

(1) Nothing in this section shall affect laws relating to non-medical use, possession, production or sale of marijuana.

(2) Nothing in this section authorizes the use of medical marijuana by anyone other than a qualifying patient.

(3) Nothing in this section allows the operation of a motor vehicle, boat, or aircraft while under the influence of marijuana.

(4) Nothing in this law section requires the violation of federal law or purports to give immunity under federal law.

(5) Nothing in this section shall require any accommodation of any on-site medical use of marijuana in any place of education or employment, or of smoking medical marijuana in any public place.

(6) Nothing in this section shall require any health insurance provider or any government agency or authority to reimburse any person for expenses related to the medical use of marijuana.

(d) DUTIES OF THE DEPARTMENT. The Department shall issue reasonable regulations necessary for the implementation and enforcement of this section. The purpose of the regulations is to ensure the availability and safe use of medical marijuana by qualifying patients. It is the duty of the Department to promulgate regulations in a timely fashion.

(1) Implementing Regulations. In order to allow the Department sufficient time after passage of this section, the following regulations shall be

promulgated no later than six (6) months after the effective date of this section:

a. Procedures for the issuance of qualifying patient identification cards to people with physician certifications, and standards for the renewal of such identification cards.

b. Procedures for the issuance of personal caregiver identification cards to persons qualified to assist with a qualifying patient's medical use of marijuana, and standards for the renewal of such identification cards.

c. Procedures for the registration of Medical Marijuana Treatment Centers that include procedures for the issuance, renewal, suspension, and revocation of registration, and standards to ensure security, record keeping, testing, labeling, inspection, and safety.

d. A regulation that defines the amount of marijuana that could reasonably be presumed to be an adequate supply for qualifying patients' medical use, based on the best available evidence. This presumption as to quantity may be overcome with evidence of a particular qualifying patient's appropriate medical use.

(2) Issuance of identification cards and registrations. The Department shall begin issuing qualifying patient and personal caregiver identification cards, as well as begin registering Medical Marijuana Treatment Centers no later than nine months (9) after the effective date of this section.

(3) If the Department does not issue regulations, or if the Department does not begin issuing identification cards and registering Medical Marijuana Treatment Centers within the time limits set in this section, any Florida citizen shall have standing to seek judicial relief to compel compliance with the Department's constitutional duties.

(4) The Department shall protect the confidentiality of all qualifying patients. All records containing the identity of qualifying patients shall be confidential and kept from public disclosure other than for valid medical or law enforcement purposes.

(e) LEGISLATION. Nothing in this section shall limit the legislature from enacting laws consistent with this provision.

(f) SEVERABILITY. The provisions of this section are severable and if any clause, sentence, paragraph or section of this measure, or an application thereof, is adjudged invalid by any court of competent jurisdiction other provisions shall continue to be in effect to the fullest extent possible.

Effective Date:

Article XI, Section 5(e), of the Florida Constitution states that, unless otherwise specified in the Florida Constitution or the proposed constitutional amendment, the proposed amendment will become effective on the first Tuesday after the first Monday in January following the election. This amendment does not specify an effective date and will be effective as stated in Article XI, Section 5(e), of the Florida Constitution. However, the amendment delays implementation of certain provisions by allowing the Department of Health six months after the effective date to promulgate regulations and nine months after the effective date to begin issuing identification cards.

B. Effect of Proposed Amendment

According to People United for Medical Marijuana[2] the amendment would:

- Legalize medical marijuana for use by qualifying patients;
- Define qualifying patients as individuals with debilitating diseases as determined by a physician where the benefits of the use of medical marijuana would outweigh the potential harms;
- Remove criminal and civil penalties from qualifying patients, physicians who recommend the use of medical marijuana, caregivers who assist with the administration of medical marijuana to people who are very debilitated and weak; and
- Set up a regulatory structure through the state Department of Health that allows the state to:
    - Keep a database of the folks that are qualifying patients and caregivers;
    - Register treatment centers that would grow, produce, and distribute medical marijuana; and
    - Put safety and quality checks on the product coming out and to establish guidelines for quantities that people can have.

[2] See http://www.unitedforcare.org/q_a_the_effort_to_make_medical_marijuana_legal_in_florida. (Last visited on Oct. 10, 2013).

Background

Current Legal Status Marijuana in Florida

Florida law defines Cannabis as "all parts of any plant of the genus *Cannabis*, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin"[3] and places it, along with other sources of tetrahydrocannabinol (THC), on the list of Schedule 1 drugs.[4] Schedule 1 drugs are substances that have a high potential for abuse and no currently accepted medical use in treatment in the United States. As a Schedule 1 drug, possession and trafficking in cannabis carry criminal penalties that vary from a misdemeanor of the first degree[5] up to a felony of the first degree with a possible minimum sentence of 15 years in prison and a $200,000 fine.[6] Paraphernalia[7] that is sold, manufactured, used, or possessed with the intent to be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance is also prohibited and carries criminal penalties ranging from a misdemeanor of the first degree to felony of the third degree.[8]

The Necessity Defense in Florida

Despite the fact that the use, possession, and sale of marijuana is prohibited by state law, Florida courts have found that circumstances can necessitate medical use of marijuana and circumvent the application of any criminal penalties. The necessity defense was successfully applied in a marijuana possession case in Jenks v. State[9] where the First District Court of Appeal found that "section 893.03 does not preclude the defense of medical necessity" for the use of marijuana if the defendant:

- Did not intentionally bring about the circumstance which precipitated the unlawful act;
- Could not accomplish the same objective using a less offensive alternative available; and
- The evil sought to be avoided was more heinous than the unlawful act.

[3] S. 893.02(c), F.S.
[4] S. 893.03(c)7. and 37., F.S.
[5] For possessing or delivering less than 20 grams. See s. 893.13(3) and (6)(b), F.S.
[6] Trafficking in more than 25 pounds, or 300 plants, of cannabis is a felony of the first degree with a minimum sentence that varies from 3 to 15 years in prison depending on the amount of cannabis. See s. 893.135(1)(a), F.S.
[7] As defined in s. 893.145, F.S.
[8] S. 893.147, F.S.
[9] 582 So. 2d 676

In the cited case the defendants, a married couple, were suffering from uncontrollable nausea due to AIDS treatment and had testimony from their physician that he could find no effective alternative treatment. Under these facts, the First District found that the Jenks met the criteria for the necessity defense and ordered an acquittal of the charges of cultivating cannabis and possession of drug paraphernalia.

Medical Marijuana Laws in Other States

Currently, 20 states and the District of Columbia[10] have some form of law that permits the use of marijuana for medicinal purposes. These laws vary widely in detail but most are similar in that they touch on several recurring themes. Most state laws include the following in some form:

- A list of medical conditions for which a practitioner can recommend the use of medical marijuana to a patient.
    - Nearly every state has a list of medical conditions though the particular conditions vary from state to state. Most states also include a way to expand the list either by allowing a state agency or board to add medical conditions to the list or by including a "catch-all" phrase.[11] Most states require that the patient receive certification from at least one, but often two, physicians designating that they have a qualifying condition before they can be issued an ID card.
- Provisions for the patient to designate one or more caregivers who can possess the medical marijuana and assist the patient in preparing and using the medical marijuana.
    - The number of caregivers allowed and the qualifications to become a caregiver vary from state to state. Most states allow 1 or 2 caregivers and require that they be at least 21 years of age and, typically, cannot be the patient's physician. Caregivers are generally allowed to purchase or grow marijuana for the patient, be in possession of the allowed quantity of marijuana, and aid the patient in using the marijuana, but are strictly prohibited from using the marijuana themselves.
- A required identification card for the patient, caregiver, or both that is typically issued by a state agency.
- A registry of people who have been issued an ID card.

[10] These states include Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois (effective 2014), Maine, Maryland, Massachusetts, Michigan, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington. California was the first to establish a medical marijuana program in 1996 and Illinois was the most recent state to pass medical marijuana legislation in August of 2013. Illinois legislation does not become effective until 2014. See http://www.ncsl.org/issues-research/health/state-medical-marijuana-laws.aspx. Last visited on Oct. 17, 2013.

[11] Such as in California's law that includes "any other chronic or persistent medical symptom that either: 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, or If not alleviated, may cause serious harm to the patient's safety or physical or mental health."

- A method for registered patients and caregivers to obtain medical marijuana.
    - There are two general methods by which patients can obtain medical marijuana: either they must self-cultivate the marijuana in their homes, or the state allows specified marijuana points of sale or dispensaries. The regulations governing such dispensaries, in states that allow them, vary widely.
- General restrictions on where medical marijuana may be used.

Medical Marijuana Laws and the Federal Government

Regardless of whether or not an individual state has allowed the use of marijuana for medicinal purposes, or otherwise, the Federal Controlled Substances Act lists it as a schedule 1 drug with no accepted medical uses. Under federal law possession, manufacturing, and distribution of marijuana is a crime.[12] Although state medical marijuana laws protect patients from prosecution for the legitimate use of marijuana under the guidelines established in that state, such laws do not protect individuals from prosecution under federal law should the federal government choose to act on those laws.

In August of 2013, the United States Justice Department issued a publication entitled "Smart on Crime: Reforming the Criminal Justice System for the 21st Century." [13] This document details the federal government's changing stance on low-level drug crimes announcing a "change in Department of Justice charging policies so that certain people who have committed low-level, nonviolent drug offenses, who have no ties to large-scale organizations, gangs, or cartels will no longer be charged with offenses that impose draconian mandatory minimum sentences. Under the revised policy, these people would instead receive sentences better suited to their individual conduct rather than excessive prison terms more appropriate for violent criminals or drug kingpins." This announcement indicates the justice department's relative unwillingness to prosecute low-level drug cases leaving such prosecutions largely up to state authorities.

Proposed Florida Laws

Distinct from the petition initiative, legislation was proposed to enact concepts similar to the subject of the amendment. During the 2013 legislative session, identical bills were introduced in the Senate and House of Representatives relating to medical cannabis. The bill established regulatory responsibilities and rulemaking authority for the Department of Health (DOH) and the Department of Business and Professional Regulation (DBPR), and provided rulemaking authority for the Department of Revenue (DOR) specific to taxation and reporting responsibility for specified entities. The bill:

[12] The punishments vary depending on the amount of marijuana and the intent with which the marijuana is possessed. See http://www.fda.gov/regulatoryinformation/legislation/ucm148726.htm#cntlsbd. Last visited Oct. 17, 2013.
[13] See http://www.justice.gov/ag/smart-on-crime.pdf. Last visited on Oct. 17, 2013

- Authorized a qualifying patient and the patient's qualified caregiver to possess and administer medical cannabis to a qualifying patient, and to possess and use paraphernalia for specified purposes;
- Provided procedures and requirements for DOH administration;
- Authorized a physician to recommend use of medical cannabis under specified procedures and requirements;
- Required DBPR to regulate licensure of cultivation centers and dispensaries, under related procedures and requirements;
- Established a medical cannabis section within DBPR, including procedures and requirements to authorize a medical cannabis farm to possess, cultivate, and manufacture medical cannabis, medical cannabis-based products, and marijuana plants for wholesale in this state, including permitting and licensing procedures and fees, administrative fines, license suspension, and injunctive relief.
- Required rule adoption by specified dates;
- Provided that use of medical cannabis is a defense to certain offenses, and does not create defense to certain other offenses;
- Made conforming revisions to a variety of criminal provisions, including changes to the Offense Severity Ranking Chart;
- Included a severability clause; and
- Provided an effective date of July 1, 2013.

The bill stipulated that fees established by DOH must offset all expenses of implementing and administering the provisions of the bill, specified fee caps for DBPR permitting purposes, and indicated that fees collected by DOH, DBPR, and DOR be applied first to administering the responsibilities assigned under the provisions. Senate Bill (SB) 1250, introduced by Senator Clemens and one co-sponsor, was referred to four committees of reference. House Bill 1139, introduced by Representative Edwards and five co-sponsors, was referred to four committees of reference. A related public records exemption bill, SB 1214, was also filed by Senator Clemens. When the 2013 session ended, each bill died in its initial committee of reference, having not been heard.

Tab 10

Analysis Data

Analysis Data

The following presents a summary of applicable fees in those states and the District of Columbia with approved medical marijuana provisions.

Applicable Fees in those States and DC with Approved Medical Marijuana Provisions

State	Patient Registry	Caregiver Fee	Dispensary / Source Fee
Alaska	$25 initial / $20 renewal	$25 initial/$20 renewal	Dispensaries are not allowed
Arizona[1]	See note below[2]	See note below[3]	See note below[4]
California	$66, or $33 for Medi-Cal participants, plus applicable county fees		See note below[5]
Colorado[6]	$35	none	See note below[7]
Connecticut[8]	"Reasonable fee" set by state rule, currently $100 for each[9].		Non-refundable fee is $1,000; Upon approval additional fee of $5000. Renewal fee is $5,000[10]
DC	$100 initial or renewal fee, or $25 for low income patients	$100 initial or renewal fee, or $25 for low income caregivers	See note below[11]
Delaware	$125 (a sliding scale fee is available based on income)	$125 (a sliding scale fee is available based on income)	See note below[12]
Hawaii	$25		Dispensaries are not allowed
Illinois	To be determined via rulemaking. Signed into law Aug. 1, 2013; law effective date Jan. 1, 2014; Department has 120 days from effective date to develop rules		
Maine	$0	Caregivers pay $300 / patient (limit of 5 patients; if not growing marijuana, there is no fee)	See note below[13]
Massachusetts[14]	$50 annually / Hardship cultivation $100		Agent registration $500. Phase 1 application $1,500; Phase 2 application $30,000; Annual registration $50,000
Michigan	$100 new or renewal application / $25 Medicaid or SSI patients	No separate fee from patient registry fee	Michigan Supreme Court ruled that dispensaries are illegal: State of Michigan vs. McQueen, Docket No. 143824
Montana	$25 new application / $10 renewal (reduced from $50 as of Oct. 1, 2009)	Effective July 1, 2011 caregiver's cards will no longer be valid. Individuals will need to register with the department as a provider if they wish to provide marijuana to patients.	Provider/Marijuana Infused Products provider (MIPP) application fees are $50. Providers and MIPPs must reapply annually.
Nevada	$50 application fee, plus $150 for the card (new or renewal), plus $15-42 in additional related costs. SB 374 requires the fee to be reduced at least by half before Apr. 1, 2014		Dispensaries are not allowed

State	Patient Registry	Caregiver Fee	Dispensary / Source Fee
New Hampshire	To be determined during the rulemaking process		
New Jersey	$200 (valid for two years). Reduced fee of $20 for patients qualifying for state or federal assistance programs		Application fee of $20,000, $2,000 of which is non-refundable
New Mexico	$0		See note below[15]
Oregon[16]	$200 for new applications and renewals; $100 for application and annual renewal fee for persons receiving SNAP (food stamp) and for Oregon Health Plan cardholders; $20 for persons receiving SSI benefits		Allowed starting in 2014, currently developing rules and fees[17]
Rhode Island	$100 / $25 for applicants on Medicaid or Supplemental Security Income (SSI)[18]		
Vermont	$50	$50[19]	$2,500 non-refundable application fee; $20,000 dispensary fee in first year and $30,000 in subsequent years
Washington	No state registration program has been established		Not allowed

Source: Initially compiled with information from: http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881 on October 7, 2013; and from http://www.mpp.org/assets/pdfs/library/State-by-State-Laws-Report-2011.pdf on October 11, 2013, and updated with information as listed below.

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[1] Arizona

The fees are listed in rules and are detailed below. For all there is:

- $10 to amend, change, or replace a registry identification card.

[2] Arizona

- $150 for an initial or a renewal registry identification card for a qualifying patient. Some qualifying patients may be eligible to pay $75 for initial and renewal cards if they currently participate in the Supplemental Nutrition Assistance Program.

[3] Arizona

- $200 for an initial or a renewal registry identification card for a designated caregiver. A caregiver must apply for a new card for every patient under their care (up to five patients).

[4] Arizona

- $500 for an initial or a renewal registry identification card for a dispensary agent.
- $5,000 for an initial dispensary registration certificate.
- $1,000 for a renewal dispensary registration certificate.
- $2,500 to change the location of a dispensary or cultivation facility.

[5] California

- Dispensaries are licensed at the local level. For example, Oakland imposes graduated fee based on number of patients served: $5,000 for under 500 patients to $20,000 for over 1,500 patients (2011).

[6] Colorado

- No general funds have been designated for this program. The Colorado Constitution authorizes CDPHE to collect fees to cover the costs of administering the program.

[7] Colorado

- Currently the fee is $35, and is evaluated annually by CDPHE. The fee was lowered from $110 on June 1, 2007, and was again lowered from $90 on January 1, 2012.
- State application fees for medical cannabis businesses are: $7,500 for 300 or fewer patients, $12,500 for 301 to 500 patients, and $18,000 for those serving 501 or more patients. A cultivation license is $1,250, and an infused products manufacturer license is $1,250. For further detail see: http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22MED+Fee+Schedule.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251857124942&ssbinary=true
- State retail marijuana business license fees are $3,750 for 300 or fewer patients, $8,750 for 301 to 500 patients, and $14,000 for those serving 501 or more patients. For further detail, see http://www.colorado.gov/cs/Satellite?c=Page&childpagename=Rev-MMJ%2FCBONLayout&cid=1251646187389&pagename=CBONWrapper

[8] Connecticut

- Details of the fees are specified in Sec. 21a-408-28 commencing on page 34 of: http://www.ct.gov/dcp/lib/dcp/pdf/laws_and_regulations/reg-medical_marijuana-final06sept2013.pdf.

[9] Connecticut

An applicant shall submit the following fees with each license and registration

- The non-refundable application fee and each renewal fee for each qualifying patient and for each primary caregiver application shall be twenty-five dollars. In addition, there shall be a non-refundable fee of seventy-five dollars for administrative costs for each qualifying patient application, for a total non-refundable fee of one hundred dollars per qualifying patient application and for each renewal.
- The non-refundable fee for a replacement registration certificate for a qualifying patient or primary caregiver whose information has changed or whose original registration certificate has been lost, stolen or destroyed shall be ten dollars;

[10] Connecticut

An applicant shall submit the following fees with each license and registration

- The non-refundable fee for a dispensary facility license application shall be one thousand dollars. In addition, upon approval of the applicant's dispensary facility license, the applicant shall pay an additional fee of five thousand dollars prior to receiving a license;
- The non-refundable fee for each renewal of a dispensary facility license shall be five thousand dollars;
- The non-refundable fee for a dispensary license and for each renewal shall be one hundred dollars;
- The non-refundable fee for a dispensary technician and dispensary employee registration and each renewal shall be fifty dollars;
- The non-refundable registration fee and each renewal fee for a dispensary facility backer shall be one hundred dollars;
- The non-refundable fee for an application to change a dispensary facility name shall be one hundred dollars;
- The non-refundable fee for a change of dispensary facility manager form shall be fifty dollars;
- The non-refundable fee for an application to expand or change the location of a dispensary facility shall be one thousand dollars. If the application is approved, the applicant shall pay an additional one thousand five hundred dollars upon such approval;
- The non-refundable fee for an application to make a physical, non-cosmetic alteration of a dispensary facility or a dispensary facility department, other than an expansion, shall be five hundred dollars;

- The non-refundable application fee for a producer license shall be twenty-five thousand dollars. In addition, if an application for a producer license is approved, the applicant shall pay a fee of seventy-five thousand dollars prior to receiving a license;
- The non-refundable fee for each renewal of a producer license shall be seventy-five thousand dollars per production facility location;
- The non-refundable application fee for a producer to open an additional production facility location shall be twenty-five thousand dollars. In addition, if an application for an additional location is approved, the applicant shall pay a fee of seventy-five thousand dollars prior to receiving permission to open an additional production facility.
- The non-refundable fee for a production facility employee registration and for each renewal shall be one hundred dollars;
- The non-refundable fee for a producer backer registration and for each renewal shall be one hundred dollars;
- The non-refundable fee for an application to change a producer name or production facility name shall be one hundred dollars;
- The non-refundable fee for an application to expand or change the location of a production facility shall be three thousand five hundred dollars. In addition, upon approval of the application, the applicant shall pay an additional fee of one thousand five hundred dollars;
- The non-refundable fee for an application to make a physical, non-cosmetic alteration of a production facility, other than an expansion, shall be five hundred dollars; and
- The non-refundable fee for a producer to register a marijuana brand name with the department shall be twenty five dollars per brand name.

[11] District of Columbia

Registration and Permit Fees:

- The annual fee for a medical marijuana dispensary registration shall be ten thousand dollars ($10,000). This fee shall also cover any audit and inspection costs incurred by the Department.
- The annual fee for a cultivation center registration shall be five thousand dollars ($5,000). This fee shall also cover any audit and inspection costs incurred by the Department.
- The annual fee for each director, officer, member, incorporator, or agent registration shall be two hundred dollars ($200).
- The annual fee for an employee registration shall be seventy-five dollars ($75).
- The fee for a medical marijuana certification provider permit shall be three hundred dollars ($300).
- The annual fee for a Manager's registration shall be one hundred fifty dollars ($150).
- The annual fee for a transport permit shall be twenty-five dollars ($25).
- The fee for a duplicate registration or replacement of a lost registration shall be twenty-five dollars ($25).
- The fee for a duplicate permit or replacement of a lost permit shall be twenty-five dollars ($25).

Application Fees:

- The fee for the filing of an initial application for a medical marijuana dispensary shall be five thousand dollars ($5,000).
- The fee for the filing of an initial application for a medical marijuana cultivation center shall be five thousand dollars ($5,000).
- The fee for the filing of a renewal application for a medical marijuana dispensary shall be three thousand dollars ($3,000).
- The fee for the filing of a renewal application for a medical marijuana cultivation center shall be three thousand dollars ($3,000).
- The fee for the filing of a medical marijuana certification provider permit shall be one hundred dollars ($100).
- The fee for a change of director, officer, member, incorporator, or agent shall be one hundred dollars ($100).
- The fee for a corporate or trade name change shall be one hundred dollars ($100).

[12] Delaware

- The request for proposals (RFP) to open a compassion center will be advertised in December 2013. Questions and answers will be posted on the state's website in February and completed bids will be due in mid-March 2014. This RFP progression will follow the established State of Delaware contracting process. There will be a substantial cost associated with submitting an application.

[13] Maine

- The state requires all dispensary applicants to pay a $15,000 application fee, $14,000 of which is refunded if they are not awarded a registration, and the annual renewal fee is $15,000.

[14] Massachusetts

- Updated with information from http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/medical-marijuana/fee-structure.pdf. Phase information at: http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/medical-marijuana/registered-marijuana-dispensary-application-process.html

[15] New Mexico

- Imposes a graduated fee schedule based on how long the non-profit producer has operated: $5,000 for those licensed less than a year, $10,000 for those licensed for more than one year, $20,000 for more than two years, and $30,000 for more than three years.

[16] Oregon

- An additional $50 grow site registration fee is charged if the patient is not his or her own grower.

[17] Oregon

- Oregon's medical marijuana dispensary law: http://www.oregon.gov/oha/Pages/medicalmarijuanadispensaries.aspx

[18] Rhode Island

- Updated with information from: http://www.health.ri.gov/forms/registration/MedicalMarijuanaNewApplication.pdf

[19] Vermont

- Updated with information from: http://vcic.vermont.gov/marijuana_registry/faq

Analysis Data

The following presents a summary of program financial information in those states and the District of Columbia with approved medical marijuana provisions.

Medical Marijuana Program Financial Information by State

Medical Marijuana Program Financial Information by State
Revenues from Registries and Licenses and Program Expenses (State-Level)

State	Population[1]	Program			Per 1,000 Population			Year
		Revenues[2]	Expenses	Net	Revenues	Expenses	Net	
Alaska	731,449	$ 20,633	$ 22,277	$ -1,645	$ 28	$ 30	$ -2	FY 2012
Arizona	6,553,255	7,945,277	2,380,459	5,564,818	1,212	363	849	FY 2012
California	38,041,430	45,700	276,000	-230,300	1	7	-6	FY 2011-12
Colorado	5,187,582	6,500,000	5,900,000	600,000	1,253	1,137	116	see below
Dept. of Health[3]		3,800,000	3,800,000	0				FY 2012-13
Dept. of Revenue		2,700,000	2,100,000	600,000				FY 2011-12
DC	632,323	60,000	N/A	N/A	95	N/A	N/A	FY 2012-13
Hawaii	1,392,313	409,325	N/A	N/A	294	N/A	N/A	2013
Maine	1,329,192	612,370	466,028	146,342	461	351	110	2012
Michigan	9,883,360	9,900,000	3,600,000	6,300,000	1,002	364	637	FY 2012
Montana	1,005,141	550,900	N/A	N/A	548	N/A	N/A	2012
Nevada	2,758,931	713,000	N/A	N/A	258	N/A	N/A	2013
New Jersey	8,864,590	300,000	784,000	-484,000	34	88	-55	2013
New Mexico	2,085,538	598,000	598,000	0	287	287	0	FY 2013
Oregon	3,899,353	6,000,000	2,650,000	3,350,000	1,539	680	859	2010
Rhode Island	1,050,292	566,655	589,086	-22,431	540	561	-21	FY 2011 & 2012
Vermont	626,011	140,800	138,500	2,300	225	221	4	FY 2013

[1] U.S. Census Bureau, Population Division, Annual Estimates of the Population for the United States, Regions, and States: July 1, 2012, released December 2012.
[2] In some cases revenues might have been estimated based on patient counts and user fees rather than obtained from the respective departments. Therefore, revenues may be overestimated due to possible discounts for indigent or Medicaid patients whose counts are not known.
[3] This is an estimate calculated from user fees and patients, based on the self-funding provision of the program. No general funds are appropriated for Colorado's program.

Source: State Medical Marijuana Programs Financial Information, Marijuana Policy Project, www.mpp.org, Report provided by e-mail correspondence dated October 18, 2013.

State Medical Marijuana Programs
Financial Information

State medical marijuana programs have generally had no trouble covering their expenses and have even generated substantial surpluses. Most states require the departments that administer their medical marijuana programs to set the fees high enough to cover all costs of administering the programs. Medical marijuana dispensaries typically have to pay an annual fee of between $5,000 and $30,000, while patients typically pay between $25 and $100 for registry identification cards that they renew once every year or two. In Michigan, Oregon, and Arizona, patient registry programs, dispensary regulation programs, or both, have brought in millions of dollars in surpluses. Other states, such as New Mexico and Maine, have been able to run comprehensive medical marijuana programs for under $700,000, including dispensary regulation, while covering the program costs through fees. In addition to fee-related revenue, most of the states that allow dispensaries impose their generally applicable sales tax on medical marijuana. In Colorado alone, the annual state and local tax revenue from medical marijuana businesses exceeds $11 million. In California, the state sales tax revenue from dispensaries is estimated at up to $105 million per year.

In **New Mexico**, which was the first state to license entities to produce and provide medical marijuana, the entire program will cost $598,000 in FY 2013.[1] The program initially charged minimal fees and was an unfunded mandate. Now, however, it is self-sustaining and covers all of its expenses, despite the fact that the only patients who are charged a fee are those who both cultivate marijuana for themselves and whose income is more than 200% above the federal poverty line.

The total FY 2013 staff costs for the state's program (salary and benefits) are $453,200. The program has seven full-time staff members. Its non-personnel expenses total $134,800 for the fiscal year. Those expenses include office supplies, telephone, mileage, lab testing, attorney fees, mail costs, and other office expenses. The program uses a combination of Microsoft Excel and Access and did not require development of any new software. When the program was new, it purchased a machine to make holographic cards, which cost about $6,000-$8,000.

As of August 30, 2013, 9,760 patients and 23 non-profit producers were licensed in New Mexico. There is a non-refundable $1,000 fee for licensed producer applications. Producers' annual renewal fees depend on how long the non-profit producer has operated. The fee is $5,000 for those who have been licensed less than a year. The fee is $10,000 for those licensed for more than one year, $20,000 for more than two years, and $30,000 for more than three years. 3,119 patients have personal cultivation licenses. Of the revenue in FY 2013, $508,000 comes from licensed producer fees, while $90,000 is generated from patients' personal production license fees.

In New Mexico, medical marijuana sales are subject to a gross receipts tax of 5.125% to 8.8675%, depending on the locality. According to the state Department of Health, in FY 2012, the state collected approximately $650,402 in gross receipts taxes from dispensaries.[2] This is in addition to annual revenue collected from fees, which will equal the regulatory costs of the medical marijuana program.

Colorado has the largest state-regulated dispensary program in the nation. As of FY 2012, more than 1,700 medical marijuana businesses were operating in the state — 532 medical marijuana

[1] The source of the FY 2013 financial information is a March 5, 2013 email from Andrea Sundberg of the New Mexico Department of Health. The information from prior years was obtained via phone calls and emails in 2010 and 2011 to Dominick Zurlo of the New Mexico Department of Health.

[2] Email communications with Andrea Sundberg, June 13, 2013. Ms. Sundberg noted, "This is an approximation as we obtained this information from our Producers and there were some reports that were not submitted."

centers (dispensaries) and 1,459 cultivation facilities and infused products manufacturers.[3] Although there have been a few bumps in the regulatory road after the state regulatory department overestimated revenue and made some questionable large expenditures while not focusing on the more essential aspects of regulation,[4] the program is still fairly new, and it is the most ambitious medical marijuana regulatory program in the nation. Medical marijuana taxes and fees have been quite lucrative, both at the city and state levels. State and city tax, registry, and licensing medical marijuana revenues exceeded $20 million in FY 2012. On November 6, 2012, Colorado voters approved allowing all adults 21 and older to use, grow, and purchase marijuana, but adult retail marijuana sales will not begin until around December 30, 2013, so all of these figures are limited to medical marijuana.

The Department of Public Health and Environment runs the state's patient and caregiver registry, and both the Department of Revenue's Medical Marijuana Enforcement Division (MMED) and individual cities license dispensaries. The state's patient and caregiver registry collects a $35 fee from each patient to cover its costs. No general funds have been appropriated to the program. The department re-evaluates the fee each year, and the fee was reduced from $110 to $90 on June 1, 2007.[5] It was reduced again on January 1, 2012, after the $90 fee generated a substantial surplus.[6] The department has issued about 109,622 current registrations,[7] meaning it generated at least $3.8 million in the past year. The surpluses from patient registrations have been so great in past years that they have been redirected to other purposes. In 2010, the legislature shifted a $3 million surplus from the patient ID program, and then-Governor Bill Ritter discussed using $9 million more from the medical marijuana registry program to help reduce the state's $60 million budget shortfall.[8]

In addition to the patient registry program revenue, the MMED collected $3.779 million in fees in FY 2011-2012. The total MMED expenses for the year were $5.262 million.[9] Although the program was in the red for the year, it started the year with a balance of more than $3.8 million, so it actually ended the fiscal year with a balance of $2.37 million. The decline in revenue was due to the fact that new applications were not accepted for additional medical marijuana businesses, and — as is the case with all businesses — some businesses that had been approved the prior year failed. Another factor was that annual medical marijuana business fees are relatively modest in the state and, in the case of medical marijuana centers, are lower than application fees.

The state application fees for medical marijuana centers are $7,500 for 300 or fewer patients, $12,500 for 301 to 500 patients, and $18,000 for those serving 501 or more patients. A cultivation application is $1,250, as is an infused products manufacturer application.[10] Annual renewal fees are lower, with centers' fees ranging from $3,750 to $14,000, depending on the center's size. Cultivation and infused products manufacturers' annual fees are $2,750.

In addition to medical marijuana patient and business fees, medical marijuana in Colorado generates substantial tax revenue. Unless a patient who has been certified by the state as indigent purchases it, medical marijuana is subject to state and city sales taxes in Colorado. In the 2012 fiscal

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[3] Colorado Department of Revenue, 2012 Annual Report. See p. 38, M-1 and M-2.
[4] http://www.denverpost.com/ci_22872574/colorado-audit-adequate-medical-marijuana-oversight-doesnt-exist
[5] http://www.cdphe.state.co.us/hs/medicalmarijuana/statistics.html. Viewed March 2, 2011.
[6] http://www.cdphe.state.co.us/hs/medicalmarijuana/index.html. Visited September 28, 2011.
[7] http://www.colorado.gov/cs/Satellite/CDPHE-CHEIS/CBON/1251593017044. Accessed on October 18, 2013.
[8] "Governor Ritter wants to use fees from medical marijuana to close budget gap," NBC11news.com, August 27, 2010. "Medical marijuana: Does using $9 million in fees for budget shortfall screw MMJ patients?," *Westword*, August 25, 2010. http://blogs.westword.com/latestword/2010/08/medical_marijuana_does_using_9_million_in_fees_for_budget_shortfall_screw_mmj_patients.php
[9] Colorado Department of Revenue, 2012 Annual Report. See p. 38, M-1 and M-2.
[10] http://www.colorado.gov/cs/Satellite?c=Page&childpagename=Rev-MMJ%2FCBONLayout&cid=1251643932266&pagename=CBONWrapper

year, medical marijuana sales taxes brought in more than $5.4 million to state coffers.[11] In Denver alone, the city collected $2.4 million in sales tax for FY 2012,[12] with a rate of 2.9%. Statewide, it appears that at least $6.3 million was collected in county and local sales taxes on medical marijuana in FY 2012.[13]

Cities have also collected substantial revenue from business licensing. For example, Denver charges $2,000 for a dispensary application fee and $3,000 for an annual or renewal license fee.[14] As of October 2012, there were 266 licensed dispensaries with 272 applications pending,[15] generating $1.35 million in application and licensing fees. Denver reports there were no start-up costs involved when it began licensing dispensaries, and any costs incurred are part of the department's regular operating budget. Medical marijuana is but one of the 91 types of licenses the Community Planning and Development Department provides, and the medical marijuana business licenses do not have a separate dedicated staff.[16]

In **Arizona**, the state's medical marijuana program generated $5.5 million more than it spent from mid-2011 through mid-2012. That was before any sales taxes were collected, since dispensaries did not begin to open until late 2012. The program is generating so much revenue that it has been able to make several substantial non-essential expenditures.

Arizona's medical marijuana fees totaled more than $7.9 million from April 14, 2011 through June 30, 2012.[17] About $2.4 million of the revenue was from dispensary fees and about $5.5 million was from patient ID card fees. Meanwhile, the program — including both patient ID cards and dispensaries — cost under $600,000 in salaries and wages to run. (This does not include litigation, such as Arizona's unsuccessful lawsuit questioning whether federal law preempted the law.) It incurred an additional $1.5 million in operating expenditures and $300,000 on capital equipment.

Arizona's medical marijuana program had approved 98 dispensaries and 28,977 patient applications as of the time the annual report was published. Other than salaries and wages, the expenditures were generally not ones that are essential to a medical marijuana program. For example, the expenses include $284,325 to improve physicians' ability to check the prescription drug monitoring database and $200,000 to the University of Arizona to review the evidence and make recommendations on adding debilitating conditions.

In addition to the $5.5 million surplus generated by Arizona's medical marijuana program last year, marijuana is subject a 6.6% sales tax. It is unknown what the total sales tax revenue will be. The first dispensary opened in late 2012 and about 70 are operational as of October 2013.

In **California**, dispensaries have operated for more than a decade, but no state agency is charged with regulating them. Instead, several cities and counties have set up regulations and collect licensing fees. San Francisco, for example, charges a non-refundable permit application fee of

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[11] "Colorado Medical Marijuana Dispensary Retail Sales and State Sales Tax by County FY2012," Colorado Department of Revenue.

[12] http://blogs.westword.com/latestword/2012/10/medical_marijuana_dispensaries_266_licensed_colorado.php?page=2

[13] This estimate is based on applying local or county sales tax rates to the revenue listed by city in the Colorado Department of Revenue's "Colorado Medical Marijuana Dispensary Retail Sales and State Sales Tax by County FY2012."

[14] http://www.denvergov.org/businesslicensing/DenverBusinessLicensingCenter/BusinessLicenses/MedicalMarijuanaCenters/tabid/441765/Default.aspx. Viewed October 18, 2013.

[15] http://blogs.westword.com/latestword/2012/10/medical_marijuana_dispensaries_266_licensed_colorado.php?page=2

[16] Email communication with Sue Cobb, Communications Director, Denver Community Planning & Development. August 27, 2010.

[17] Arizona Medical Marijuana Program Annual Report – 2012 http://www.azdhs.gov/medicalmarijuana/documents/reports/az-medical-marijuana-program-annual-report-2012.pdf

$8,459.[18] While the state does not regulate medical marijuana sales, it does tax them. The state Board of Equalization collects sales taxes from dispensaries and estimates that they generate $58-$105 million in annual sales tax revenue.[19] In addition to the statewide sales tax of 7.5%, cities levy up to 1.5% more in local sales taxes. In 2012, Los Angeles collected $2.5 million on a 0.6% gross receipts tax on medical marijuana, which was in addition to state and local sales taxes on medical marijuana.[20]

The California Department of Public Health also runs a voluntary registry program for patients, which fewer than 2% of patients utilize. Although there are estimated to be well over 500,000 patients in California, only 5,798 patients obtained registry cards in FY 2012/2013 because the cards are optional.[21] California's registry program is the most complex because each of 58 counties had to implement it. The program funds itself with registry fees, but borrowed $1.5 million in FY 2004/2005 for start-up costs, which were incurred expecting a much higher rate of participation. In FY 2011/2012, the program generated $457,000, and its expenses totaled $276,000.[22] The program has two full-time analysts and one supervisor.

Maine's original medical marijuana law passed in 1999 and voters added dispensaries and a registry system in November 2009. The Department of Human Services' Licensing and Regulatory Services approved eight dispensaries by August 2010, and as is the case with most other states, Maine's program has easily covered its expenses. In 2012, the medical marijuana program generated $10,261 in medical marijuana license application fees and $602,109 in registration fees. It spent $466,028.45 that year.[23] When one adds in sales tax revenue — which totaled $265,655 in 2012[24] — the 2012 surplus was more than $400,000.

The Department of Human Services' Licensing and Regulatory Services requires all dispensary applicants to pay a $15,000 fee, $14,000 of which is refunded if they are not awarded a registration.[25] The annual renewal fee is also $15,000, and a $5,000 fee is charged to change locations. Meanwhile, each employee ID card costs $56 per year, which includes $31 for a background check. Ninety-five dispensary employees were licensed in 2012.

In 2010, the department issued a total of eight non-profit dispensary registrations, which brought in a total of $120,000 in revenue. Thirty-one unsuccessful applications brought in an additional $31,000. The eight dispensaries continue to be registered.

In Maine, patient ID cards are free and voluntary. In 2012, the state issued 1,455 patients identification cards. Meanwhile, the state issued 1,311 cards to 575 caregivers at a cost of $331 each for those who cultivate marijuana (a $300 cultivation fee, plus a $31 background check fee) and $31 for a background check for those that do not cultivate.

As of 2011, the program planned to have two staff run the program — a program specialist and an administrative support person. The department did not provide updated staffing numbers in its 2012 annual report, but it did include the total cost of personnel: $119,460.65. The non-personnel

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[18] San Francisco Health Code, Article 33, Sec. 3304.
[19] "Berkeley cannabis collectives slapped with huge tax bills," *Berkeleyside*, February 3, 2011. http://www.berkeleyside.com/2011/02/03/berkeley-cannabis-collectives-slapped-with-huge-tax-bills
[20] See: http://www.smartvoter.org/2013/05/21/ca/la/meas/D/
[21] http://www.cdph.ca.gov/programs/MMP/Pages/MMPCardDATA.aspx. Viewed October 18, 2013.
[22] The California Budget Act 2012, HHS, Department of Public Health, pages 48-49. http://www.ebudget.ca.gov
[23] "Maine Medical Use of Marijuana Program: January 1, 2012 - December 31, 2012. Annual Report to the Maine State Legislature."
[24] Douglas Rooks, "Tipping point on legal marijuana," *Seacoast Online*. April 14, 2013. http://www.seacoastonline.com/articles/20130414-OPINION-304140317

[25] http://www.maine.gov/dhhs/dlrs/rulemaking/adopted.shtml

expenses in 2012 totaled $346,567.80. The state did not provide an itemization of those expenses in 2012, either. The previous year, it provided more detailed numbers. That year, the department spent $125,000 in IT expenses, which included both monthly expenses and start-up costs for a data management system. There was also a one-time $47,000 expense for law enforcement to confirm the validity of cards roadside.

Rhode Island's medical marijuana registry program opened in 2006, and compassion centers (dispensaries) were added to the law in June 2009. The department finalized rules in March 2010 and registered three compassion centers on March 15, 2011. Because of mixed signals from the federal government and other delays, however, compassion centers did not begin operating until 2013. There are now two operational compassion centers.

In 2011-2012, inclusive, the state's program took in $566,655 in fees, and it spent slightly more — $589,086.16 in personnel and equipment costs.[26] The medical marijuana program shared 2.1 full-time staff (FTE) with other programs, and added 1.25 FTE in 2012, though they were also assigned to other programs. The delays in implementing the compassion center program likely reduced revenue, since there was no need to renew compassion center registrations or register compassion center staff during that time. Another factor in Rhode Island's modest shortfall is that the compassion center fees are lower than in most states.

There were two rounds of compassion center applications, in which first 15, then 18, applicants paid a very modest, non-refundable $250 fee. Each compassion center that was registered paid a $5,000 fee, which will be charged annually. In addition, compassion center agents pay $100 and caregivers are charged $200 in annual fees for registry identification cards. Patients' cards cost $100, unless they receive benefits from Medicaid, SSI, or SSDI, in which case their fee is $25. All of the registry identification card fees were increased in 2012 to ensure adequate funding. As of September 9, 2013, there were 5,941 registered patients and 3,458 registered caregivers in Rhode Island.[27]

Michigan voters approved that state's medical marijuana law in November 2008. The state issues patient and caregiver registry cards, but there are no state-registered dispensaries. The Michigan Department of Licensing and Regulatory Affairs (LARA) is responsible for processing applications and setting fees that are sufficient to cover all program costs.

As of May 31, 2013, LARA has issued 128,441 current patient ID cards.[28] The last time the program responded to the inquiry, it reported that about 60% of applicants are charged $100, and 40%, who demonstrate low-income, are charged $25.[29] Caregivers are also required to pay an application fee of $100 per patient (with a maximum of five). As of May 31, 2013, 26,875 caregiver registrations had been issued, with a "large backlog" awaiting processing.[30] In mid-2012, the program had one manager, 16 full-time staff, seven temporary staff, and one student. During fiscal year 2012, the program generated $9.9 million in revenue, with just $3.6 million in expenditures, leaving a $6.3 million surplus for the year.[31]

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[26] Rhode Island Department of Health, "Rhode Island Medical Marijuana Program Report,", January 1, 2013.
[27] September 9, 2013 telephone communication with Mike Simoli, Acting Health Program Administrator, Licensing Team/Prescription Monitoring Program, Office of Health Professionals Regulation, Rhode Island Department of Health.
[28] http://www.michigan.gov/lara/0,4601,7-154-35299_63294_63303_51869_60731---,00.html. Viewed October 18, 2013.
[29] Email communication with program administrator Rae Ramsdell, June 8, 2009.
[30] Michigan Medical Marihuana Program Data: http://www.michigan.gov/lara/0,4601,7-154-35299_63294_63303_51869_60731---,00.html.
[31] Melissa Anders, "Michigan rakes in $9.9 million in medical marijuana card fees; see patient/caregiver numbers by county," February 7, 2013. (http://www.mlive.com/news/index.ssf/2013/02/michigan_medical_marijuana_1.html)

The **Oregon** Medical Marijuana Program (OMMP) began in 1998 and is run entirely on registry fees. It operates a registry for patients, caregivers, and grow sites. Beginning in 2014, the state will also license dispensaries in Oregon. The OMMP has been in the black every biennium except the first one (ending in 1999), when it was in the red by $14,000. The OMMP surplus was so substantial in 2005 that the Oregon Legislature siphoned off $902,000 to pay for other non-medical-marijuana-related budget needs for the Oregon Department of Human Services.[32] The legislature siphoned off an additional $168,286 to the general fund during the July 2007 to June 2009 fiscal period.[33] At the end of the fiscal period ending in May 2010, the program had a $269,354 balance. Since 2011, the program has not been responsive to MPP's inquires about financial information.

Despite the fact that the program was already generating a surplus, in late 2011, the state doubled the standard patient registry fees to $200, with a discount of $100 for food stamp recipients, or $20 for those patients who receive SSI benefits. On October 1, 2013, it revised the fees to charge $60 to patients receiving food stamps and $50 for patients enrolled in the Oregon Health Plan. It maintained the $20 fee for patients who receive SSI benefits. As of October 1, 2013, there are 58,484 registered patients and 29,323 caregivers.[34] The OMMP website does not provide a breakdown for how many patients pay the discounted rates. The program started out with only one manager and one employee, computers, and basic software. It has slowly grown and, as of early 2011, had 24 full time employees (FTE), including temporary workers. The OMMP initially used Microsoft Access, but the program became more complex after a 2007 law passed, so it developed a custom database. The program also pays expenses for travel and related expenses for a medical marijuana advisory committee.

Although we have not received recent expense data from **Montana**'s medical marijuana program, in the past, the program generated a surplus even with much lower patient fees. The state does not have state registration or regulations for dispensaries. Patients' registry fee was initially set at $200, but that was steadily reduced since such a large fee was not needed to cover costs. The fee had been reduced to $25 for new patient applications and $10 for renewals as of September 2011, but the legislature increased the fees in 2011. The annual registration fee for patients is now $75, and providers are charged $50. As of September 2013, there were 7,150 registered patients.[35] The program, which is housed in the Department of Public Health & Human Services, generated a minimum of $550,900 during the past year. As of mid-2011, when it had far more patients enrolled, the program involved a portion of two supervisors' time and the equivalent of eight full-time employees.

Vermont has operated a patient and caregiver medical marijuana registry since 2004. In 2011, the legislature approved the licensing of four non-profit dispensaries, two of which opened in 2013. The Department of Public Safety, which operates the medical marijuana program, produced a report on actual and projected revenues for the program on January 9, 2012.[36] The report shows that the program expected to operate on a very modest budget of about $140,000, and that it expected to have fee revenue cover all of its costs.

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[32] "Oregon Lawmakers Discover Unexpected Revenue from Medical Marijuana," *Associated Press*, June 1, 2005, *available at* http://www.firstcoastnews.com/news/strange/news-article.aspx?storyid=38168. See also Oregon Medical Marijuana Program Advisory Committee on Medical Marijuana minutes, December 14, 2005, *available at* http://mercycenters.org/ommp/libry/wrkgrp_minutes_121405.doc.

[33] "Oregon Medical Marijuana Program Financial Statement," June 1, 2010.

[34] http://public.health.oregon.gov/diseasesconditions/chronicdisease/medicalmarijuanaprogram/pages/data.aspx. Accessed October 17, 2013.

[35] http://www.dphhs.mt.gov/marijuanaprogram/. Viewed October 18, 2013.

[36] "Report from the Department of Public Safety: In compliance with S.17 of the 2011 Vermont General Assembly, Section 2a and Section 3 of the Act for the Marijuana for Medical Symptom Use by Persons with Severe Illness," Vermont Department of Public Safety, January 9, 2012.

In March 2011, the program reported an estimated annual revenue of $22,000 and an annual cost of $8,000, including $3,700 in staff time (about 16 hours per month) for the year.[37] In its early 2012 report, the department found that the actual revenue in FY 2011 was slightly higher than was projected — $22,750. That figure did not include a final tally for expenses for the year.

For FY 2013, the department estimated annual revenue of $140,800 and estimated the program's cost at $138,500, including $90,000 for a full-time administrator and $30,000 for a half-time data entry staffer. The remaining expenses were for software and office supplies.

Each applicant for a dispensary registration must pay a $2,500 application fee, and those granted registration must pay an annual registration fee of $20,000 their first year and $30,000 in subsequent years. The department also charges patients, caregivers, and dispensary personnel each $50 for registry identification cards. As of September 9, 2013 the program had 846 patients,[38] making it one of the smallest programs in the nation. Those numbers have significantly increased, however, over the years and especially since medical marijuana access improved with the opening of dispensaries.

In **New Jersey**, the state has been very slow to implement its medical marijuana program, which was approved by the legislature and then-Governor Jon Corzine in early 2010. Despite the law providing for six alternative treatment centers (ATCs) initially, only one has opened as of October 2013, with a second expected to open soon. The sole ATC has been unable to meet patient demand,[39] which likely reduces the number of patients registering. The slow implementation has likely reduced both patient registry revenue and revenue from ATCs.

New Jersey Department of Health and Senior Services charges ATC applicants a $20,000 annual fee, $2,000 of which is non-refundable. Every two years, patients must apply for an ID card, which costs $200, unless the patient receives certain benefits, in which case it costs $20. As of September 9, 2013, there were 1,200 patients and 114 caregivers active in New Jersey.[40]

As of March 2013, the program had an annual budget of $784,000. At the time, the program had 12 full-time employees and one part-time employee. It also has assistance from several sister agencies that provide services within their areas of expertise, such as investigations, testing, and legal issues.[41] Gov. Chris Christie requested $1.6 million for the program in FY 2014, and the medical marijuana program requested authorization during FY 2014 to expand its FTEs to a total of 18. Medical marijuana sales are subject to a 7% sales tax.

Alaska has one of the smallest medical marijuana programs in the country. In FY 2012, there were 917 patients and caregivers in the program, which does not allow dispensaries. The state charges a very low fee — $25 for initial applications and $20 for renewals — so it does not cover its modest costs. The state reported the program generated an estimated $20,632.50 in FY 2012. As of

[37] Email communication with Sheri Englert, March 2, 2011.
[38] September 9, 2013 telephone communication with Jeffrey Wallin, Director, Vermont Criminal Information Center.

[39] Jan Hefler, "NJ Marijuana Patients Now At 1000 But Most Just Wait," June 26, 2013 http://www.philly.com/philly/blogs/burlington/NJ-Marijuana-Patients-Now-At-1000-But-Most-Just-Wait.html#wMH280orSBtWcJ5W.99

[40] September 9, 2013 telephone communication with New Jersey Department of Health Medicinal Marijuana Program staffer.

[41] Email from program director John O'Brien, March 19, 2013.

FY 2012, the program took a portion of one staffer's time, totaling $13,410 in personnel costs. The program was also spending $5,272.75 to send out cards and incurring $3,594.64 printing ID cards.[42]

Hawaii officials did not respond to requests for information. The state has a registry program for patients and caregivers, but it does not have a dispensary program. The Hawaii program is run by the state Department of Public Safety's Narcotics Division, but is moving to the health department pursuant to a law passed in 2013. Patients' annual fee is $35.

Nevada's program currently only includes a patient and caregiver registry, but in 2014, it will expand to include a regulated medical marijuana industry. The program is run by the state Health Division, which charges patients $50 for an application and $150 to process the application each year. In addition, patients must pay $11-$22 to the DMV for the ID card and $4-$20 for fingerprinting. Nevada's program has generated such a substantial surplus that one state legislator proposed transferring $700,000 from the fund to substance abuse education each year for the next two years.[43]

Nevada's dispensary law will reduce the maximum patient fee to $100.[44] It sets a schedule of fees for medical marijuana dispensaries (of which there may be up to 66), medical marijuana cultivation facilities, infused product manufacturers, testing laboratories, and staff. The initial fees range from $3,000 for a cultivator to $30,000 for a dispensary. Renewal fees range from $1,000 to $5,000. Annual staff ID cards will be $75. Finally, in addition to standard sales taxes, there is also a 2% excise tax at the wholesale level and a 2% excise tax at the retail level.

Delaware, **Massachusetts**, **Washington D.C.**, **New Hampshire**, and **Illinois**' laws were all enacted recently, between 2011 and 2013. All five jurisdictions are in the process of implementing their programs, so it is too soon to determine their total costs or revenue. They will all regulate dispensaries and issue patients and caregivers ID cards.

In **D.C.**, the District began licensing patients, cultivation locations, and dispensaries in 2012-2013, though the law passed in 2011. The health department is charging $100 per year for patient and caregiver ID cards, but low-income patients and caregivers instead pay $25 per year. Dispensaries are charged $10,000 annually for a registration, and cultivation centers are charged $5,000 annually.[45] In addition, both dispensary and cultivation center applications are $5,000, $2,500 of which is non-refundable. Dispensary and cultivation center directors, officers, members, agents, and incorporators' fees are $200, while managers' are $150, and employees' are $75.[46]

There are currently three medical marijuana dispensaries and three cultivation facilities operating within the city limits. There is a 6% tax on the gross receipts for medical marijuana sales. The health department has not responded to requests for a breakdown of total revenue and expenses, nor did it provide a number of identification card holders.

The **Delaware** Medical Marijuana Act took effect on July 1, 2011. The law calls for three dispensaries ("compassion centers") to be open statewide. However, due to concerns from Gov. Jack Markell, the Delaware Department of Health and Social Services delayed implementation of compassion center rules, and then — in draft rules released on October 1, 2013 — reduced the number of compassion centers to only one. Those concerns were based on mixed signals from the U.S. Department of Justice, which has clarified its position since Gov. Markell announced the requested changes to the program.

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[42] Email communication with Andrew Jessen, March 18, 2013.
[43] "Bill: Divert Nevada medical marijuana money for treatment," *Reno Gazette-Journal*, May 1, 2011.
[44] SB 374 (http://www.leg.state.nv.us/Session/77th2013/Bills/SB/SB374_R3.pdf)
[45] http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Rulemaking_for_MMP_2013.pdf
[46] http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/1210MMPDirector_etalFinal.pdf

As a result of the lack of access to medical marijuana, very few patients have registered, resulting in very limited revenue. Delaware's proposed rules would charge a non-refundable $5,000 application fee to compassion centers. Any compassion centers that are approved would pay a $40,000 annual fee. Patients and caregivers are charged $125 annually for medical marijuana identification cards.

On June 1 2012, **Connecticut** Gov. Dannel Malloy signed a bill to legalize medical marijuana for severely ill patients. Under the state's law, patients may not grow their own medical marijuana. Instead, patients will obtain marijuana from a registered dispensing facility, which in turn will obtain marijuana from a licensed producer. The Department of Consumer Protection proposed draft rules in 2013, which were approved and are now final. The state charges producers far more than other states do for application fees, which may reduce access significantly.

The department requires a non-refundable $25,000 application fee from producers, plus an additional $75,000 annual fee if they are accepted.[47] For dispensaries, the department requires an initial non-refundable application fee of $1,000. If accepted, there is a $5,000 fee for registration and a yearly renewal fee of $5,000.[48]

As of October 15, 2013 1,115 patients have been registered into Connecticut's medical marijuana program.[49] They are charged $100 each for the registration. Caregivers are charged $25. The state has not responded to requests for any additional information on expenses and revenue for the new program. As of October 17, 2013, the state has issued a request for producer applications, but it has not yet licensed producers and dispensary facilities.

On November 6, 2012, **Massachusetts** voters approved Question 3 with 63% voting in favor of establishing a medical marijuana program. Once the law is fully implemented, there should be up to 35 non-profit dispensaries statewide.

Prospective medical marijuana dispensaries are now applying through a two-phase application process. Applicants were required to pay a $1,500 fee for submission and consideration of the Phase 1 application. The Department of Public Health reported receiving 181 dispensary applications by its August 22, 2013 deadline.[50] That generated $271,500 in application fees. Of those applicants, 158 were approved to submit a Phase 2 application. Those that qualify for a Phase 2 application must pay $30,000 to be considered. All of the fees are non-refundable. Dispensaries that are selected will be required to pay a $50,000 annual fee for a certificate of registration. There will also be a $500 annual registration fee for each dispensary agent.[51]

Patients are charged $50 per year for applications. Patients who demonstrate a hardship, including a financial hardship, may be eligible to cultivate a modest supply of their own marijuana. An application for a hardship cultivation license is $100.

On July 23, 2013, Gov. Maggie Hassan signed a bill to allow seriously ill **New Hampshire** residents access to medical marijuana. Currently, New Hampshire is in the process of rulemaking and implementation. Under this law, the state is expected to allow four non-profit alternative treatment centers (dispensaries). ATCs are unlikely to open before late 2014, and the patient registry will

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[47] http://www.ct.gov/dcp/cwp/view.asp?a=4287&q=527988
[48] http://www.ct.gov/dcp/cwp/view.asp?a=4287&q=527978
[49] http://www.ct.gov/dcp/cwp/view.asp?a=4287&q=533228&dcpNav=|&dcpNav_GID=2109

[50] Dan Ring, "Massachusetts releases list of 181 applications for medical marijuana stores," *Mass Live*, August 23, 2013.

[51] http://www.mass.gov/eohhs/gov/newsroom/press-releases/dph/applications-for-registered-marijuana-dispensaries-.html

probably not be available before 2014. The law did not specify the fee structure for ATCs or patient and caregiver applications.

On August 1, 2013, **Illinois** became the most recent state to authorize a medical marijuana program, when Gov. Pat Quinn signed HB 1. Illinois' medical marijuana law will become effective on January 1, 2014. At that point, three state departments will have four months to implement rules, including setting a fee structure for patients, dispensaries, and cultivation centers. The state plans on having 60 dispensaries around the state, with 22 cultivation centers statewide. Illinois also plans on a 7% excise tax and a 1% sales tax for medical marijuana.[52]

Finally, **Washington**'s law is the only one of the 21 that does not provide for a registry card, and there are also no state-regulated dispensaries. Voters, however, approved regulating and taxing marijuana for sales to all adults. Any adult 21 or older will be able to buy marijuana beginning in mid-2014.[53]

[52] http://www.ilga.gov/legislation/98/HB/PDF/09800HB0001lv.pdf
[53] The fiscal analysis for I-502 is available at http://vote.wa.gov/guides/2012/I-502-Fiscal-Impact.html

State	Registered Patients	State Regulated Dispensaries	Breakdown of Expenses	Fees	Total Annual Revenues	Total Annual Expenses
Alaska (population 731,449)	917 patients and caregivers (2012)	No.	Personnel: $13,410 Printing cards: $3,594.64 Mail: $5,272.75	$25 per patient or caregiver; $20 for renewal	Estimated $20,632.50 (FY 2012)	$22,277.39 (FY 2012)
Arizona (population 6.55 million)	40,328 (as of 10/02/13)	98 have been approved, 70 are open as of October 2013.	Salaries, wages and benefits: $570,972 Operating expenses: $1,505,023 Capital equipment**:** $304,464	$5,000 dispensary application fee, $1,000 renewal; $150 per patient, $75 reduced fee for low-income applicants; $200/patient for caregivers; $500 for dispensary agents; 6.6% sales tax	$7,945,277 (FY 2012) plus tax revenue	$2,380,459 (FY 2012) At least some of the surplus is used for interagency expenses, including a lawsuit where Arizona sought unsuccessfully to overturn the law.
California (population 38.04 million)	5,798 patients and 396 caregivers in FY 2012/2013	No, all dispensary regulation is local. (Under state law, they are called collectives and cooperatives.)	Registry program: two full-time, one supervisor; operating expenses and equipment; and indirect costs.	$66 per card to the state, $33 reduced fee for Medi-Cal patients; dispensary fees vary by locality; 7.5% sales tax; local taxes varies	$457,000 to the state registry program (FY 2011-2012); state sales tax: est. up to $100 million	$276,000 for state registry (FY 2011-2012)
Colorado (population 5.19 million)	109,622 (as of 08/31/13)	Yes, in 2012, there were 532 medical marijuana centers (dispensaries) as well as 1,459 infused products manufacturers and cultivation facilities.	The health department (patient registry) did not respond; the Medical Marijuana Enforcement Division (MMED) has 15 staff	$35 patient fee; Annual state dispensary fee: $3,750-$14,000; Annual infused products maker or cultivation fee: $2,750 (applications are more); 2.9% state sales tax; local sales tax varies	MMED revenue: $2.7 million ($3.8 million the prior year); Registry: $3.8 million; State sales taxes: $5.4 million; Local sales taxes: >$6 million	MMED: $2.1 million ($5.2 million the previous year) Health department (patient registry) did not respond, but the fees are set to cover costs, so it was no more than $3.8 million.

State	Registered Patients	State Regulated Dispensaries	Breakdown of Expenses	Fees	Total Annual Revenues	Total Annual Expenses
Connecticut (population 3.59 million)	1,115 (as of 10/15/13)	Yes, there will be a number of dispensaries that is TBD and three to 10 growers.	N/A — The law passed in 2012 and has not been fully implemented yet.	Producers: non-refundable $25,000 application fee and $75,000/year; Dispensaries: non-refundable application fee of $1,000 and $5,000/year; Patients: $100; Caregivers: $25	N/A	N/A
Delaware (population 917, 092)	21	On hold, there would have been three initially, now only one.	Not available	Patient fee: $125; Compassion center rules have not been promulgated yet	Not available, and program is mostly stalled	Not available, and program is mostly stalled
D.C. (population 617,996)	Not available	Six cultivation centers and four dispensaries have been approved. Three dispensaries and three cultivation facilities are open as of October 2013.	Did not respond to inquiry	$5,000 dispensary and grower applications; $5,000 annual fee for cultivators; $10,000 annual fee for dispensaries; $75-200 per staffer; patient and caregivers: $25 or $100; 6% sales tax	Unknown, $60,000 just from the existing cultivator and dispensary annual fees, plus ID cards	Unknown, did not respond to inquiry
Hawaii (population 1.39 million)	11,695	No	Did not respond to inquiry	$35 annual patient fee	At least $409,325	Did not respond to inquiry
Illinois (population 12.88 million)	N/A — program is not yet operational	Yes, the state plans to allow 60 dispensaries statewide and 22 growers.	N/A — program is not yet operational	N/A — program is not yet operational	N/A — program is not yet operational	N/A — program is not yet operational

State	Registered Patients	State Regulated Dispensaries	Breakdown of Expenses	Fees	Total Annual Revenues	Total Annual Expenses
Maine (population 1.33 million)	Registry is voluntary to patients, 1,455 are registered	Yes, eight nonprofit dispensaries.	Staff: $119,460.65 Other: $346,567.80.	$15,000/year per dispensary; staff IDs: $25; no patient fee; $300/patient for most caregivers; 5% sales, plus 7% meals/rooms taxes for edibles	$612,370 in fees in 2012, plus $265,655 in sales tax	$466,028.45 was expended through December 31, 2012
Massachu-setts (population 6.45 million)	N/A — program is not yet operational	Yes, 35 should open in 2014.	N/A — program is not yet operational	Dispensary non-refundable application fees: $1,500 (Phase 1), $30,000 (Phase 2); Annual fee: $50,000; Patients: $50/year, $100 for hardship cultivation certificates	Not yet available, dispensary application process is not done	N/A — program is too new
Michigan (population 9.89 million)	128,441 (as of 05/31/13)	No.	One manager, 16 full-time, 7 temp staff, one student	$100 per patient; reduced fee $25; $100/patient for caregivers	$9.9 million (FY 2012)	$3.6 million (FY 2012)
Montana (population 1.01 million)	7,150 (as of 10/01/13)	No.	Has not provided updated information yet	$75 per year per patient application; $50 per provider per year	At least $550,900 in the past year	Unknown, but significantly less than the revenue
New Hampshire (1.32 million)	N/A — program is not yet operational	Yes, but officials have until January 2015 to establish rules for dispensaries.	N/A — program is not yet operational	N/A — program is not yet operational	N/A — program is not yet operational	N/A — program is not yet operational
New Jersey (population 8.87 million)	1,200 (as of 09/09/13)	One opened in 2012, five more were approved but are not yet open.	12 full-time (FTE), one part-time; MOA with other agencies for various services	$20,000 dispensary fee each year; $2,000 for unsuccessful applicants; $200 or $20 patient ID card fee; 7% sales tax	Should exceed $300,000, not counting sales tax	Current budget: $784,000; Total expected budget for FY 2014: $1.4 million

State	Registered Patients	State Regulated Dispensaries	Breakdown of Expenses	Fees	Total Annual Revenues	Total Annual Expenses
New Mexico (population 2.09 million)	9,760, 3,119 of which have received licenses for personal cultivation (as of 08/30/13)	Yes, 23 "licensed producers."	Seven full time staff; office supplies, telephone, mileage, lab testing, attorney fees, mail costs, office expenses	$30 cultivation license for some patients; $1,000 producer application; annual producer fee: $5,000-$30,000; gross receipts tax of 5.125% to 8.8675%	$598,000 in program fees (FY 2013), $650,402 in gross receipts tax (2012 estimate)	$598,000 (FY 2013)
Nevada (population 2.76 million)	4,322 (as of 09/04/13)	Not yet; there will be up to 60 dispensaries, plus infused products makers, growers, and labs.	Unknown, did not respond to inquiries	Annual patient fees total at least $165-$192; will be reduced to $100 Initial fees range from $3,000 for a cultivator to $30,000 for a dispensary. Renewal fees range from $1,000 to $5,000. Staff IDs: $75 2% excise tax at wholesale and retail level	Exceeds $713,000 in the past year	Did not respond to inquiry, but generated enough of a surplus that a legislator proposed siphoning off $700,000/year
Oregon (population 3.9 million)	55,937 (as of 07/01/13)	Not yet; dispensary law passed in 2013 and they will be registered in 2014.	As of 2011, 24 full-time staff; travel for advisory committee meetings; IT support, including database; office expenses	$200 per patient; reduced fees of $60 (food stamps), $50 (state health program), and $20 (SSI benefits); $50 grow site fee for applications in which patient is not cultivator	Est. at $6 million (Est. $12 million for the 2011-13 biennium)	Est. at $2.65 million (Est. $5.3 million for the 2011-13 biennium; expenses in the biennium: $29,478)

State	Registered Patients	State Regulated Dispensaries	Breakdown of Expenses	Fees	Total Annual Revenues	Total Annual Expenses
Rhode Island (population 1.05 million)	5,941 (as of 09/09/13)	Yes, three "compassion centers" were approved. Two centers are open; it is unclear when the third will open.	Staff: the equivalent of 3.35 full-time as of Jan. 2013; shared card machine with other licensing program	Compassion centers: $250 application fee; $5,000 registration fee; $100 staff fee; $20 or $100 patient fee; $200 caregiver fee	$566,655 2011-2012 combined, without taxes (Note: ID card fees all increased at the end of 2012)	$589,086.16 for 2011-2012, combined
Vermont (population 626,011)	846 (as of 09/09/13)	Two dispensaries are open as of June 2013. Two more dispensaries are set to open in the near future.	One full time staffer, one part-time staffer, software, office supplies	$50 annual fee for patients and caregivers; $2,500 application fee for dispensaries; annual registration fee of $30,000 ($20,000 in first year) for dispensaries	Estimated $140,800 for FY 2013. Revenue expected to increase with more dispensaries and fees.	Estimated $138,500 for FY 2013
Washington (population 6.9 million)	N/A – no registry	No, but the state will allow regulated, taxed sales of marijuana to all adults 21 and older in late 2013.	N/A	N/A	N/A	N/A

Analysis Data

The following presents a variety of analysis methodologies to determine a range of estimates of possible Florida medical marijuana registrants.

Estimates of Medical Marijuana Users in Florida

A. Summary of estimates of medical marijuana users in Florida in 2015 by various estimation approaches

Estimates of Florida Medical Marijuana Users

Estimation Approach	April 1, 2015
I. States with medical marijuana laws	452 to 417,252
II. Disease prevalence	1,295,922
III. Disease incidence	116,456
IV. Use by cancer patients	173,671
V. Deaths	46,903
VI. Self-reported marijuana use	1,052,692 to 1,619,217
Range	**452 to 1,619,217**

B. Description of estimation approaches

I. Medical marijuana registrants in states that have legalized medical use of marijuana

Estimated Marijuana Users for Certain Medical Conditions in Florida
Based on Registered Users in States with Legalized Marijuana for Medical Conditions
Ranked by Estimated Florida Users

State	Year Passed[1]	Report Date	Patient Registry	Marijuana Users[2]	Population[3] (2012)	Percent of Population	Florida Estimates (2012)[4]	Florida Estimates (2015)[5]
Colorado	2000	2013	Mandatory	109,622	5,187,582	2.11%	403,074	417,252
Oregon	1998	2013	Mandatory	58,484	3,899,353	1.50%	286,086	296,149
California	1996	2012	Voluntary	553,684	38,041,430	1.46%	277,624	287,389
Washington	1998	2013	None	99,943	6,897,012	1.45%	276,403	286,126
Michigan	2008	2013	Mandatory	128,441	9,883,360	1.30%	247,885	256,605
Hawaii	2000	2012	Mandatory	11,183	1,392,313	0.80%	153,205	158,594
Montana	2004	2013	Mandatory	7,150	1,005,141	0.71%	135,685	140,457
Arizona	2010	2013	Mandatory	38,564	6,553,255	0.59%	112,247	116,196
Rhode Island	2006	2013	Mandatory	4,849	1,050,292	0.46%	88,063	91,161
New Mexico	2007	2012	Mandatory	9,607	2,085,538	0.46%	87,866	90,957
Alaska	1998	2012	Mandatory	1,246	731,449	0.17%	32,493	33,636
Nevada	2000	2013	Mandatory	4,449	2,758,931	0.16%	30,759	31,841
Maine	1999	2012	Voluntary	1,455	1,329,192	0.11%	20,880	21,614
Vermont	2004	2012	Mandatory	559	626,011	0.09%	17,033	17,632
New Jersey	2010	2012	Mandatory	239	8,864,590	0.00%	514	532
Delaware	2011	2012	Mandatory	21	917,092	0.00%	437	452
Connecticut	2012	N/A	Mandatory	N/A	3,590,347	N/A	N/A	N/A
DC	2010	N/A	Mandatory	N/A	632,323	N/A	N/A	N/A
Massachusetts	2012	N/A	Mandatory	N/A	6,646,144	N/A	N/A	N/A

Note:
Florida 2015 estimates were developed by applying the 2012 use rates to Florida's April 1, 2015 population. The rates are not age-adjusted. The estimation assumes usage rates will remain the same.

Sources:
[1] ProCon.org, http://medicalmarijuana.procon.org/view.answers.php?questionID=001199, Last updated Dec 2012, accessed Sep 25, 2013.
[2] The Office of Economic and Demographic Research obtained 2013 data for Colorado, Oregon, Washington, Michigan, Montana, Hawaii, Arizona, Rhode Island, and Nevada (see notes below by state). The estimates for the remaining states were developed by the Marijuana Policy Project and published by ProCon.org, http://medicalmarijuana.procon.org/view.answers.php?questionID=001199, Last updated Dec 2012, accessed Sep 25, 2013.

Arizona:	This is a count of active qualifying patient cardholders (individuals) as of August 2013; application counts are higher than cardholder counts because individuals can have more than one application; This count excludes caregiver and dispensary counts; patients are often caregivers and/ or dispensaries; Arizona Department of Health; Arizona Medical Marijuana August 2013 Report, http://www.azdhs.gov/medicalmarijuana/documents/reports/arizona-medical-marijuana-end-of-year-report-2012.pdf
Colorado:	This is a count of the number of patients with valid ID cards as of August 2013; Colorado Department of Public Health and Environment, Medical Marijuana Registry; http://www.colorado.gov/cs/Satellite/CDPHE-CHEIS/CBON/1251593017044
Hawaii:	This is a count of registered patients as of June 2012, Hawaii Department of Public Safety, Narcotics Enforcement Division, Annual Report 2012, http://dps.hawaii.gov/wp-content/uploads/2013/02/PSD-ANNUAL-REPORT-2012.pdf
Maine:	Voluntary patient registry effective December 31, 2012. Maine Department of Health and Human Services, Medical Use of Marijuana Program, 2012 Annual Report, http://www.maine.gov/dhhs/dlrs/mmm/annual-report.pdf
Michigan:	This is a count as of May 2013, Michigan Department of Health, http://www.michigan.gov/lara/0,4601,7-154-35299_63294_63303_51869_60731---,00.html
Montana:	This is a count of active patients as of September 2013, Montana Marijuana Program, Department of Public Health and Human Services, http://www.dphhs.mt.gov/marijuanaprogram/mmpregistryinformation.pdf
Nevada:	This is a count of current patient cardholders as of October 2013, Nevada Health Division, Medical Marijuana Program, http://health.nv.gov/PDFs/MMP/Reports/2013-09_MedicalMarijuanaReport.pdf
New Mexico:	This is a count as of August 2013, http://www.abqjournal.com/245506/news/new-light-shed-on-nm-medical-marijuana.html
Oregon:	Counts are as of October 1, 2013, Oregon Health Authority, Medical Marijuana Program, http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/Pages/data.aspx
Rhode Island:	This is a count of registered patient cardholders as of January 2013, Rhode Island Department of Health, Medical Marijuana Program, http://www.health.ri.gov/publications/programreports/MedicalMarijuana2013.pdf
Washington:	No patient registry. Estimate confirmed with Washington Department of Revenue. Washington does not have a registry, so counts of medical marijuana patients are not kept.

[3] U.S. Census Bureau, Population Division, Annual Estimates of the Population for the United States, Regions, and States: July 1, 2012, released December 2012.
[4] Florida's official April 1, 2012 population estimate was used to generate these estimates.
[5] Florida Demographic Estimating Conference, July 2013, population projection for April 1, 2015 was used to generate these estimates.

II. Disease prevalence[a] (people alive with the disease)

Florida Prevalence of Selected Diseases

Medical Condition	2002-2012	2015
Cancer (2010)[1]	795,135	835,060
Hepatitis C (2002-2006)	300,000	326,289
HIV (2012)	130,000	134,573
Total cancer, hepatitis C, and HIV	**1,225,135**	**1,295,922**

Notes:
Estimates include cancer, hepatitis C, HIV, and ALS prevalence rates. Prevalence rates for the remaining specified conditions in the petition initiative were not identified but they are expected to be relatively low.
[1] Estimates for cancer were developed by applying a national cancer prevalence rate to the Florida April 1, 2010 population.
Florida 2015 estimates were developed by applying the 2002- 2012 prevalence rates to Florida's April 1, 2015 population. The rates are not age-adjusted. The estimation assumes prevalence rates will remain the same.

Sources:
Cancer complete prevalence 2010 data, Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov). Prevalence database: "US Estimated Complete Prevalence Counts on 1/1/2010". National Cancer Institute, DCCPS, Surveillance Research Program, Data Modeling Branch, released April 2013, based on the November 2012 SEER data submission.
Hepatitis C complete prevalence 2002-2006 data, Florida Department of Health, Hepatitis C surveillance report 2002-2006, published 2009, http://www.doh.state.fl.us/disease_ctrl/aids/hep/5_Year_Report_Jan2_09_FINAL.pdf.
HIV prevalence 2012 data, Florida Department of Health, 2012 HIV/AIDS Annual report, http://www.doh.state.fl.us/disease_ctrl/aids/trends/epiprof/HIVAIDS-annual-morbidity-2012.pdf.
Florida Demographic Estimating Conference, July 2013, population projection for April 1, 2015.

III. Disease incidence[b] (newly diagnosed with the disease)

Florida New Cases with Selected Diseases

Medical Condition	2011	2015
Cancer (2009)	103,783	109,658
Hepatitis C	100	104
HIV	6,046	6,315
ALS (Lou Gehrig's disease)	362	378
Total cancer, hepatitis C, HIV, & ALS	**110,291**	**116,456**

Notes: Estimates include cancer, hepatitis C, HIV, and ALS incidence rates. Incidence rates for the remaining specified conditions in the petition initiative are not available.
Florida 2015 estimates were developed by applying the 2011 prevalence rates to Florida's April 1, 2015 population. The rates are not age-adjusted. The estimation assumes incidence rates will remain the same.

Sources:
Florida Department of Health, 2011 Annual Morbidity Report, http://www.doh.state.fl.us/disease_ctrl/epi/Morbidity_Report/Section3.pdf.
Florida Department of Health, Florida ALS Surveillance Project.
Florida Demographic Estimating Conference, July 2013, population projection for April 1, 2015.

[a] Prevalence represents the proportion of people alive on a certain day who were diagnosed with the disease, regardless of how long ago the diagnosis was made; National Cancer Institute definitions; complete prevalence: http://surveillance.cancer.gov/prevalence/complete.html; limited prevalence: http://surveillance.cancer.gov/prevalence/limited.html
[b] Incidence: number of new cases during a given time period; National Institute of Health definition: http://painconsortium.nih.gov/symptomresearch/chapter_19/sec4/cihs4pg1.htm

IV. Use rates by cancer patients

Florida Medical Marijuana User Estimates Based on Average Medical Marijuana Usage Rates among Cancer Patients across Seven States

Population Categories	2011	2015
Population with cancer	795,135	835,060
Medical marijuana users	5,622	5,905
Total medical marijuana users	**165,368**	**173,671**

Note:
Using counts for medical marijuana use by cancer patients and cancer prevalence data across the seven states in the table below, an average share of marijuana users among cancer patients was calculated. The share was applied to the Florida cancer population to estimate Florida marijuana users with cancer. The average share that cancer patients represent among all marijuana users from the table below was applied to the estimate of Florida marijuana users with cancer to estimate the total Florida population that may use medical marijuana. The estimation assumes usage rates will remain the same.

Sources
100,000 Reasons: Medical Marijuana In The Big Apple, Appendix: Methodology, New York City Comptroller John C. Liu, August 2013.
Cancer complete prevalence 2010 data, Surveillance, Epidemiology, and End Results (SEER) Program (www.seer.cancer.gov). Prevalence database: "US Estimated Complete Prevalence Counts on 1/1/2010". National Cancer Institute, DCCPS, Surveillance Research Program, Data Modeling Branch, released April 2013, based on the November 2012 SEER data submission.
Florida Demographic Estimating Conference, July 2013, population projection for April 1, 2015

Cancer Patients Using Medical Marijuana for Selected States

A	B	C	D	E	F	G
					Cancer Patients Using Marijuana	
State	Population	Total Users of Medical Marijuana	Users of Medical Marijuana with Cancer	Cancer patients	% of All Cancer Patients	% of Total Users of Medical Marijuana
Arizona	6,392,017	36,634	696	270,327	0.26%	1.90%
Colorado	5,029,196	106,817	2,843	212,692	1.34%	2.70%
Hawaii	1,360,301	11,164	152	57,529	0.26%	2.00%
Michigan	9,883,640	124,131	2,526	417,993	0.60%	2.10%
Nevada	2,700,551	4,173	143	114,210	0.13%	3.40%
Oregon	3,831,074	55,937	2,332	162,021	1.44%	4.20%
Rhode Island	1,052,567	4,849	354	44,515	0.80%	7.30%
Total/ Average	**30,249,346**	**343,705**	**9,046**	**1,279,287**	**0.71%**	**3.40%**

Source:
100,000 Reasons: Medical Marijuana In The Big Apple, Appendix: Methodology, New York City Comptroller John C. Liu, August 2013.

V. Deaths from specified diseases (as primary cause of death)

Florida Deaths by Selected Causes

Primary Cause of Death	2012	2015
Cancer	41,696	43,235
Glaucoma	N/A	N/A
HIV	923	957
AIDS	N/A	N/A
Viral Hepatitis	523	542
Amyotrophic lateral sclerosis (ALS)	N/A	N/A
Crohn's disease	89	92
Parkinson's disease	1,824	1,891
Multiple sclerosis	178	185
Total	**45,233**	**46,903**

N/A – not available
Note:
Data for hepatitis C only were not available; data for viral hepatitis were used instead.
Florida 2015 estimates were developed by applying the 2012 cause of death rates to Florida's April 1, 2015 population. The rates are not age-adjusted. The estimation assumes death rates will remain the same.

Sources:
Florida Department of Health, Florida Vital Statistics Annual Report 2012.
Florida Demographic Estimating Conference, July 2013, population projection for April 1, 2015.

VI. Self-identified marijuana users from the 2011 National Health and Drug Use Survey

(This approach was used to estimate the potential number of recreational marijuana users in the fiscal impact statement for the Washington State initiative to legalize recreational marijuana)

Florida Self-Reported Marijuana Use[1]

Age Group	Marijuana Users	2011	2015
Population 18-24	31.19%	544,678	566,525
Population 25+	7.61%	1,001,331	1,052,692
Total		**1,546,009**	**1,619,217**

[1] Has used marijuana once or more times during the past year.

Note:
Marijuana use rates for 18-25 and 26+ groups for Florida for 2011 were applied to Florida's April 1, 2011 and 2015 population estimate/projection for ages 18-24 and 25+ groups, respectively. The estimation assumes usage rates will remain the same.

Sources:
Substance Abuse & Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011 (2010 Data - Revised March 2012), http://www.samhsa.gov/data/NSDUH/2k11State/NSDUHsaeTOC2011.htm.
Florida Demographic Database, August 2013 based on results from the Florida Demographic Estimating Conference, February 2013 and the Florida Demographic Estimating Conference, July 2013.