How can the draft rules be improved?

Open-Ended Response

We could improve on some rule by just plain removing them. They are going to cause more harm than good. I believe that rules R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). • Any Arizona physician may in a single visit prescribe "speed," e.g., Adderall, to a kindergartner-without 4 visits spread out over 1 year any Arizona physician may prescribe to a kindergartner a drug that can kill that child by heart attack, stroke, seizures, or other "side effects." • Cancer, HIV, Hepatitis C, and ALS patients often do not have 1 year to live. • The patients that do live are cruelly being told to change doctors or suffer for 1 year. • Deadly and addictive drugs such as the opiates are prescribed in a single visit by Arizona physicians and, despite the best efforts of physicians, some of those deadly and addictive drugs are illegally diverted, but that does not cause the AzDHS to demand 4 visits, 1 year of visits, or that the pain specialist assume primary care of the patient. • Marijuana is 100% safe, gives patients good relief, and cures some conditions-Marijuana is not deadly and is not addictive. • The alternative offered by the AzDHS to avoid 1 year of suffering, the cannabis specialist takes over the primary care of the pt's qualifying condition, is done nowhere else in medicine-Nowhere else in medicine does a specialist take over a patient's primary care. • The AzDHS does not have the authority to define or re-define the patient-physician relationship or the number of doctors visits, or the length of time for those visits-that infringes on the patient's choice • The draft regulations are cruel and unreasonable. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine.

The provisions calling for ADHS to decide what are future covered illnesses are ludicrous. It should be solely the responsibility of the doctor recommending marijuana to make that call. It will cost millions in lawsuits,administrative costs and manpower and serves no purpose to create another branch of ADHS to provide oversight here when the doctors carry malpractice insurance and are going to be well paid for their recommendations..Also unless docotrs the administrators at ADHS have absolutely no business making this call. It is also an invitation to lawsuits to require any more of a patient or doctor regarding

a marijuana recommendation then for any other prescription. Most of the poor and uninsured have not bee to a doctor four times in the last year for anything,much less a coninued chronic condition. This provision will make medical marijuana only available to those who can afford a family doctor and are well insured. Your own statistics should have shown this.
There is no legitimate reason a patient cannot grow their own Medical Cannabis in the security and comfort of their own home, regardless of the 25 mile rule. The reason, is because you wouldn't be able to control the people and we all know the government is about control.
R9-17-101: 16 – "Ongoing" – I have glaucoma and would qualify as a patient. My doctor objects to Medical Marijuana and has told me in the past he will never prescribe it. I believe I would have to change doctors in order to change medicines if I decide that this medicine may be cheaper/better suited/more natural etc and that will take time under the ongoing rules. I think it should be able to be prescribed immediately by a qualified physician once a condition has been properly documented without changing health care providers. permanently. A doctor can adequately assess a patient's need for medical marijuana in a single visit. 16(b) provides for the important ongoing monitoring of the patient's progress, and is good for monitoring after the fact instead of a year before the fact when the patient needs medicine. R9-17-307 – C(1) – The 70/30 rule will create shortages for patients in rural areas and increase prices across the state because facilities better suited to cultivation will not be able to adequately supply those better suited to dispensing. Please reject this rule in favor of a open relationship that does not impose supply restrictions. R9-17-310 – Other health professionals are capable of serving in the role of medical director. As written this is too restrictive because of the continued illegality of medical marijuana on the federal level and many doctors' hesitance to embrace "new" medicines soon after they are made available. R9-17-311,12 – Maintaining dispensary records for five years is excessive, and records should be kept by patient and caregiver ID, not name.
How do you plan to ensure that outside sources, like cartels and undesirable financial sources, from other states are not funding any of the registered dispensaries. In other states any share holder with greater than 5% share must have a back ground check as well, because otherwise what is to keep a cartel from fully funding a dispensary, just put under another Arizona residents name? • R9-17-302.B.15.d asks, "Whether the dispensary has a surety bond and, if so, how much." will you be looking into these surety bonds to help determine the source, to see if this is the case?
The definition of "Medical Director" must be expanded to include Naturopathic Physicians. As the definition is written now in the draft rules, "Medical Director" means "a doctor of medicine who holds a valid and existing license to practice medicine pursuant to A.R.S. Title 32, Chapter 13 or its successor or a doctor of osteopathic medicine pursuant to A.R.S. Title 32, Chapter 17 or its successor and who has been designated by a dispensary to provide medical oversight at a dispensary." This definition has wrongly omitted a licensed Naturopathic Physician. Naturopathic Physicians are certainly no less capable of performing the duties of a Medical Director, and in fact may be in a better position to guide the alternative care required for medical marijuana patients. According to the Association of Accredited Naturopathic Medical Colleges "naturopathy is a traditional approach to health that is holistic, meaning that it encompasses the whole being. It is based on natural and preventative care. Naturopathic medicine combines many methodologies, such as acupuncture, massage, chiropractic adjustment, homeopathy and herbal cures, along with sensible concepts such as good nutrition, exercise and relaxation techniques. The exclusion of Naturopathic Physicians is not only illogical but is also unfounded based on the language of existing statutes and the language of Prop 203. For example the education and licensure requirements for Naturopaths are no less stringent than those for M.D. and both are afforded nearly identical authority to treat patients (See A.R.S. Title 32, Chapter 14). Further, Naturopaths have specialized education in botany and herbal therapies, making them uniquely qualified

to serve as Medical Directors for a dispensary. Excluding them from serving as Medical Directors does a severe disservice to patients. Finally Naturopaths qualify as a “Physician” as defined in Proposition 203 §36-2801(12). Thus, Naturopathic Doctors will be permitted to recommend MM to patients under State Law. How then can they be excluded from serving as Medical Directors? This seems contrary to the intent of the law at best and discriminatory and potentially illegal at worst. Naturopathy is a legitimate and widely accepted field that focuses on natural and primarily non-invasive therapies to treat disease, stimulate healing, and promote overall health. Naturopaths are trained to understand the way herbs and homeopathic remedies affect the body. Since, licensed Naturopathic Physicians can and likely will legally recommend the use of MM to patients according to State Law, it seems axiomatic that the same credentials should entitle a person to work as a Medical Director at a MM Dispensary. Further, Naturopathic doctors above other professionals included in the definition of “Physician” set out in Proposition 203 §36-2801(12), are uniquely qualified to understand and oversee the use of MM by registered users, because they understand how natural remedies effect the body.

- The recommending physician should not be compensated (directly or indirectly) from any dispensary. -Registry ID Cards should only be issued first to the terminally ill then six month later to those diagnosed with a qualifying disease and finally after 1year to those with severe nausea and/or chronic pain. (This would be done so that those that truly need the medical marijuana can get it without waiting on those just want to get high.) - Patients "suffering" from severe nausea and/or chronic pain must show proof that they have attempted to treat said affliction for at least one year with conventional medical therapies prior to applying for medical marijuana. (If they cannot show this proof than they are not truly suffering.) - The diagnosis of severe nausea and/or chronic pain can only be made by a doctor of medicine who holds a valid and existing license to practice medicine and not an osteopathic doctor. Since the osteopath is lacking the training to separate a true condition from fraud. - In an effort to stop the "headshop" circus that is happening in California, dispensaries should only be able to sell/dispense the medical marijuana not any other paraphernalia such as syringes, pipes etc. - One problem with the time lines in the draft rules is that if it only takes 30 days to get a registry id card but 90+ days to get a dispensary then every person that gets an id card within the first 90 days will have a license to grow their own marijuana for one year since there is no way that there is a dispensary within their area. - In the section about the ongoing physician/patient relationship it should be "...on at least four visits over at least four months". (This should be done to stop the four visits from being conducted in one setting.)

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1. From your FAQ: "Will there be medical oversight at a dispensary? Yes, a dispensary would be required to employ or contract with a medical doctor or osteopath to be the medical director for the dispensary (informal draft rules R9-17-307(A)(3)) and to carry out the functions described in the informal draft rules (R9-17-310(C)). The term "medical director" is defined in the informal draft rules (R9-17-101(15). A medical director could not provide a written recommendation for medical marijuana to a qualifying patient (informal draft rules A.A.C. R9-17-310(D))." This directly violates the law! You can't do anything to an Arizona Doctor that limits them from writing recommendations! There will also not be many Doctors that will agree to add this position to their current responsibilities. The few who do would need to be available to 15-20 dispensaries (not 3) to make this remotely viable for both parties. This also conflicts with the patients relationship with their own Doctor, the Doctor who has already recommended marijuana and advised them of the potential benefits and dangers of its use. This also creates an undue burden in the form of an expense and as such violates the law: ARS 36-2803.4 . This is completely unnecessary as a Doctor is already advising each and every medical marijuana patient. We want every patient to be very aware of the dangers of using and misusing marijuana, but you need to find a legal way to help us do this. The Medical Director Position is a great idea that just doesn't work in the real world! 2. Surety Bond for a dispensary, R9-17-302, 15-D. You have not released the amount that you would require and due to the nature of this business a bond might be not even be available, or unreasonably expensive. Either way this directly violates the law! Again ARS 36-2803.4 . We do understand your intentions, but this is also a slippery slope heavily in favor of only the abundantly wealthy. 3. Requiring a dispensary applicant to build an operating dispensary and grow operation before a license application would be approved, R9-17-302, B-5. This violates the law! Yet again, ARS 36-2803.4 . If you don't change this, we will be one of thousands of organizations that will sue you. That is not a threat, that is a solemn oath! We agree with the recommended two stage application process. That will meet all your needs and give people a fair chance to not lose their home in order for you to exclude them from competing for a license in a fair contest. Having the people who desire to help the patients that will truly benefit from this, and will do it the right way to the letter of the law is what is best for all of Arizona! Only reasonable financial ability is what is mandated here! 4. The prices for patient licenses. These need to be half of what you have proposed! For some comparison, drivers licenses directly allow people to put other members of society at risk and cost $12 for 25 years! You are pricing these to try and keep people from being able to afford them and those people are our sick and dying. I understand you don't want to give a drug abuser a card for free, but you can't penalize our genuinely suffering because a few people will slip through the cracks. Drop them down to fair and reasonable fees, or it will end up costing much more than what the outrageous amounts bring in to defend them in court and ultimately end up lowering them anyway. This is only the initial draft of the rules and your agencies response appears to be a knee-jerk one to try and kick this law back out of the state! That's simply futile; it's time to except this for all the pros and cons, not just the fears. I'm very glad this is the law here now, and that being said I do not want this to become like Amsterdam, L.A., or Denver! This is about patients, not about potheads. Please do what you can to keep abuse minimal; but don't abuse the patients in the process, that's the line. There also seems to be some blatantly obvious intentions within these rules to support only the filthy rich and exclude all others. I have pointed out numerous examples of this, to prove differently you'll simply have to change your position on some of these issues.

The Rules don't address in Article 2, R9-17-201. "Is a convicted felon" eligible as a qualifing patient or designated caregivers. This should be addressed. In R9-17-205, What is "an excluded felony offense"?

1) Each location where marijuana is produced, infused or sold must have a separate dispensary certification. 2) Caregivers must undergo training (at least 8 hours) on, and pass a test on, the effect and hazards of marijuana, the terms of the initiative, DHS rules governing medical marijuana and applicable laws. 3) Caregivers, Cardholders and Dispensary Agents must be residents of Arizona and must possess an Arizona driver's license or identification card. 4) Private marijuana use "clubs" should be prohibited. 5) Medical professionals that wish to issue medical marijuana certificates must be registered with DHS in order to issue certifications and a reasonable fee should be charged. 6) The medical professional issuing the certification should be given the authority to revoke a patient's certification at any time. In addition, the medical professional should be required to revoke if they haven't seen the patient within 6 months. 7) The legislature should impose criminal penalties for smoking marijuana in public. 8) The legislature should impose criminal penalties for smoking marijuana in the presence of children.

R9-17-101: 16 – "Ongoing" – The definition for ongoing is facially discriminatory in that it discriminates against low-income patients, veterans, and uninsured potential medical marijuana patients. The definition does not follow the purpose of the proposition as voted on by the citizens of Arizona because it serves to deny medical marijuana to those patients who discover shortly before death that they have a qualifying condition. These are some of the people that most need access to medical marijuana, and denying them based on lack of a one-year doctor patient relationship will only serve to frustrate the purpose of the statute. A doctor can adequately assess a patient's need for medical marijuana in a single visit. 16(b) provides for the important ongoing monitoring of the patient's progress, and is good for monitoring after the fact instead of a year before the fact when the patient needs medicine. R9-17-307 – C(1) – The 70/30 rule will create shortages for patients in rural areas and increase prices across the state because facilities better suited to cultivation will not be able to adequately supply those better suited to dispensing. Please reject this rule in favor of a open relationship that does not impose supply restrictions. R9-17-310 – Other health professionals are capable of serving in the role of medical director. As written this is too restrictive because of the continued illegality of medical marijuana on the federal level and many doctors' hesitance to embrace "new" medicines soon after they are made available. R9-17-311,12 – Maintaining dispensary records for five years is excessive, and records should be kept by patient and caregiver ID, not name.

One discrepancy I found was that although Naturopathic Physicians are included in the law as referring physicians, we are not defined in the rules to serve as Medical Directors of the dispensaries. I believe this is an oversight. Naturopathic Physicians, are licensed primary care physicians and also have DEA numbers, so that they can prescribe pharmaceutical drugs as well, when needed. They are covered by some insurances as both in-network & out-of-network providers.

You should be able to grow and dispense in the same building . It would be way more efficient to have them in one building . The money saved from using one building oppose to two would help keep the price of the medicine down . The state would also save having only one building to regulate rather than two . A Dispensary should be able to Grow 100% of it's medicine or Buy 100% of it's medicine from other dispensary's-patients or care givers . Not all dispensary's should have to grow . A Medical director at the dispensary is not needed . Again that's an expense that the patient (already over burdened) does not need . Any medical questions the patient's have should be answered by their own Doctor . The dispensary can answer any questions about marijuana if needed . But the dispensary is just there to dispense . Only the state and patient need to know where the dispensary's are . The state should supply a list of dispensary's to the patient . No advertising needed . The patient first goes to the doctor to get a recommendation . Then the patient goes to state to get a permit and locations of dispensary's . Then the patient goes to the dispensary and buy's the medicine . Then the patient goes home to medicate . The end . We have to have Regulation . But over Regulation should be controlled . Over regulating adds

to the cost and time for the patient and the state .
Re: Draft Rule R9-17-101 (16) The physician-patient relationship and the term described as "ongoing" with "one year" existing relationship and "at least four visits" is my largest concern. Veterans who receive care at the VA Medical Facility have the largest problem establishing a "ongoing" relationship with any physician, due to the high turnover rate of their doctors. In twenty years as a patient at the Phoenix VA, I have never had the same primary care physician for more than 1 year. In addition, since it is a Federal Facility, the doctors are unable to prescribe Medical Marijuana under Federal Law. This means that only Disabled Veterans, must now go to a third party doctor, pay for more than four visits and wait for over a year to receive any medicine to relive their pain and nausea. As there are currently 525,000 veterans in Arizona and the VA estimates 13%- 20% have a Service Connected Disability, this could represent between 68,250 - 105,000 Arizona patients. Is it really fair to force only the Veterans of our State to endure a more expensive, time consuming and prohibitive process than the rest of the patients. In my case I have had the same severe nausea and wasting syndrome, known as Gulf War Syndrome, since 1991 and have piles of Medical Records to prove it. Yet now I must pay another outside doctor for four visits and remain sick for a whole year, due to this language in the draft. Most disabled veterans are on a fixed income and this addition to the law is an unreasonable and extremely costly process for one segment of the population only. In the case of cancer patients, why must they wait for a year, if one doctor does not want to prescribe the medication that the patient believes will work for them. With other medications, one doctor may choose to use a particular drug while another doctor chooses an entirely different course of treatment. Pharmaceutical Representatives visit doctors offices every month to convince the doctor that their medication is better for his patients than the competition. It seems your rules are unfairly targeting Medical Marijuana and are attempting to influence the doctor-patient relationship only in the case of prescribed Medical Marijuana. Why isn't the process the same as it is with other controlled substances, which rely on the doctor to ensure only the right patients get their hands on those drugs? These same doctors are trusted with much stronger medications like cocaine, oxycontin, morphine and others but your draft rules are taking the position that they can't be trusted. It seems your concern over the few who might attempt to get Medical Marijuana, is ensuring that those who actually need it most will not get it.
Although I am not an attorney and have not had time to read through the rules completely, I would suggest the following: 1) Review the suggestions made by MATForce and implement them. They are designed to prevent illicit use and sale of marijuana. Because the colation is headed by the Yavapai County Attorney and the former Chief of Police of Cottonwood, AZ, they are aware of the issues and problems. 2) Review the current medical marijuana laws in states where they exist Reserach the problems those states have had because the rules and laws were not clear. Drug users and dealers will go to great lengths to preserve and enhance the status quo. It's up to you to think outside the box, think like a dealer and a user and outwit them.
Eliminate from the Debilitating Medical Conditions list the following items: 11, and 13. These open the door to abuse. It is far better to begin very stringently, and loosen up at a later date if it is prudent, than to go the other way. The last half of this lise includes repeated use of the term "chronic debilitating disease or medical condition...". "Chronic" and "debilitating" MUST be clearly defined. The definition should include a clearly identifiable pathology, that has been detected by blood or body fluid tests, or by X-rays or other standard medical imaging techniques, Such disease or medical condition must have been treated by a physician, surgeon, or psychiatrist for a minimum of 90 days without remission or significant relief. Chiropractors, and P.A.'s should not be included as eligible caregivers. 2. In your list of Debilitating Medical Conditions you should also define specifically what constitutes

"severe nausea" (#10). There must be some more or less objective criteria. It cannot be left totally up to the patient. That will lead to all sorts of lying and abuse. Here again, the nausea needs to stem from a well-accepted medical condition that has been historically associated with severe nausea. 3. In item #9 you MUST define what "severe chronic pain" is. This should be pain that does not remit even with medically supervised treatment with the strongest known tolerable narcotic analgesic, and has persisted for over 60 days.

Doctor patient relationship I my opinion your requiring that I either have a one year four visit in that year doctor/patient relationship or that if I go to a " pot doctor" your words not mine that this cannabis specialist has to take over that portion of my primary care is flat out ridiculous! Not all of us get free health care from the taxpayers Mr. Humble...I pay every time out of pocket to my primary physician for me and my family. Because my wife and myself make too much for us to be one of the government programs like you and your staff and we have to little to pay for our own insurance. In no other case in Arizona do you the "health department" require that a sick or dying person go to a specialist for that primary care. That is why we call them specialist not primary doctors so you are telling me one of the citizens of this great state of Arizona who this law was voted in for... that I need to leave my primary doctor who I have going to for twenty years and doesn't want to deal with the tracking issue that you will impose. That I now have to go through the yellow pages to find a new primary doctor who not only lets me pay in payments but has an office near by and will want to deal with that 24 hour a day tracking that you and the police department will require....come on this law states reasonable regulations not some arbitrary idea that the current health director decided is a good way to protect society from this hideous and dangerous plant that has never killed anyone! My patient/doctor relationship should be decided by my physician and me not you Mr. Humble.

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doctor who I have going to for twenty years and doesn't want to deal with the tracking issue that you will impose. That I now have to go through the yellow pages to find a new primary doctor who not only lets me pay in payments but has an office near by and will want to deal with that 24 hour a day tracking that you and the police department will require....come on this law states reasonable regulations not some arbitrary idea that the current health director decided is a good way to protect society from this hideous and dangerous plant that has never killed anyone! My patient/doctor relationship should be decided by my physician and me not you Mr. Humble.
This paragraph should be removed and Department should let the local building permit approvals handle it.
The rules need to be made much more strict. These lax rules make it way too easy for people to abuse it!
More strict application
The draft rules should eliminate this requirement because certificates of occupancy are issued after a building is constructed or modified for its intended use, thereby requiring substantial commitment of dispensary resources even when there is no guarantee that a registration would be granted.
I think there are two area that could be improved. First is I believe the security requirements are a bit harsh. My father was a pharmacist for years and he regularly dispensed narcotics. His pharmacy had glass windows seperating the drugs from the avarage person. The Department seems to be treating Marijuana like it's a nuclear bomb that needs to be protected like Fort Knox. I think normal precautions such as the same ones for narcotics in a normal pharmacy would be sufficient. Second, the rules don't define what a "school" is. Is a nail salon that trains students a "school"? Is a private school for the disabled or severly handicapped considered a "school"? Is a karate training facility considered a "school? We need to define what constitutes a "school" or define the intent so legislators can use common sense to guage the danger to society or kids.
More definitions of terms, particularly thise that limit locations, e.g. what is a "school"?
II. DISPENSARIES 1. DHS must require geographic dispersion of dispensaries. 2. Each location where marijuana is produced, infused or sold must have a separate dispensary certification. (a) Modify R9-17-302(B)(5) by striking "and, if applicable, as the dispensary's cultivation site." (b) Modify R9-17-304 to strike all references to a Dispensary's Cultivation Site. (c) Modify R9-17-306 to strike all references to a dispensary's cultivation site. (d) Modify R9-17-307 to clarify that cultivation sites require separate dispensary certification. (e) Modify R9-17-313(B)(5) and (6) to clarify that food infusion sites require separate dispensary certification. (f) Modify R9-17-315 to clarify that cultivation and infusion sites require separate dispensary certification. (g) Modify R9-17-316 to clarify that infusion sites require separate dispensary certification. (h) Strike R9-17-101(6) 3. DHS may delegate inspection of dispensaries to local authorities. 4. Reasonable notice of routine inspections should be 24 hours, and occur within posted business hours. 5. Dispensaries must dispense marijuana and marijuana infused products in DHS approved and supplied containers. 6. Dispensaries may not dispense a smokeable form of marijuana unless the qualifying patient is approved by DHS to receive it. 7. Dispensaries should be required to file public reports providing information on the number of customers, marijuana sales volume, and financial status of the dispensary. III. PATIENTS, CAREGIVERS AND DISPENSARY AGENTS 1. Caregivers must pay a separate fee for each patient they care for. 2. Caregivers must undergo training (at least 8 hours) on, and pass a test on, the effect and hazards of marijuana, the terms of the initiative, DHS rules governing medical marijuana and applicable laws. 3. Caregivers, Cardholders and

Dispensary Agents must be residents of Arizona and must possess an Arizona driver's license or identification card. 4. Caregivers and patients allowed to cultivate marijuana must be subject to the same security, inspection and reporting requirements as dispensaries. 5. Patients, or caregivers acting on behalf of patients, may not possess smokeable marijuana unless specifically authorized by DHS. 6. Private marijuana use "clubs" should be prohibited. IV. MEDICAL PROFESSIONALS 1. Policy Statement Three different types of medical professionals are authorized to provide certification for medical marijuana use under the initiative. All are governed by a different licensing board, and none of the licensing boards actively govern their respective charges with regard to medical marijuana. Unless DHS monitors the activities of these medical professionals, there is no central authority to monitor and govern the actions of medical professionals authorized to certify medical marijuana use under the initiative. Under the initiative, DHS is charged with regulating possession and use of medical marijuana. DHS thus has the authority to qualify medical professionals designated under the act as appropriate to issue certification for medical marijuana use. Such a system would ensure a centralized authority to monitor medical professionals for abusive or illicit issuance of certifications, preventing fraud and abuse. 2. Medical professionals that wish to issue medical marijuana certificates must be registered with DHS in order to issue certifications and a reasonable fee should be charged. Implementation: Create Article 4 for the Medical Marijuana Program in DHS Rules that governs medical professionals wishing to issue medical marijuana certifications in Arizona. Medical professionals must meet the following requirements: (a) DHS must create and administer a medical professional certification registry. (b) Qualified medical professionals that wish to issue certificates under the initiative must register annually with DHS and pay a reasonable annual fee to offset the cost of registry administration. (a) Medical professionals must be Arizona licensed in and primarily practice in Arizona. (b) No more than 30 active patient registry cards may be issued based on the certification of an individual medical professional at any one time. (c) Medical professionals must see their certified patient at least once every 6 months, face to face, and document they have done so in annual certifications. (d) Medical professionals may not issue certificates to themselves or immediate family. (e) Medical professionals undergoing discipline or substance abuse problems (f) Medical professionals recommending the patient be dispensed a smokeable form of marijuana, must provide a statement detailing at least 3 efforts of the medical professional and patient to administer infused marijuana, a statement detailing why such attempts were unsuccessful, and a declaration from the medical professional why only smokeable marijuana will alleviate the patient's condition. must not be authorized to issue certifications. 3. The medical professional issuing the certification should be given the authority to revoke a patient's certification at any time. In addition, the medical professional should be required to revoke if they haven't seen the patient within 6 months. V. LEGISLATIVE ACTION 1. The legislature should set a presumptive THC metabolite level for impairment (similar to presumptive blood alcohol level) effective in situations of driving, machinery operation and employment 2. The legislature should set enhanced penalties for cardholders, caregivers, and dispensary agents that produce, transport, sell, or possess marijuana outside of the terms of their authority granted by the initiative. 3. The legislature should impose criminal penalties for smoking marijuana in public. 4. The legislature should impose criminal penalties for smoking marijuana in the presence of children.

they are way to restrictive. I can get a prescription for hydrocodone and get it refilled twice for a sore tooth. Why is this so tight? Loosen up he ability to get a prescription without causing the doctor so much grief. We have voted for this law three seperate times. Please.

You are relying on Doctors that have no previous experience prescribing Marijuana to do so, and they will not do it. Why would they? 1. It is illegal at the Federal level 2. No doctor has a license to prescribe schedule 1 narcotics. 3. They don't need to prescribe it, they are already practicing medicine and have an established practice of doing so. 4. Prescribing Marijuana unnecessarily complicates their lives (fees, forms, licensing). 5. Prescribing Marijuana could jeopardize their careers, be it short term or long term (see reason #1, #2). 6. Doctors risk a social stigma of being "one of those doctors" among peers. 7. Etc, etc, etc. I talked to my Doctor, he will not prescribe Marijuana to anyone, and why would he?

No Doctor will prescribe it unless they are involved, aware and sympathetic to Marijuana's medicinal properties in relation to their patients. There is a reason that specific doctors in other states have had to prescribe this, these reasons are stated above. You have effectively neutered the state of Arizona's medical marijuana program by making the medicine unavailable because no doctor will prescribe it. Very, very few patients will have access to this medicine. And when the people that oversee this are scratching their heads as to why the number of patients getting their medical marijuana cards and the number of doctors prescribing it are a small fraction of the predicted numbers, it will be because of reasons stated above. You need to take steps and do the the research necessary to insure that this medicine will actually be prescribed, rather than assume that it will. Because it won't. And the people like me, that need an effective medicine, will have to move to a state where it is actually legally available. And I will.

I believe the proposal to require each dispensary to have a Medical Director that is a medical doctor (either an M.D. or a D.O.) will effectively put control of the entire industry in the hands of a few. While I see the need for Medical Directors, I believe Registered Pharmacists should also be allowed to act as Medical Directors for dispensaries. This will open up the pool of candidates that could potentially act as Medical Directors for dispensaries, thereby eliminating the potential monopoly doctors could have over the industry. Forcing dispensaries to keep a Doctor on staff would create an inflated expense for the business operations of the dispensary and may effect their ability to compete. It may also create a situation where Doctors are the only one's able to afford to run a dispensary because they would not have to pay themselves (and incur the business expense). If Doctors become entrenched as Medical Directors, they could control what they charge dispensaries for their services and have unfair control over business cost structure. Pharmacists are regulated, licensed professionals in the field of healthcare and have expertise in counseling patients on how to use medication. Let them be part of the solution, help keep costs under control, and prevent a monopolization of the industry. Furthermore, under the draft gudielines, the onsite Medical Directors would not be allowed to "recommend" medical marijuana anyway. The patient would have to obtain their recommendations prior to coming to a dispensary, so doctors will still be a part of the process, just not with a stranglehold on the cost structure of the dispensary operations. This is being submitted by [redacted]. I have been a [redacted]. I can be reached [redacted] for further comment. I appreciate your time taken to review the many submissions you must be receiving.

1) The legislature should set a presumptive THC metabolite level for impairment (similar to presumptive blood alcohol level) effective in situations of driving, machinery operation and employment This should include people who are work with for children or minors specificly. 2) Dispensaries should be required to file public reports providing information on the number of customers, marijuana sales volume, and financial status of the dispensary We will need to create an auditing process for this to ensure accuracy of this. 1. Dispensaries may not dispense a smokeable form of marijuana unless the qualifying patient is approved by DHS to receive it. I am an advocate, but I do not see any reason for using smoke able marijuana as it exposes others to the effects. If we are truly doing this for medicinal purposes there should be no second hand exposure to a controlled substance.

These preliminary rules word be burdensome and delay a qualifying patient’s registration as well as legal acquisition of marijuana and should be eliminated. The provision for a physician to take on primary responsibility for a patient’s use of marijuana may cause a conflict for doctors because it’s use is still illegal under federal law and may be problematic for doctors’ licensing.

I am concerned that there is nothing in the rules about driving and operating heavy machinery. I don't like the thought of somebody who is under the influence of marijuana driving on the same street as me with my baby in the backseat, yet it seems as though it will be perfectly legal. The same can be said with patients who need to operate heavy machinery at work--it seems that it would put their co-workers at great risk if they were high while doing so. Employers should also have a right to not have their employees unable to work because of medical marijuana. Should there not be guidelines for these areas set up?
I have suffered from severe, debilitating headache for over 5 years. I've literally been to over 20 different MD's and DO's. Most of them prescribed me medications that helped very little and caused severe side effects. I've been prescribed Demerol, oxycontin, morphine and other highly addictive drugs within 1 or 2 visits - not the 4 visits it would take for a far safer marijuana recommendation. However, I've seen two Naturopathic doctors and both of them spent over an hour taking my history, compared to 5-15 minutes with their MD/DO counterparts. They took a much more thorough history and preformed a more detailed physical exam. One of them made proper referral for imaging which ultimately determined the cause of my headaches. All completely missed by the 20+ other doctors! It's simply my personal experience that Naturopaths are very fine doctors who understand conventional medical diagnosis and treatment as well as MD's and DO's and who utilize pharmaceutical medications conservatively. It would be unfair and harmful to the public to exclude Naturopaths and especially since many citizens choose them exclusively as they primary care physicians. Further, it's simply my experience that not including Naturopaths as dispensary medical directors would harm the public by excluding perhaps the most diligent and well trained physicians from making these dispensaries the best they can be.
As a high school teacher, I am extremely concerned that our schools are not protected in this draft. Please, Please, Please consider adding regulations to keep our schools and teachers safe. Schools need to remain Drug-Free School Zones
Need to define other products or by products, including Hash, Keef and oils. Need to define dispensary offering patients that cannot leave home on how delivery would work.
SURETY BOND IS IMPOSSIBLE TO GET. I HAVE HAD ONE FOR 20 YEARS AND ASKED AROUND. NO ONE WILL WRITE ONE FOR A DISPENSARY/GROW FACILITY. NO NEED FOR MED DIR, RECOMMENDING DR. IS FAMILIAR WITH PATIENTS CONDITION. YUMA COUNTY NEEDS MORE THAN 2 OR 3 DISPENSARIES. IT HAS 200,000 PEOPLE,IS OVER 5,000 SQUARE MILES WITH 3 CITIES, 1 TOWN, AND 4 COMMUNITIES. IT IS ABOUT 100 MILES FROM WELTON TO SAN LUIS AZ. WHEN WINTER VISITORS ARRIVE THERE WILL BE THOUSANDS MORE PATIENTS WITH QUALIFYING CONDITIONS. TWO OR THREE CAN'T HANDLE THE LOAD. ALLOW CARD HOLDERS FROM OTHER STATES TO USE AND PURCHASE MEDICALMARIJUANA STOP TREATING MEDICAL MARIJUANA DISPENSARIES LIKE A CRIMINAL ENDEAVOR. WALMART SELLS ALCOHOL, DANGEROUS DRUGS LIKE OXYCODONE, VALIUM, ETC. AND GUNS AND AMMO UNDER ONE ROOF YET CHILDREN RUN RAMPANT THROUGH THE STORE. IT HAS BEEN VOTED IN BY THE PEOPLE. MAKE IT MORE ACCEPTABLE, REMOVE THE STIGMA, AND STOP TRYING TO MAKE IT IMPOSSIBLE TO GET A DISPENSARY LIC. MANY PATIENTS NEED THIS. INSTRUCT THE COUNTIES TO BE REASONABLE. YUMA COUNTY IS CONSIDERING REQUIRING A SPECIAL USE PERMIT, WHICH IF ALL GOES WELL, WILL ADD AT LEAST 4 MONTHS TO THE PROCESS. DISPENSARY OWNERS SHOULD BE COUNTY RESIDENTS.
Please make strict penalties for recreational users who WILL abuse the system. Please make strict penalties for the "medical professionals" who knowingly prescribe or recommend marijuana to patients who do not, or should not qualify. Please allow cities and towns to opt-out altogether if there are

facilities in neighboring cities. Small towns don't need to have dispensaries if there are already some nearby. As this is not a constitutionally protected land-use, municipalities should be allowed to list the uses as prohibited if it is the local desire.
Patients should not be subject to arbitrary requirements, such as those relating to length of time under a specific physician's care. Firstly, many patients may not have a year to live. Additionally, many patients are not in a financial position to afford the multiple doctor visits required in the first draft. Many patients, having established a relationship with a physician, may be loathe to bring up the subject of medical marijuana due to the understandable fear said physician may have of reprisals from Federal authorities. Therefore patients must have the alternative of seeking out medical care from someone other than an individual whose prescribing privileges and medical practice could be at risk if he or she were to come under scrutiny by the Federal government. Reasonable comparisons with other substances commonly prescribed must be made. It is unreasonable to require the kinds of security measures for medical marijuana growers and distributors proposed, when these rules are not in place for traditional medical pharmacies carrying chemicals which have been shown to possess many potential harms, such as addiction, overdose and even death, e,g, narcotics, amphetamines and chemotherapeutic drugs.
The preliminary rules at R9-17-202. Applying for a Registry Identification Card for a Qualifying Patient or a Designated Caregiver F.5.e.i and ii. should be eliminated
The proposed patient and caregiver fees must be significantly reduced so that it doesn't look like they were heavily influenced by the KEEP ARIZONA DRUG FREE people with the intent of minimizing the legitimate use of medical marijuana in Arizona, or by the illegal drug cartels who want this law to put the smallest possible dent in their business.
We need to protect our schools. 1. Bars are not allowed within so many feed of a school. Dispensaries should be the same. 2. There should be ways for schools to penalize or discharge marijuana users who drive school busses, supervise children, or come on a school campus while under the influence. 3. Law states that parents cannot even bring cigarettes on a school campus. It should be the same for marijuana There are laws about open alcohol containers. Since marijuana containers are to be sealed etc. it schold be against the law to transport open containers.
The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require “ongoing” care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient’s care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department’s regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients’ rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not (or cannot afford) to seek other medical care at all (whether prior or subsequent to application). R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to

accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year.
Require each physician who recommends medical marijuana to be certified by his/her board of examiners. This certification would include a specified number of hours of continuing medical education directed but not limited to the pharmacology and pharmacognosy of the various strains of cannabis, contraindications and drug-herb interactions, ethical and legal issues. Limit the number of patients to whom a physician can recommend medical marijuana. This would prevent certain physicians from becoming seen as cannabis practitioners. Not sure about the limit, although I think 100 would be an appropriate number (similar to the limit for buprenorphine prescriptions). These requirements could be based on the DEA's requirements regarding the prescription of Buprenorphine. Naturopathic physicians should be added to the definition of Medical Director. The scope of practice of NDs as defined in statute meets the responsibilities of a dispensary medical director. NDs receive training in pharmacology and pharmacognosy, and understand the indications, contraindications, and interactions of botanical medicines in patient care.
1) The fee schedule for Qualifying Patients and Designated Caregivers seems onerous. I do not have a problem with the charges for the first time charges for Qualifying Patients and Designated Caregivers. The Health Department has the start up expenses of administering this new act including personnel, training, office equipment, software and the like. So even though the fees are high, they can be justified for startup. But the renewal fees for Qualifying Patients and Designated Caregivers are way out of line. Renewing the registration paperwork for Qualifying Patients and Designated Caregivers is not significantly different than renewing a driver's license. The fee for renewing should be approximately the same. (In my case, $10.00). 2) Many, perhaps most of the Qualifying Patients and Designated Caregivers are dealing with chronic conditions. Those with chronic conditions should be registered for an appropriate period of time, providing the physician evaluates and continues the recommendation for the use of medical marijuana. I suggest that the registration renewal for these Qualifying Patients and Designated Caregivers be 5 years.
I strongly disagree that a one must be a US citizen and resident of Arizona to benefit from this program. I believe allowance should be made for foreign tourists who are visiting Arizona residents. I believe that a foreigner who otherwise meets all the requirements for obtaining medical marijuana, such as a debilitating medical condition (multiple sclerosis) and a doctor's prescription, should be allowed to obtain medical marijuana for the duration of his or her visit to Arizona. The rules should allow the prescribing doctor (the one who is currently caring for the foreigner) of above individuals to be a foreigner, otherwise it would take forever for a person to be able to get the needed medical marijuana. I have such a friend who is agony while she visits me. If the rules can not accommodate this, then the rules should make allowances for the host of the foreigner to become the temporary caregiver, thereby allowing the host (an Arizona resident and US citizen) to obtain the medical marijuana for the visitor.
I'm a 5th generation farmer. The idea that each dispensary has to grow 70% of what it sells strikes me as difficult and hard to enforce. Would you rather regulate 125 culitivation sites or 5 cultivation sites designed and operated by people who know what they are doing and have the money to build a state of the art facility. I farm 2000 acres. We own and operate a large produce compnay in Vegas. We grown millions of heads of lettuce, millions of pounds of tomatoes, cucumbers, onions, parsley, basil, green beans, and potatoes. If we didn't have a central location, the business modeal would not work because you could not influence the quality. I watched and listened to many people who want to

own and operate a dispensary. 99% must think you can sprinkle pixie dust on the floor and marijuana will magically begin the grow. It doesn't work that way, especially indoors. We do lettuce and tomatoes indoors. Tomatoes have the same life cycle, the same diseases, the same pests, and use the same fertilizers. It is very difficult and extremely expensive to set up an operation that will consistently produce quality agreicultural products. If marijuana is perhaps the most diffiucult to grow of all herbs. You will have a difficult time controlling these culitivation sites.

These concepts must be eliminated or streamlined. The alternative to a long, ongoing relationship is presumed by ADHS to be R9-17-101.16.b where, "The physician assumes primary responsibility for providing management and routine care of the patient's debilitating medical condition..." This is NOT a viable alternative because few physicians will be willing to take on RESPONSIBILITY for management of routine care, THAT IS, THE USE OF MARIJUANA. The Department would place physicians in a vulnerable professional position because conspiring to provide marijuana would be a federal crime and leave the doctors' licenses at risk.

ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services will make rules "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not (or cannot afford) to seek other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and

medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(4) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. R9-17-301.2 is arbitrary and unreasonable. The Corporation Commission requires only 1 person to incorporate any Arizona corporation. There must be 1 incorporator and 1 director. The director and the incorporator are often the same person. The requirement for two officers of the corporation exceeds the Arizona Corporation Commission requirements by double. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on record keeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse.

Eliminate the "ongoing" requirement of the definition of a "Physician-patient relationship" in paragraph

17 of Article 1, R9-17-101. There was nothing in Prop. 203 that required a person with a new physician to wait for a year before becoming eligible to register with DHS as a qualifying patient. In fact some otherwise eligible qualifying patients are currently under the care of physicians who are prevented by policy from prescribing marijuana; i.e., V.A. doctors. These patients will necessarily need to seek a different physician and have that physician review their respective medical records to assess their suitability for a prescription.

Suggestions below

The requirement for a Dispensary Medical Director should be eliminated

Delete §R9-17-307(C) from the rules completely. This section has many implications, none of which are good for the industry, DHS, patients, or the State as a whole. Requiring every dispensary to have its own cultivation operation is a security risk. Essentially this rule necessitates more variables in an equation that already has inherent dangers. The more cultivation facilities, the more difficult they will be to monitor and keep secure. Additionally, by requiring each dispensary to grow its own marijuana you create a quality control issue. How can a patient rely on the consistency of the product when it is grown by different operations under varying conditions? How will DHS manage to analyze that multitude of plants? Logistically it would be much easier to ensure a high quality product reaches the end user by permitting the market to establish fewer high production cultivation operations that supply multiple dispensaries. Unfortunately, as written now, §R9-17-307(C) does not allow for this. Realistically, §R9-17-307(C) closes the door on the possibility for central grow operations can establish themselves. This creates a heavy burden on DHS and other authorities not just for security and quality reasons, but also in terms of monitoring and tracking inventory. If a dispensary needs to grow 70% of what it sells, can only import 30% of what it sells, and may not export more than 30% of what it grows to other dispensaries, there will be a book keeping nightmare. Not only will the rules will be greatly simplified by deleting §R9-17-307(C), but it is in the State's best interest to do so. It will reduce the burden on an already underfunded government to monitor and secure over one hundred and twenty cultivation operations, and ensure that pure and safe medicine reaches those who are in need of it.

Improved: R9-17-107. Time-frames B. A registration packet for a dispensary is not complete until the applicant provides the Good overall R9-17-306. Inspections D. The Department shall not accept allegations of a dispensary's noncompliance with A.R.S. Title 36, Chapter 28.1 or this Chapter from an anonymous source. (This is a great clause as it makes for accountability. Not using the system for vindictive or competitive reasons.) R9-17-307. Administration (This whole section is great. It lays out guidelines for establishing professionalism and good working practices and helps establish the industry correctly from the onset. It helps operators understand what will be expected of them on an ongoing basis prior to application so a decision of weather to be a part of this industry is of interest knowing the responsibilities. Other states have had operators before rules which have made it very chaotic for everyone involved. C. A dispensary: 1. Shall cultivate at least 70% of the medical marijuana the dispensary provides to qualifying patients or designated caregivers; 2. Shall only provide medical marijuana cultivated or acquired by the dispensary to another dispensary in Arizona, a qualifying patient, or a designated caregiver authorized by A.R.S. Title 36, Chapter 28.1 and this Chapter to acquire medical marijuana; 3. May only acquire medical marijuana from another dispensary in Arizona, a qualifying patient, or a designated caregiver; 4. May acquire up to 30% of the medical marijuana the dispensary provides to qualifying patients and designated caregivers from another dispensary in Arizona, a qualifying patient, or a designated caregiver; and 5. Shall not provide more than 30% of the medical marijuana cultivated by the dispensary to other dispensaries. These are all great definitions. There should be some type of measure or time frame such as "1. Shall cultivate at least 70% of the medical marijuana the dispensary provides to qualifying patients or designated caregivers in any rolling calendar year." The rolling calendar year helps smooth out sales vs. supply. Example when a store first opens it may only be selling 2 pounds per month. As that store gains business over the course of a year it

may go as high as 40 or 50 lbs per month and may go up or down based on completion or other market forces. Since it takes roughly 110-120 days from seed to ready the cultivation needs time to adjust for volume fluctuations. It would also be helpful to allow for some inventory helping to smooth supply and demand also. The live database to track that the system is not abused is awesome. R9-17-314. Product Labeling and Analysis 5. A list of all chemical additives, including nonorganic pesticides, herbicides, and fertilizers, used in the cultivation and production of the medical marijuana; and this is great for everyone. R9-17-317. Cleaning and Sanitation A. A dispensary shall ensure that any building or equipment used by a dispensary for the cultivation, harvest, preparation, packaging, storage, infusion, or sale, of medical marijuana is maintained in a clean and sanitary condition. (Great Section!) Good overall R9-17-306. Inspections D. 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A dispensary shall ensure that any building or equipment used by a dispensary for the cultivation, harvest, preparation, packaging, storage, infusion, or sale, of medical marijuana is maintained in a clean and sanitary condition. (Great Section!) Department with written notice that the dispensary is ready for an inspection by the Department. (Possible clarification depending on intent. It is likely that a location will not be ready for an inspection until a license has been granted and dispensary has been constructed or built out. The license must come prior to any inspections. This section is confusing.) R9-17-302 Section 1 j. Whether the dispensary and, if applicable, the dispensary's cultivation site are ready for an inspection by the Department; k. If the dispensary and, if applicable, the dispensary's cultivation site are not ready for an inspection by the Department, the date the dispensary and, if applicable, the dispensary's cultivation site will be ready for an inspection by the Department; (Same logic as above it seems unreasonable to expect that anything would be ready prior to a license. Unless it's just a site visit prior to construction. Once approved for a dispensary it would be reasonable to except dispensary completion within 120 days. Getting permits, constructing and beginning operations of the cultivation site could take 6-9 Months depending on jurisdiction and how fast they can approve location/plans for permit.) 5. A copy of the certificate of occupancy or other documentation issued by the local jurisdiction to the applicant

authorizing occupancy of the building as a dispensary and, if applicable, as the dispensary's cultivation site; The logical progression for a dispensary would be application, application approval by city and state, construction permitting within a reasonable time frame, construction completion within reasonable time frame, and final review by building department/ fire/ health or applicable agencies. Issuance of CO by City. Submittal of CO to state. R9-17-303. Changes to a Dispensary Registration Certificate A. A dispensary may not transfer or assign the dispensary registration and certificate. (This seems unreasonable as so many variables change with time. The establishment of this type of business requires a significant amount of time and equal if not more investment of capital. To define terms that allow an exit or recoupment of these efforts through a business sale acquisition or transfer would be beneficial to all parties involved) R9-17-306. Inspections B. A dispensary shall provide the Department with authorized remote access to the dispensary's electronic monitoring system. (While completely understood that this allows for more efficient use of available funds to regulate and inspect it also seems that it has some significant legal issues regarding privacy if at all applicable to this type of business.) C. R9-17-307. Administration 3. Employ or contract with a medical director; (While completely understood that this allows for more efficient use of available funds to regulate and inspect it also seems that it has some significant legal issues regarding privacy if at all applicable to this type of business.) R9-17-308. Submitting an Application for a Dispensary Agent Registry Identification Card I would be extremely helpful to allow for a dispensary agent registry identification for out of state consultants or employees to help these businesses. There are significant resources and lessons that have been learned in other states that would be beneficial for Arizona locations. This would be most useful in cultivation operations as licensed commercial growing has only existed for a very short time and there are significant barriers to entry for those who have not yet had to make all the mistakes. Consultants can help save resources capital and frustration for everyone involved from the building departments to state regulatory agencies. For example having someone who has already perfected a great inventory chain of custody which comes by way of trial and error in another state could help everyone in the industry. There are at least a hundred reasons why opening the industry to some type of out of state help would benefit all parties. C. A dispensary shall provide to the Department upon request a sample of the dispensary's medical marijuana inventory of sufficient quantity to enable the Department to conduct an analysis of the medical marijuana. This also great. There should maybe be more teeth in this maybe add. It is a violation of the statute If the product that is tested is found to have chemical substances not listed. There are many chemicals used in cultivation that can be harmful to people's health, especially those already in weakened state or with compromised immune systems. It's crucial to keep hazardous chemicals out of the medicine! R9-17-315. Security D. To prevent unauthorized access to medical marijuana at the dispensary and, if applicable, the dispensary's cultivation site, the dispensary shall have the following: (Possibly consider adding more protection. The more obvious this is and the better the prevention the less likely crime. A series of double one way doors in and out with buzzers to operate "mantrap". Steel security doors at dispensary and location with some specified security rating or higher. A home depot wood door isn't very secure.) Bulletproof window at entrance to allow verification of card and id prior to entry to medicine holding area. R9-17-319 B. The Department may deny an application for a dispensary registration certificate if a principal officer or board member of the dispensary: 1. Has not provided a surety bond (could you clarify all the talk of what the surety bond means?) C. The Department shall revoke a dispensary's registration certificate if: 1. The dispensary: c. Acquires usable marijuana or mature marijuana plants from any person other than another dispensary in Arizona, a qualifying patient, or a designated caregiver; or (possibly define mature plants?) The initial stock must come from somewhere, seed, clone where is it allowed to come from? Can seeds be purchased from seed distributors either in the US or outside the US?

It seems to me that the state is putting up unnecessary burdens to the program. The doctor patient relationship seems that it adds extra burden to obtaining medical marijuana. The voters have spoken, let the determination of a doctor, not the state definition of a "doctor-patient relationship" be the one to decide on who may receive it. The state seems worried that this program will lead to abuse. I feel there

are far more abuses in other "prescription" drugs, which the state would never question. The fees also seem to be high for both dispensary and patient. The fee's should be reduced to a "reasonable" administration charge and not looked at like an income generator.
See next section.
- Better language on how dispensaries will be selected. - Clarification on whether homegrowers will be allowed to purchase from dispensaries. - Clarification on how much marijuana can be stored by users, including maximum amounts (concerns about stockpiling) - Require certification from local jurisdictions stating that the building to be utilized meets local zoning requirements rather than relying on a sworn statement from the applicant. - Clarification on transportation criteria from cultivation facilities, and from patients to dispensaries. i.e. amounts, and identification required. Also concerned with allowing dispensaries to deliver to patients, believe that the authorized caregiver should be only one allowed to make deliveries from dispensaries to patients. - Clarification on how much marijuana a dispensary can grow on-site, particularly in light of building codes and requirement for a single secure entrance.
- Please clarify and provide more information on the surety bond that may or may not be required for a dispensary. Also, how much the surety bond is to be for. The rules are very vague on the surety bond a dispensary may or may not need and for how much. - Please provide more information on the Medical Director needed for each dispensary. Is the medical director not allowed to write medical marijuana recommendations to any of their patients? If so, how can a doctor become a dispensary's medical director and not recommend medical marijuana to any of his or her patients, ever. Is the doctor supposed to then refer his or her patients to another doctor for medical marijuana? Is it the intent of the rules for the medical director to be employed full time by each dispensary? - Please clarify "Dispensary by-laws containing provisions for the disposition of revenues and receipts". - Please clarify the inspection process step by step for each dispensary. Are the dispensaries to be fully operational with grow and dispensary setups prior to state approval for a dispensary license? - Is the dispensary to name the dispensary agent in charge of inventory control on the initial dispensary application?
With the presumption that AZDHS WILL NOT GIVE/ALLOW any preferential consideration to any formed organization such as (Marijuana Policy Project “MPP”, Arizona Medical Marijuana Association “AMMA”, Arizona Association of Dispensary Professionals “AZADP” and must be totally independent and fair in qualifying acceptable applicants… only one (1) FAIR solution would be above reproach and accusation of unfairness. Assuming 1000 applicants could meet all qualifications an open Public Lottery of these 1000 applicants for the 125 Licenses is the only solution to Fairness and Transparency! Thus any suggestion of collusion or corruption on the part of the AZDHS or its representatives COULD NOT be accused. This system would also alleviate and or dismiss any form of Appeals by non-successful applicants and give BOTH the Middle and Upper classes a fair, equal and balanced chance of successfully obtaining a License.
They will be improved if they offer less opportunity for only wealthy marijuana mill types of business to apply. Reducing the unrealstic and excessive requirements regarding the procurment of a physical location is a start. This should be an opportunity for small Arizona businesses to be cultivated. If, not-for-profit is the requirement some language regarding how the business will contribute to the community might be added. Instead there are fees and other bureaucratic disentitlements that may preclude maximizing this chance to contribute to our economy. The law states that non-profits would be the applicants, but the rules show everything from individuals to LLC's as eligible to apply for a license - very confusing. The rules would be improved by being congruent with the law. A medical

director that hands out info is not really a compliance measure but an added financial burden to the operation. Perhaps the dispensarys could have rules more similar to pharmacies instead of methadone clinics.

ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services will making be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not (or cannot afford) to seek other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of

information R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse.

STOP BEING CRUEL AND UNREASONABLE WITH THE RULES.

I am concerned for patient welfare in regard to the Cannabis consulting physician assuming primary care and monitoring of the patient's qualifying condition. There is not a physician training program that can teach a provider to take the place of a Gastroenterologist (Crohn's, persistent nausea, Hep C, cachexia), a Neurologist (Alzheimer's, severe muscle spasms,seizures, ALS), an Oncologist (cancers of all types), an Infectious Disease Specialist (HIV/AIDS, Hep C), Ophthalmologist (glaucoma), Anesthesiologist (chronic pain), or a Pain Management Specialist. Standards of care would expect each of the qualifying serious and debilitating conditions are being managed by the patient's primary care physician who incorporates specialist recommendations into the patient's full care plan. Anything less than this would be putting patients at undo risk, exactly what we physicians took an oath to prevent. Medical marijuana is intended to be an adjunct to the patient's current care plan, and not, in any way, supposed to be a replacement for the diagnostic and treatment clinical standards already in place and shaped by evidence based clinical research.

Scrap most of them and dispense Mrijuana through established drug outlets under doctor's

perscriptions.
Reduce the renewal fees charged to patients and caregivers to $25 and $50. The rules reduced the renewal fees for dispensary to $1000, 1/5 the cost of intial registration. Reduce the require doctor's visit to 2 per year. Create two overlapping but seperate rules, one for patients, caregivers and doctors and one for dispensary's.
There should be an effort to maintain the term "evaluation". Some legislators are trying to push for full physical exams in the first cannabis evaluation. They also want to force evaluating physicians to take responsibility for those patients. Those seeking medical cannabis should be maintained by their PCP. In other states, a greater segment of society has been served by evaluating patients by telemedicine. Telemedicine is legal in Arizona. Free training is offered to AZ residents. The patient goes to an evaluation center where a medical assistant or nurse takes vitals, history. The records are faxed to the evaluating physician from different centers around the state. Our position should be to maintain the status of "evaluating physicians." Patients' PCP and/or other specialists are not going to want to turn their patients over to the evaluating physician if it means losing a patients.
In the Az Republic there is an article where the DHS went over some of the policy concerns... stating some couldnt be changed because they were part of the original law and couldnt be changed...if thats the case then you must cease in trying to define a doctor patient relationship, and come up with a preliminary approval plan for dispensaries, also please consider the 70/30 aspect. some dispensaries may not be able to afford to grow that much medical marijuana by enforcing some 70/30 standard , you are interfering with the free market, and placing restrictions that could do irreparable harm to those who want to open a dispensary. you are re-writing the law...which is illegal, not saying most of the requirements and restrictions arent needed, but you are stepping over bounds a bit with some burdeness language. What this does is create a venue for attorneys and lawsuits by people who really dont care about patients but more about revenue, which only hurts us legitimate and qualified Non Profit Groups who would like to move forward and open a licensed caregiving dispensary and care center. And stop using the words, recreational use..... this is not what this law is about, so we all must get past it, people who use recreationally, always will, (i personally do not) but, your restrictive policy writing is not going to have any bearing on whether someone can purchase marijuana illegally. It will always be there. Always. Goerge Washington had acres of it as a cash crop, and traded the smoking portion of the plant to the Indians where it was used for medicine, the rest was used in Hemp Production. It was around in the 70's and 80's when i was young, and its around now. No Prohibitive Law will stop its use. Sad to Say, but true. I am in full support of having regulations and understand the premise behind them, But this small letter i am writing is coming from the Heart. So by worrying about recreational use, you are making it hard for dispensaries to due proper free market business. Its not about the quantity of marijuana we sell and revenue, its about compassion and helping everyone in need. Some dispensaries are going to be open just for revenue, but the good ones who will end up making it and staying, are in it for the compassion of patients, and please remember, as the DHS you should know this, there is a larger problem with kids and adults and Perscription opiates in this country and State, with farther reaching consequences than any Medical Marijuana use could ever have. please remember that, i am going to be applying for a dispensary license, we have a concept unlike any others, Acupuncture, massage therapy, Traditional Chinese Medicine as well as medical Marijuana. we are here for the patient, in a small day spa like setting. I just cant envision spending $250,000 dollars on 2 Commercial buildouts and TI work for a retail and an indoor grow facility when there is no PRELIMINARY APPROVAL PROCESS. I know it will take time but you must do things in a cognitive way..... look through each dispensaries application, look at business model, biz plan, the background of the non profit foundation, abililities, etc. and make an educated decision on who is going to be preliminarily approved, then i would be happy to spend my hard earned money to complete the process.

being in the building and construction sector, these things take time, as do all good things. but from pre approval to buildout completion and operational readiness is about 3 to 6 months. Remember that as well. With DHS inspections, Building Inspections, and all that goes with a significant TI and buildout, you are looking at a realistic timeframe of 4 to 8 months to be up and operational and have inventory available to patients that need it. So please dont focus on the negative aspects of this, I am really quite pleased with some of the things i have seen in the draft rules, i have had 4 family Members go through Cancer, my Brother sits on [redacted] Advisory Council Board and is probably the most sought after Cancer Patient Consultant in The US for Pharmacutical Companies and Marketing Firms. He is On our Board of Consultants as well for Our Groups Dispensary license Business Model and soon to be application in The State of Arizona. So some of us are really concerned about the patient and not just the revenue. There are good people and good experienced groups willing to try to open here (with a significant monetary Investment in a restrictive market, so please dont make it so restrictive that we cannot help the patient. Please take a hard look at our application when the time arrives, we are planning on separating ourselves from the crowd. The Name will be GreenLeaf Compassion and Wellness Centers. Thanks so much for your time [redacted]Allweask.org (all we ask.org) A cancer and AIDS non profit Foundation and The Hopefully New..... GreenLeaf Compassion and Wellness Center

Regarding R9-17-302, B. 1b. I don't think requiring the applicants to have secured a location for a dispensary before their application is approved makes much sense. To have a physical address would mean to have leased a space before being approved. This is to me like putting the cart before the horse. When an applicant is approved and has paid their initial application fee, it is up to them to secure a location which will satisfy the rules and regulations set forth from the Department of Health Services. If they do not pass inspection within the approved timelines, they may have to forfeit their application fee. Regarding R9 -17-302 B. 1. g: and R9- 17-310 Medical Director: The role of Medical Director should not be limited to MD or DO degrees. All of the responsibilities mentioned in this section falls directly under the role of a pharmacist. Pharmacists are trained and currently fulfill all of these requirements in all sorts of pharmacy settings now. Pharmacies do not have medical directors, and pharmacists are responsible for providing all of the drug information listed in this section. I agree that if a dispensary is being operated by a "lay" person, there should be a health care professional available to them. I just don't believe that only medical doctors should be included. Patients are already under the care of a physician. Regarding R9-17-307 Administration C. The dispensary should not be required to cultivate. There are so many reasons for this. 1. The dispensaries should be focused on providing access and information to registered users and their families not horticulture. 2. There will be wide variability if dispensaries not trained in proper cultivating provide their own product for patients to consume. 3. The model should be suppliers to dispensaries to patients. This may improve oversight since there would be 2 distinct areas for the Department to handle: cultivation sites and dispensaries. 4. It should be up to the individual dispensaries if they wish to get into the cultivation business. That is the rationale for the 2 Registration Certificates: Dispensary and Cultivation Site.

I would like to see an area dedicated to the requirements of a physician no longer being willing to write the Rx. I did not see anywhere in there on who can check up in the case of patient/caregiver if we suspect the caregiver is using the MM.

After reading the article in today"s (1-6-2011) Az. Rep. (Pot Rule Comments Weighed), I again would ask that you adapt or remove entirely the restrictions placed on the doctor/patient relationship. According to this article, Mr. Salow, identified as an acting administrative counsel and rules @ ADHS, states that the requirement that the recommending doctor have seen the patient four times within one year for the qualifying condition or assume primary responsibility addresses this issue. I disagree and continue to feel that this requirement is overly burdensome and will cause unneccessary pain and suffering to many Arizonans. If the concern is that too many doctors will make these referrals without proper examination then I feel that these problems should be addressed by the monitoring of the

doctors providing these referrals. I believe this is how narcotics prescriptions are currently tracked and I feel that the recommendation by a doctor for medical marijuana should be no more cumbersome or restrictive than those currently in place for (what most people would agree) are much more dangerous and addictive substances. Thank you for this opportunity to express my opinion.

Oh where do I start. You obviously are not interested in following AMMA which was signed into state law by your boss Jan Brewer. What don't you understand about the initiative that clearly set up the rules for how to implement medical marijuana in this state. You are more interested in ripping off the patients and caregivers with your exhorbitant fees (renewal the same cost as new applications... get real). You are skating on thin ice with our civil liberties and no way will surveillance cameras on staff and the patients/caregivers coming into the dispensaries will fly. You are bringing down lawsuits by this unconstitional invasion of our privacy. You just don't get it Humble, we are not Colorado and your insistence on treating marijuana like heroin or even Oxycontin is wrong. Do some research and even check out NORML's website which contains information on the medical benefits of cannabis. Also stop referring to medical supplies (vaporizers and such) as paraphernalia. The Medical Marijuana Act allows patients to use these supplies and nowhere is the word paraphernalia used. I am most disturbed by the charges leveled against your department by [redacted] who is a dispensary education specialist in the Phoenix area. Since you are not putting up any of the written comments submitted I have to wonder why? This is all part of the public record and I have made copies of my comments so when the lawsuits start (and believe me you will be sued) I'm going to see what you did with the written comments you do not like. So how much has [redacted] influenced your rulemaking? Why is it these three gentlemen have all been telling people before you even posted the rules what the rules were going to be? Is it perhaps you worked these out in a backroom deal and now the chickens are coming home to roost? You are a government paid bureaucrat and not the paid toadie of MPP and paper trails exist.

AZDHS and MPP Acting in Collusion to limit access to Dispensary Applicants.... There is evidence that this is true. Unfair!

The best suggestion I've heard so far is to award dispensary contracts geographically so that every square inch of Arizona lies within 25 miles of a dispensary. This way there would be no home grow houses, which pose risks to families, neighborhoods and are set-ups for crime. This is entirely in keeping with the law; home grows are only to be used if the dispensary system does not provide. What I really like in this suggestion is the requirement that anyone who gets a dispensary contract in a metropolitan area is also required to run a rural dispensary.

1. It is improbable that anyone can obtain a Certificate of Occupancy for a dispensary prior to at least a temporary license. Most communities will allow you time to get your business going. As a developer I would recommend giving temporary licenses for nine months to a year with no definitive location to allow the establishment to get all local approvals and to do the required buildout during that window. In fact you could have checkpoints where the location had to be defined within 3 months, have a C of O in six months and be AZ approved in 12 months. That is much more logical. 2. I am working with assisted living operators and as it stand the rules make it difficult for these patients to get medicine without having multiple caregivers per location. So the issue is 1) can't it be one per facility and 2) can there be some flexibility around transporation to invalid patients. If you can't deliver it to a medical facility, waht good is it? 3. Finally the Medical Director seems to conflict with the arms length relationship that is appropriate between prescriber and dispensary. I do not believe that adds any value.

It is impractical that R9-17-107(B) requires each dispensary applicant to be prepared for an inspection at the time the application is submitted in order to be deemed “complete.” Inasmuch as not all applicants will be issued registration certificates, it appears impractical to require each applicant to build

out and equip (with security systems, etc.) its premises. I would suggest as an alternative that if an applicant is tentatively approved by the Department, the issuance of its registration certificate should be contingent upon the inspection and compliance with the statutory and regulatory physical requirements. A.R.S. §36-2801(11) provides that a medical marijuana dispensary is a not-for-profit entity. Other than limited purpose corporations and associations not for profit provided for in Chapter 19 of Title 10, the only nonprofit entities expressly provided for under Arizona law are nonprofit corporations, provided for in Chapter 24 of Title 10. However, the Arizona Medical Marijuana Act and the proposed rules expressly state that individuals and entities other than nonprofit corporations may be medical marijuana dispensaries. This is inconsistent with other Arizona statutes that provide that such other entities are for profit, including A.R.S. §10-140(14) (which defines a "corporation" or "domestic corporation" to mean "a corporation for profit ...") and A.R.S. §29-1012(A) (which contemplates that partnerships are formed to conduct for profit businesses). It provides as follows: "Except as otherwise provided in subsections B and C, the association of two or more persons to carry on as co-owners a business for profit forms a partnership, whether or not the persons intend to form a partnership."). In addition, Arizona statutes provide that the profits and losses of entities other than nonprofit corporations shall be allocated among their shareholders, partners or members in the course of the entities' operations as well as upon liquidation (A.R.S. §§29-329, 29-347 with respect to limited partnerships; A.R.S. §§29-703, 29-708 and 29-709 with respect to limited liability companies; A.R.S. §29-1077 with respect to general partnerships; A.R.S. §§10-640 and 10-1405 with respect to corporations). In R9-17-105(3), the following language is unduly restrictive: "that the cardholder submitted when the cardholder obtained the registry identification card." For example, if the qualifying patient lost his driver's license, neither the newly-reissued driver's license nor his passport photograph page would meet the requirement, as presently drafted. In addition, in connection with obtaining a replacement registry identification card, submission of an Arizona driver's license or identification card issued before October 1, 1996 and one of the supplemental documents should be permitted, as it is permissible in R9-17-107(F)(1)(d) and R9-17-202(F)(2). R9-17-107(C)(2) refers to 60 working days. However R9-17-107(C)(3) refers to 60 calendar days. Those timeframes should coincide. It appears that the "notice of deficiencies" referenced in R9-17-107(A)(3), with respect to which a 60 working-day response period applies, relates to an incomplete application and that the "comprehensive request" referenced in R9-17-107(D)(3), with respect to which a 10 working-day response period applies, relates to additional information beyond that which is required to submit a complete application. This section might be clarified to state that or to state an alternate distinction. The Department may be precluded from issuing a registration certificate because the number of dispensaries would exceed the number authorized by A.R.S. §36-2804. R9-17-107(F) should be revised to include a denial notice stating that the Department is not authorized to issue a registration certificate because the number of dispensaries would exceed the authorized number. In R9-17-107(F)(1)(d), the word "of" should be inserted after the word "copy."

The patient fee of $150.00 is excessive. Many patients seeking medical marijuana suffer debilitating illnesses and are living on a limited income. The high price may be prohibitive to those who need it most. I think a fee of $50.00 would be much more appropriate. Requiring a patient to have a lengthy relationship with their doctor is also prohibitive. Many patients do not have medical insurance and may not be able to have a consistent relationship with a single doctor. A good alternative would be to require a two visit minimum and follow-up appointments. Having a for-profit dispensary program that can pay local and state taxes will contribute to the poor local and state economies. Healthy competition will keep prices down and many dispensaries in other states offer care packages for lower income patients. The state of Colorado recently used $9 million from the sales of Medical Marijuana to balance their state budget. I think it could be a boon for the state economy! Prescription drug companies are allowed to make a profit and are really no different from medical marijuana. In fact, more people abuse and die from abuse of prescription drugs. Shy should medical marijuana be required to have separate rules? I question the requirement to grow the product at the site of the dispensary. This increases security issues and limits the dispensaries from doing what they would do best: distribution. Having separate licensed growing operations can help to increase product quality and provide a competitive

market. It would allow more businesses to focus on a single operation, whether it's growing or distributing. It would also increase the ability of dispensaries to provide a wide variety of strains and other medicinal products. Limiting a dispensary to 30% of product from other suppliers only hurts the patients. One dispensary may focus on growing a limited amount of strains and can trade with dispensaries that grow other strains, if growth is required on site. This provides the patients with a wider variety of options to best suit their medicinal needs. Also, medicinal edibles, or "medibles," baked goods, medicated drinks, tinctures, etc. could be offered for patients who prefer not to smoke their medical marijuana. Creating a limit of product from other manufacturer's limits patients options. Meeting the multiple needs of patients should be the focus of the program.

1. Allow private cultivation, regardless of proximity to dispensaries. 2. Reduce patient fees.

leave [redacted] out of it!

I am a Child, Adolescent, and Adult Psychiatrist. No one under 21 should be able to get MJ (marijuana) for any reason. This opens up too much easy abuse and scam behavior by the youth and or parent etc. No medical condition should be allowed except as per IOM report (below) AND severe wasting condition that has been proven to have been treated with multiple real medical treatments for reasonable time periods and failed, including Marinol. MJ should not be smoked. eg simply HIV+ or AIDs os MS or glaucoma or Crohn's or pain or nausea etc is inadequate. Their condition must also be devastating and thoroughly treated. Otherwise this and the ability to add conditions with "may" clause makes this all as nonsense as CA and CO etc. AND the doctor must have been seeing the "patient" a year with monthly visits (no real sick patient is seen only 4 times in a year !). AND the doctor must have ongoing treating follow up of patient re the condition, re new and other treatment options, and re the MJ effects and side effects, dosing, and evaluating cont'd need justification etc (monthly while on MJ). Yearly re-evals for MJ certifcation should happen. No legit Dr ever gives a med or therapy without follow-up. Below are 3 relevant excerpts from my article on this topic: 1) The Institute of Medicine (IOM) http://www.iom.edu/ is an objective, medically scientific, broadly respected medical organization which studies and puts out reports addressing a wide range of nationally and internationally important health related topics intended to provide policy guidance to the public, governments, and other medical scientific bodies. An IOM blue ribbon panel reviewed all available research and related information on the pros and cons of medical usage of available forms of marijuana (cannabis). In 1999 the IOM published its almost 300 page report. The 2003 Executive Summary is available for free at: http://iom.edu/Reports/2003/Marijuana-and-Medicine-Assessing-the-Science-Base.aspx I will excerpt selected highlights of their findings here. Sections in red are quoted directly from the IOM report summary. Efficacy = effectiveness, does it help? “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.” Dependence and Withdrawal? “... a concern associated with chronic marijuana use is dependence on the psychoactive effects of THC. Although few marijuana users develop dependence, some do. Risk factors for marijuana dependence are similar to those for other forms of substance abuse. ... A distinctive marijuana withdrawal syndrome has been identified, but it is mild and short lived. The syndrome includes restlessness, irritability, mild agitation, insomnia, sleep disturbance, nausea, and cramping.” Marijuana as a “Gateway drug” “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.” IOM’s overall Recommendation “Short-term use of smoked marijuana (less than six months) for patients with debilitating symptoms (such as intractable pain or vomiting) must meet the following conditions: 1) failure of all approved medications to provide relief has been documented, 2) the symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs, 3) such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness, and 4) involves an oversight strategy comparable to an

institutional review board process that could provide guidance within 24 hours of a submission by a physician to provide marijuana to a patient for a specified use." Past and current scientific data and research from good quality studies such as reviewed by the IOM show potential medical marijuana benefit, as well as pros outweighing cons, ONLY for appetite enhancement of the physical wasting and malnutrition of some patients with late stage AIDS, the severe nausea and vomiting of chemotherapy in some cancer patients, and some severe pain caused by some diagnosable severe conditions not responding to standard therapies. Use for the myriad other conditions claimed and listed in various Med MJ propositions are based on opinions, anecdotes, testimonials, case reports, and pseudoscience rather than double blind placebo controlled studies. Marijuana is not advised for chronic use, should not be smoked longer than 6 months due to respiratory concerns including potential heightened risk of cancer, other more appropriate treatments should be tried first and failed, and MJ should not be just "recommended" by a physician but should be prescribed, dosed, and monitored for positive and negative effects including abuse, dependence, and diversion (sell, give away, to others, etc.) just like any other medically useful controlled substance. 2) Did you know physicians can already legally prescribe synthetic oral (pill) THC (the primary active ingredient in marijuana) called Marinol (dronabinol) for our patients who need it? By the way, if smoking was the only effective means to deliver marijuana why are so many non smoke forms of MJ products available in Med MJ dispensaries and clubs? Check this link: http://www.marijuanagrowing.com/blog/archives/109 Logically, and clinically, if marijuana is a legitimate medicine for even a few people with a few health conditions why don't we just treat it like other medicines? Some blame the FDA (even though the FDA approved Marinol years ago) or pharmaceutical companies and mainstream medicine as conspirators, or the antidrug "War on Drugs" lobby. Alternatively, others see the supplement and herbal or generic and brand pharmaceutical industries or organized crime all lobbying for a place in a new legal MJ (and more) marketplace. Can you think of any other "medicine" made available by the public voting in elections for it? And without any clinician or doctor of any type having any role besides writing a "recommendation" for its essentially unbridled use? Do you think at least some of the sponsors could have another agenda? Medical historians and anthropologists have interesting input about this and the last several thousand years human years human use of psychoactive plants and chemicals. The Arizona Medical Use of Marijuana proposition election is 11/2/10 and is typical in allowing 2.5 oz every 2 weeks and/or 12 plants home grown (if more than 25 miles from any of the maximum 120 dispensaries in the state) for registered users for cancer, glaucoma, HIV/AIDS, Hepatitis C, ALS, Alzheimer's dementia agitation, pain, or other chronic debilitating diseases bought from "nonprofit" "dispensaries" if the "patient" has a "written certification" by a physician. One can't drive high or use (just not smoke?) in public nor can a certified user be fired for a positive MJ drug test or have their use held against them in custody and visitation cases. Striking to me is that the "patient" may be any age, even a young child if their registered "caregiver" and 2 doctors approve. Just think about the many problems with that (e.g. pro MJ parent signing up his or her kids so the parent(s) can use or giving into demanding teens, or selling it, etc) versus the very small number of legitimate youth cases? If opiate and benzodiazepine abusers can find doctors to write those prescriptions excessively, one can find doctors to certify illegitimate Med MJ as we see in all other states. Supporters of this proposition state it is more restrictive than California's version. 3) Below are the most common problems I see with MJ: 1) Perceptual distortions – this is, of course one of the main points of smoking MJ. Time slows, colors, music, touch, sensations, smells, lights, etc are all altered; reaction time is delayed. This is the major MJ cause of impaired driving, DUIs, accidents, injuries. 2) Short term memory is damaged while "high" and during the up to 30 days MJ stays in your brain cells after use. The more you use and more often you use, the more "Swiss cheese memory" (holes in your memory) you cause and the longer it lasts. Brain processing speed is slowed. These effects, of course, impact school, work, and more. ADHD meds don't help "potheads" whether they have ADHD or not. 3) Amotivational Syndrome = apathy, don't care, do little, the ultimate slacker; work and school decline, the person "ain't goin' nowhere" and doesn't care and doesn't see that as a problem. Just hanging out at home with the music on, TV on, laying on the couch, munching, chillin', playing the same video game for hours, etc. Sound familiar? 4) Alexithymia – unaware of his or her feelings, out of touch with feelings, doesn't know his or her feelings, denial of sad,

down depressed, angry, etc. Again, this is often the point with substance abuse – to ALTER feelings, not feel unpleasant or unwanted feelings, not deal with or even be conscious of the sadness or anxiety related to losses, stress, or progressing through or failing at the developmental tasks of one's age and life stage. This is common and deleterious. The active substance abuser (and yes MJ is a major substance of abuse) almost always denies this until the process of recovery is far along. Some patients tout MJ as an aid for their depression, anxiety, sleep, or anger via "self medication". Others later admit their denial, report MJ worsened or caused their depression or anxiety, or eventually see their life was held back by their use. 5) Relationships with peers, parents, or romantic partners frequently suffer as the user drifts more to other users and away from those who don't use or don't approve. "Paranoia" and social anxiety with oversensitivity is often worsened by MJ amplifying the tendency to withdraw, stay home, and not mix with others. 6) While uncommon there is clear evidence that some persons' psychotic symptoms (hallucinations, delusions, irrational thinking, severe paranoia) are exacerbated or caused by marijuana. MJ abuse is a common problem worsening the difficulties folks with serious mental illness face.

R9-17-02, In reference to numbers 5 and 6. Fees are unreasonably high, especially if they are non refundable. I would suggest developing a fee schedule based on patients yearly income or ADHS should provide assistance to low income patients. Patients and caregivers should be treated as two separate entities. Patient and caregiver registration requirements should be developed with an emphasis on health and medical. Registrations requirements should benefit the patient. The department should always consider patient income and circumstances vary. Dispensary agent and dispensary registration requirements should be treated with the same restrictions as most businesses, henc higher fees, strict monitoring and strict inventory requirements. Dispensary agents and dispensary registration requirements should developed through a business/legal aspect. But should stay away from making the health facility look like a liquor store . The department should consider the fact that both the dispensary and the dispensary agent do work for a facility that provides medical assistant to qualified patients. R9-17-103, I would suggest including other options for submitting to the department: initial/renewal registration, amendment/change or replace ID cards for patients and caregivers.

R9-17-101 #15 - Medical Director should meet the definition of Physician as defined in the law (i.e. include naturopaths and homeopaths). The position of Medical Director was never included in the law passed by the voters and is not required for other pharmacies in the state. If you are going to require this position by the rule, it should at least be consistent with the definition of Physician in the original law. R9-17-102 #6 - The $150 fee for a qualifying patients is excessive. These are people with long-term, debilitating illness and possibly in hospice! At the very least, provide a sliding fee scale. R9-17-302 A - As currently written, one could argue that only a single person in a corporation need nominally be an Arizona resident. This does not appear to prevent large out-of-state "marijuana mills" from creating a company with an Arizona figurehead. All officers and board members of a corporation should be Arizona residents. Furthermore, I suggest increasing the length of residency to 5 years! R9-17-302 B 5 (and elsewhere) - A small business may have tenative lease agreements in place for a dispensary and cultivation site; however, it is unreasonable to expect any small business to have signed a lease, obtained a certificate of occupancy, prepared space improvements for security, secured bonds, etcetera prior to obtaining a license. These represent substantial investments of money that cannot be made without a business loan, and loans cannot be obtained without a license. These requirements will make it so that only the "marijuana mills" can prepare a 'complete' application. Please relax the language to allow for the application to include tenative lease agreements and the requirement for obtaining the other items prior to operation.

R9-17-102. Fees An applicant submitting an application to the Department shall submit the following nonrefundable fees: [Comment] – if denied, Application Fee should be refundable at early stage of

License Approval, should be considered nonrefundable AFTER DHS has issued written notice of preliminary approval of the dispensary registration certificate that contains the dispensary's registry identification number, as in R9-17-107 (F) As there continues to be a lot of additional stages after this preliminary approval point to be completed by both Dispensary and DHS before Full Approval of a License. 1. For registration of a dispensary, $5,000; 2. To renew the registration of a dispensary, $1,000; [Comment] – RENEWAL should be increased to $2,500 and considered a cost of doing business. Yearly Fixed Expense Not for Profit Organizations. ARTICLE 3. DISPENSARIES [Comment] - All Good Points. A Each principal officer or board member of a dispensary is an Arizona resident and has been an Arizona resident for the two years immediately preceding the date the dispensary submits a dispensary certificate application. [Comment]-GREAT POINT! Will Discourage and Eliminate out-of-state Franchises, out-of-state Investors, and absentee Dispensary Owners attempting to possibly take advantage of Arizona's Medical Marijuana Program. B. (g) The name and license number of the dispensary's medical director [Comment]-Again, a possible Problem with a Designated Medical Director Physician (and/or Pharmacist) –conflicting DEA, State and Federal Medical Licensing Law. 15 Whether: a. A registered pharmacist will be onsite or on-call during regular business hours; [Comment]-Again, a possible Problem with a Designated Medical Director Physician (and/or Pharmacist) –conflicting DEA, State and Federal Medical Licensing Law. R9-17-307. Administration C A dispensary: 1. Shall cultivate at least 70% of the medical marijuana the dispensary provides to qualifying patients or designated caregivers [Comment] – 50% - 50% Split between Grown and Acquired; 2. Shall only provide medical marijuana cultivated or acquired by the dispensary to another dispensary in Arizona, a qualifying patient, or a designated caregiver authorized by A.R.S. Title 36, Chapter 28.1 and this Chapter to acquire medical marijuana; 3. May only acquire medical marijuana from another dispensary in Arizona, a qualifying patient, or a designated caregiver; 4. May acquire up to 30% of the medical marijuana the dispensary provides to qualifying patients and designated caregivers from another dispensary in Arizona, a qualifying patient, or a designated caregiver [Comment] – 50% - 50% Split between Grown and Acquired; and 5. Shall not provide more than 30% of the medical marijuana cultivated by the dispensary to other dispensaries. [Comment] – 50% - 50% Split between Grown and Acquired

Need to change the over the top pre-application requirements for lease hold improvements (security, etc) For these to be physically in place before one even knows if they will get a dispensary is unrealistic. It would be appropriate to have the plans, estimates, written confirmation of what will be put in place if selected. Inspections will be taking place anyway to assure the dispensary complies with completing the work per the estimates.

The draft rules could be improved by more closely aligning with the law. The rules are so restrictive that it appears that medical marijuana is still illegal, rather than regulated. It appears that the law (Act) and the rules were developed without cross-reference. Improvements could be made by starting with each line of the law and working from there to produce an appropriate method for implementation with a rule. An example would be: Medical Directors as added under the rule should correlate to the types of physicians defined by the law. As the rule is written, only Osteopaths and PCP's are eligible to be Medical Directors yet the law defines Physician to include Naturopaths and Homeopaths as well. They are all legitimately licensed in Arizona so why would the rule be incongruent with the law here? I would think that with the shortage of doctors in Arizona, and nationally, we would want to accommodate including all the specialists listed and defined in the law. Another challenge appears in the costs that accumulate in the way the rules are written. As these are costs ($5000. application fee; $2500 Change of Address fee; not to mention the Tax Priviledge that is proposed to be $20. per ounce sold - unheard of!) that will be passed on to the patients ultimately. These are sick people (if the right protocols are followed) and they should not be unable to obtain the medical marijuana due to exhorbitant prices dispensarys have to charge to recoup fees and fund compliance methods. By the time tax is paid, Medical Directors are paid, staff are paid, rentals, build outs and product growing/labeling is paid, etc. - there are few dollars to return to the community to be reinvested as non-profits often do. The bond is

an issue as well. I don't think that can be done as it may not be legal to require.
R9-17-202 5e. A statement, initialed by the physician, that the physician: i. Has a professional relationship with the qualifying patient and the physician has seen or assessed the qualifying patient for the patient's debilitating medical condition during the course of the professional relationship.
Be strict with established reputable companies/individuals that can conduct such dispensaries and growing locations. Quality people. Good standing w bbb, etc
R9-17-106. Adding a Debilitating Medical Condition. C. An individual submitting a request for the addition of a medical condition to the list of the debilitating medical condition shall submit the request in January or in July of each calendar year. The draft rule should read C. An individual submitting a request for the addition of a medical condition to the list of the debilitating medical condition shall submit the request anytime during the calendar year.
ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer

financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse.

Regarding, Ongoing physician-patient relationship and Issues of Fair Access: Arizona has a large Native American and Military Veteran population utilizing federal medical facilities exclusively for their health care. The federal position on medical marijuana being illegal will prevent federal health care providers from recommending it’s use. Therefore, those utilizing Indian Health Services and Veterans

Affairs medical facilities will be denied fair access to Proposition 203. In many cases those groups utilizing federal health services have no access to private health care based on financial and/or geographic issues. These individuals as well as low income Arizonians in general are unable to comply with the doctor-patient relationship requirements as outlined in the draft. The requirement of an ongoing relationship and four doctor visits in a year prior to recommended medical marijuana not only restricts but denies access to many Arizonians. In regard to Native American and Military Veterans an exemption to the ongoing doctor-patient relationship requirement should be established. The presentation of satisfactory evidence of enrollment in a federal health care programs should grant exemption. In regard to low income, working poor Arizonians having no access to regular health care! I have no solution other than disregarding the doctor-patient relationship requirement all together.
Require the Department to notify an applicant of ALL deficiencies within the specified time-frame.
If you have a year's documented medical history of any one of the specified illnesses...there should be no requirements other than a yearly visit to any medical marijuana doctor.
Delete the requirement to notify the Department for each change of address
Relax the dr rules. One year is not right. We voted for it so let us have it. I dont want us to look like california either but limiting dispensories will do that just fine you dont need to put strain on the dr's. What if I dont want to see a Dr once a month? Relax the recomendation rules
The rules should provide for a paper form, mail-in and/or hand-in application and provide a receipt.
The draft rules can be improved by allowing patients easier access to medical marijuana. This draft is severely limiting to patients. I do not feel it is reasonable for a patient to be required to see a doctor for a year to receive the treatment they are seeking. I think the alternative option of a physician taking on the primary responsibility for managing a patients ailment is absurd and clearly shows prejudice on the part of The Division of Public Health Services. A patient should not be stifled by the views of one physician, and likewise physicians should not be limited in providing the treatment that they see fit. This draft is putting more restrictions on medical marijuana, which has no harmful side effects, than are placed on other medications that can easily be abused and many of which have serious, harmful side effects. I feel this is extreme and absolutely unacceptable bias on the part of the Arizona Department of Health Services. This legislation is clearly exceeding what has been approved by voters. When I voted yes for Prop 203, I voted to give patients access to medication that is beneficial to them. I did not vote for medical marijuana patients to be put through undue, biased harassment to seek the medication they need. Patients should not be made to feel like criminals to obtain a medication that is far safer than many easily obtained, harmful prescriptions that are available to the public. I am very dissatisfied with this draft. I feel that the Department of Health Services has not only seriously overstepped their authority, but has also showed a disgustingly uneducated and prejudiced stance on the issue.
I think that people that are from other states should be able to be part owners of a dispensary as long as there are more Native Arizonans than others on the board, or owners. There are people from other Medical Marijuana states that could really help get things started & growing here. make the fencing requirements for all besides dispensaries much more reasonable. Lower the standards of the needed fencing & covering. Also allow greenhouses as is stated in the law.
The rules should propose sliding scales as described at 36-2803.5.e

Allow for consideration of a true doctor patient relationship which begins with a single visit, exam and /or assessment. These regulations should allow for chiropractors or Naturopathic doctors to be directors of dispensaries. Why doies it HAVE to be an MD--it's natural medicine and an alternative treatment that should be able to be recommended by these professional providers. I am an RN and make holistic recomendsations to my patients often. Why can I not be a director for a dispensary. I feel quite comfortable that i would be able to recommend Medical marijuana to a patient based on his symptoms or diagnoses. I already have to patients with Neuropathy, PTSD and muscle spasms. Adding additional diseases and symptoms is dreadfully long and very inconsiderate to those suffering that may get relief from this medicine. We should definitely change this draft to Make it easier to add additional diseases and symptoms. PTSD, depression, Anxiety needs consideration NOW.
Add that personnel in the dispensary have licensure and legal papers readily available for view/examination. Area within 75' of building doors be clear of use, disposition or activity related to the marijuana. Require "hockers" or those holding signs such as "the doctor is in" be regulated.
Certain parts of the definition of public place should be deleted or otherwise refined. Only in the public areas of the locations facilities, and venues listed in R-9-18.b should patients be prohibited from smoking. Private areas such as non-public offices should not be included.
A fee of $5,000 to register a dispensary seems insignificant in comparison to what kind of profit will be realized over time. I believe the cost should be at least $10,000.
I was just reading about some of your other funding needs on your website, and wanted to point out that the State of Colorado made 21 million dollars this year in fees from its medical marijauna program. We support the fee schedule as proposed, and hope that the revenue will go to ADHS and to the Public School system, and not the General Fund of those clowns in Phoenix who claim to be our "elected" officials.
The rules will be improved by deleting §R9-17-307(C). This section ensures that the maximum number of cultivation facilities will operate in the state, and allows registered patients who grow without being monitored by the State to supply to dispensaries. This has many unintended consequences: § Creates more potential targets for crime § Increases the amount of DHS resources needed to effectively oversee the operation of these facilities § Makes quality control for purposes of drug consistency and safety logistically impossible · Makes it more difficult to obtain the specific type of medicine needed from across the state Deleting §R9-17-307(C) will have the following benefits: § The oversight of fewer cultivation facilities by DHS reducing the burden on already limited resources § There will likely be fewer potential targets for criminals looking to get their hands on marijuana across the state § Quality control will be drastically easier thus the medicine will be safer § Multiple dispensaries can carry the same product originating from single source, giving patients better continuity § Reduce the chances of medical marijuana ending up in the wrong hands by eliminating the need for cultivators to dispose of product they cannot sell to patients
I think that with the low amount of dispenseries there is a chance for a monopoly to be created. But opefully after a year of revenue comes in they will add to the number. It also seems like there is some red tape that is being put up like the $5,000 to become liscensed.
1. Medical Director Definition: Should change to include any Doctor who is permitted under Title 36 to recommend Medical Marijuana. 2. Ongoing Definition: this is merely an attempt on the part of AZDHS to create an artificial bottle neck, choking off a potential revenue stream for struggling new dispensary owners. This is an unfair, abuse of authority on the part of AZDHS, intending to further the agenda of MPP. This rule is intended to dissuade marginal (“Trivia”l) applicants from submitting applications. AZDHS should rely on the recommendation of a Arizona licensed Physician, regardless of the

relationship period, so long as the recommending physician complies with the provisions of Title 36, or until such time as there is evidence of fraud. 3. ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rule making be implemented "without imposing an undue burden on nonprofit medical marijuana dispensaries...." 4. ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. 5. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. 6. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. 7. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not (or cannot afford) to seek other medical care at all (whether prior or subsequent to application). 8. R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. 9. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. 10. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. 11. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. 12. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. 13. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information 14. R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a

caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. 15. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. 16. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. 17. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. 18. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. 19. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. 20. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. 21. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. 22. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse.

1. no undue burden on patients 2. liberal distribution to patients with prescriptions for whatever condition the doctor deems necessary..including marijuana 3. Over many years, marijuana researchers have NEVER found anything linking it to cancer, lung disease or any other harmful effects. Medical marijuana should be a decision made between patients and doctors, not politicians 4. Medical dispensaries should have the same type of requirments as a drug store does now. Drug stores dispense far more dangerous drugs than marijuana 5. It is proven to be good for so many ailments and should be dispensed with as much ease as buying aspirin or tylenol. 6. Marijuana has been used for thousands of years...it is time to admit that the drug is safe, effective and helpful in easing the pain and suffering of so many people 7. The revenue generated from marijuana could recoup so much money that can be used to make AZ even better than it is now....reduce or eliminate the deficit while helping people at the same time.. 8. It's a no brainer....if we don't legalize marijuana, then we must at least make it accessable to all people who need it to improve their lives.

LET PATIENTS SEE THEIR PRIMARY DR. OR CANER DR. AND LET THEM PRESCRIBE MEDICAL MARIJUANA, AND OUR INS. SHOULD PAY FOR IT, AND OUR INS. SHOULD COVER THE PRESCRIPTIONS. WE SHOULD NOT HAVE TO WAIT A YEAR AND SEE A STRANGE DR. FOR 4 APPT'S. THAT IS WRONG, WE SEE ONE DR. ONE TIME, ONCE A YEAR, AND WE DO NOT PAY ANY MORE FOR

OUR PRESCRIPTIONS THAN MEW MEXICO $142.00 TO $148.00 AN OZ. THE PATIENTS AND THEIR DR'S SHOULD MAKE THE RULE'S, NO BODY ELSE ! ! !
1) I have concerns about the physician relationship of at least 1 year. It seems that some conditions could be more aggressively debilitating versus others and this may lead to unintended restrictions to treatment of patients who truly would benefit from this therapy. 2) R9-17-302, B, 15, a: I have major concerns about the statement of "whether a registered pharmacist will be on-site or on-call during regular business hours". Prop 203 is in direct violation of the Arizona Statute: Pharmacy Act, Title 32, Chapter 18. Having said this, I also have concerns if pharmacists aren't included in reviewing other drug therapy and regimens for drug-drug interactions. Overall, this new law needs to be consistent with Arizona State laws regulating pharmacists in addition to federal laws. 3) I feel the inventory control section should be more specific and stricter. 4) Consider more emphasis on fingerprinting, maybe requiring individuals running dispensaries or working at the dispensary to obtain a fingerprint clearance.
At this time AzNMA has three requests for changes to the rules as the process moves forward. The requests are as follows: 1. The Naturopathic, Allopathic and Osteopathic Boards of Examiners should require physicians who recommend medical marijuana to complete no less than eight hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that covers the clinical, pharmacological, ethical and legal aspects of using medical marijuana in patient care. 2. Naturopathic Physicians should be included in the definition of “medical director” as they are included in the definition of “physician” in the voter approved Medical Marijuana Act and authorized to recommend medical marijuana to qualifying patients. In this instance naturopathic physicians have the same qualifications as allopathic and osteopathic doctors to successfully serve as medical directors. 3. Patients with a terminal illness should be exempt from the rule requiring a patient to have a professional relationship with a physician for at least one year and assessed for their medical condition on at least four visits prior to being eligible for a medical marijuana recommendation.
Remember the veterans that don't have insurance for private doctors. Think about out of staters coming here with medical marijuana cards, that don't go to Arizona doctors, and many get their prescriptions filled in Mexico, and have Mexican doctors. In this down turn in the economy left many people are out of work and the state cut backs leave many Arizonians out of money for health care and jobs for meds, especialy in the past 3 to 4 years. The dispensaries need to sell organic marijuana, with out pesticides or fertilizers which further making their problems worse Read the studies from Europe and Scandanavian countries that have an unbias scientific study of the Three hundred different varieties of this plant, not just the U.S. studies subdized by the federal governmant and has had a war on drugs. I watched the congressional hearings on this legislation and it was lop sided from the beginning. We have the penal system full of pot users and violent offenders walking the street because of over crowding, and the cost is enormous to Arizona.
1. Limit number of patients for authorized doctors/prescribers 2. Require in-person medical evaluations of patients 3. Track sales between growers, caregivers, dispensaries and cardholders 4. Guidelines are needed for proper and secure disposal of unused marijuana 5. Require city/county permits for all residential or commercial cultivation; clean-up costs are responsibility of the dispensary owner and alterations to the property require a permit and must be inspected; no cultivation of marijuana in a residence or property occupied by minor children 6. Require “warning” language on marijuana packaging that addresses the addictive nature of the drug and its impact on motor skills (e.g. do no operate a vehicle or machinery while using); also require dispensary representative to verbally discuss the side effects of the drug and impact on others.

decrease cost, if caregiver is my husband, can't he use my card since he would be shopping for me??? why would a card for him be more expensive since he is family and caregiver??? So I would have to purchase a licence (id card) ?? for me as well as my caregiver husband???? why not just say what you mean, not drag it out. think of the patient, that is why this measure passed in the first place, not to make it more difficult and expensive for the patient. get your money from the dispensaries. that would be part of their expenses.
Google google
reduce fees for low income people make it easyer for pain issues who dont have insurance to get it
The concept of physician responsibility should be changed.
Two areas of the draft rules concerned me. One was the requirement to have a Medical Director as part of the staff. This medical director would have no association with patients as far as prescribing but would be there purely in an advisory role. This may be a challenge for otherwise qualified dispensaries because finding a doctor willing to give their license number without a significant financial incentive would put smaller operations at a disadvantage. For example, you may end up with doctors demanding ownership in up to 3 dispensaries purely for the financial gain but with very little actual involvement. This will cause the industry to be associated with profit driven doctors opposed to doctors actually concerned about patient health. I think it would be good as an optional benefit to a dispensary like a pharmacist but a strict requirement is problematic given the types of doctors I have seen attracted to dispensaries in other states.
I can't change doctors because of insurance reasons. I'm disabled and poor. My doctor can't prescribe marijuana because he says the administrators say he can't. Let me see my doctor and maybe yearly see a doctor my marijuana. I have terrible spasms and can't walk.
Tell us what the selection process will be for choosing who gets a dispensary license and who does not. Is it first-come, first-served, do they go to whoever pays the most money, etc. etc. As it stands, after spending $1000's to set up a dispensary, there is no guarantee on getting a license.
For dispensaries, it seems that there is an issue with the whole chicken before the egg conundrum. The regulations are currently requiring that an entire business be in existence and be ready to operate before an applicant can even apply for the certification. It seems to be a huge and somewhat unfair risk. Even with approval and certification and inspection, a dispensary will still be 90 days out (seed to harvest) before the medication will be ready for patients. Unless you have very deep pockets, it's a huge financial risk. It seems that with these type of start-up requirements, it is inevitable that "marijuana investors" from California and other states will have their dollars tied to Arizona's profits.
While may be intended to prevent non-medical use of marijuana, it will have an impact of delaying the acquisition of marijuana by qualifying patients and may induce increases in the price of adequate quantities necessary to treat glaucoma and other conditions.
Right now, it looks like the only way to get a certificate/license for a dispensary, is to lease property, build it out and set it up as a dispensary and be ready for business by April 1st, when we can apply for a license... After putting $150,000 into a business and getting set up, isn't there some way we can get an initial 'okay' on our project? I am the [redacted] with about 185 members, ALL of which are interested in the medicinal marijuana option for relief from our pain and to help us sleep better. I have an investor from Denver CO who

wants to build a place in Mesa, but (understandably) he is hesitant when there's no guarantee of getting a license after we get ready. Is there someone I can talk to about this?

R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application).

Draft Rule R9-17-311 should be expanded to include a requirement that when verifying the qualifying patient’s identity, dispensaries must employ a biometric identity verification system, such as a thumb print scan. DHS is mandated by the Initiative to ensure that dispensaries are only releasing medical marijuana to qualifying patients who hold a validly issued registration card. If DHS required biometric verification in the rules, it would ensure that counterfeiting, identity theft, or other forgeries resulting in medical marijuana falling into the wrong hands would be prevented. This requirement will have the best chance of preventing the type of abuse we see, for example, with underage persons purchasing alcohol using fake identification. By requiring biometric identity verification, it would be nearly impossible for a dispensary employee to dispense marijuana illegally. While it is certainly expected that dispensaries will self-police their agents, under the current Rules it would be very easy for a disreputable agent to collude with a non-patient to dispense MM under somebody else’s registry number. In this scenario it would be extremely difficult for a dispensary owner to discover illegal transactions as the record would appear legitimate. However if that transaction must be accompanied by a cardholder’s thumbprint illegal transactions would be impossible. The proposed rules require a dispensary agent to verify information from the State’s medical marijuana electronic verification system and enter additional information into the system relating to the transaction. The technology is available to allow this process to be automated so that the dispensary computer directly communicates with the medical marijuana electronic verification system without a human user being required to enter the information. This automatic communication from computer-to-computer would reduce the chances of human error while reviewing

or inputting information, and thus better prevent fraud and improper dispensing of medical marijuana. It would also mean that human users could not alter or enter fraudulent information, again reducing the chances for fraud or abuse of the medical marijuana system. The rules should explicitly allow such electronic transactions by making the existing R9-17-311 part A and adding as part B: B. A dispensary may use an automated electronic system of hardware and software to verify the information required in Section A before dispensing medical marijuana to a qualifying patient or designated caregiver and to submit the required information to the medical marijuana electronic verification system.
Last week, I was one of 30 attendants at a medical marijuana college. An over whelming majority (approximately 90%) of the students were between the ages 45 to 55 years of age. All of whom are hopeful of becoming caregivers to medical marijuana patients. Limiting patients to a dispensary within 25 mile of residency is unfair to the patients and caregivers. They are the ones voted to pass the act. Patients should be free to choose their best interest. What happens if a dispensary opens within said guidline after the patient has chosen a caregiver? On behave of the majority of all independent caregivers and their patients, I beg you to consider, eliminating the unfair 25 miles restriction.
This definition should be broadened to reduce the costs of operating dispensaries and consequently the price of marijuana needed to treat glaucoma and other conditions
1. Registration fees for patients seem quite excessive. Since most insurance companies do not reimburse such expenses, it seems that this puts an undue burden on patients. 2. Listing residence address could jeopardize a patient's safety. I strongly urge either the acceptance of a mailing address for the files, or governmental agencies MUST exercise the best Internet security possible so that this information cannot be accessed by unauthorized persons. 3. While I did not find restrictions on dispensary locations, if properly regulated, and without consumption of marijuana on its premises, a dispensary should be able to be located most anywhere, without concern about proximity to schools, etc. Due to foot and automobile traffic, dispensaries should be located in commercial or industrial areas. 4. Restrictions on ongoing relationships between physicians and patients seems excessively restrictive. Some physicians either cannot write prescriptions for cannabis or lack experience with it and will not prescribe it. As currently written, this could force a patient with a satisfactory relationship with a physician to have to CHANGE physicians for the ongoing treatment. This section should be either stricken or the rules relaxed to allow a patient with a cannabis-inexperienced physician to be seen by a different physician, ad hoc, for the purpose of a cannabis evaluation and possible prescription, without altering the ongoing relationship a patient has with another physician.
Draft Rule R9-17-311 should be expanded to include a requirement that when verifying the qualifying patient's identity, dispensaries must employ a biometric identity verification system, such as a thumb print scan. DHS is mandated by the Initiative to ensure that dispensaries are only releasing medical marijuana to qualifying patients who hold a validly issued registration card. If DHS required biometric verification in the rules, it would ensure that counterfeiting, identity theft, or other forgeries resulting in medical marijuana falling into the wrong hands would be prevented. This requirement will have the best chance of preventing the type of abuse we see, for example, with underage persons purchasing alcohol using fake identification. By requiring biometric identity verification, it would be nearly impossible for a dispensary employee to dispense marijuana illegally. While it is certainly expected that dispensaries will self-police their agents, under the current Rules it would be very easy for a disreputable agent to collude with a non-patient to dispense MM under somebody else's registry number. In this scenario it would be extremely difficult for a dispensary owner to discover illegal transactions as the record would appear legitimate. However if that transaction must be accompanied by a cardholder's thumbprint illegal transactions would be impossible.
These rules should not impose restrictions on prescribing medical marjiuana that are more restrictive than those for prescribing any other prescription medication. For example, the requirement that a

person have a debilitating condition for more than a year and a specific Dr./patient relationship for more than a year before they are eligible to be prescribed medical marjiuana has no reasonable medical basis and is not required for any other prescription medication. Therefore, it is arbitrary, capricious, and unreasonable.
R9-17-101, #15: Definition of a Medical Director: anyone would has the legal authority to prescribe should also be allowed to be a medical director. R9-17-102- Fees for applications: The fee structure should encourage locally owned, small businesses. By making the application fee non-refundable, you are encouraging these huge corporations while placing undo burden on "the little guy". Also, the $2500 to change locations of the store front or the cultivation site is too hight. Again, only big corporations are able to absorb that kind of expense, thereby removing the small business owners ability to participate. The fee for the user's card is too high; people who have cancer and MS really can't afford the $150.00 fee. Recreational user CAN afford it, but you could double it and the recreational users are still going to pay it, while the sick people can't afford it. R9-17-103- Electronic submission of the application- people should have a non-electronic application option. A lot of the targeted patients are elderly and may not be comfortable with computer technology. Also, 40% of home do not have a computer. R9-17-202, #5, a-k: Requirements for the Physician- a physician can prescribe morphine or oxycontin with the stroke of a pen, but has to jump through hoops to recommend marijuana. This section creates undo burden on the physician. R9-17-302- Applying for a Dispensary Registration Certificate- (A)residency requirements should be for 5 years instead of 2, and should include every person associated with the dispensary. This would help to reduce the number of licenses given to out of state companies posing as local residents. It would be infinitely better for the dispensaries to be operated by people living in the communities they serve. (B) 1, (b) (h)- it is not realistic for someone to have a signed lease, or purchased property for a store front and cultivation site prior to receiving a license to operate the business. This eliminates the small businesses and panders to large corporations.
HOW CAN THE DRAFT RULES BE IMPROVED? The rules will be improved by deleting §R9-17-307(C). This section ensures that the maximum number of cultivation facilities will operate in the state, and allows registered patients who grow without being monitored by the State to supply to dispensaries. This has many unintended consequences: § Creates more potential targets for crime § Increases the amount of DHS resources needed to effectively oversee the operation of these facilities § Makes quality control for purposes of drug consistency and safety logistically impossible · Makes it more difficult to obtain the specific type of medicine needed from across the state Deleting §R9-17-307(C) will have the following benefits: § The oversight of fewer cultivation facilities by DHS reducing the burden on already limited resources § There will likely be fewer potential targets for criminals looking to get their hands on marijuana across the state § Quality control will be drastically easier thus the medicine will be safer § Multiple dispensaries can carry the same product originating from single source, giving patients better continuity § Reduce the chances of medical marijuana ending up in the wrong hands by eliminating the need for cultivators to dispose of product they cannot sell to patients
I believe there needs to be an ammendment to the fees. Many of the patients are on limited income. The fees seem to be excessive to begin with compared to other states regulations. I believe there needs to be a financial aid or waiver for those who cannot afford the registration/renewal. I am concerned about the safety of my personal information. The dispensaries have to be held completely accountable for the privacy and protection of medical status etc for patients.
My city will not have their rules regarding dispensaries ready until sometime in April. It makes no sense for us to sign a lease & begin to equip a building without first being granted a license from AZDHS & seeing what our city is going to require.

The people of Arizona deserve for the MM industry in our State be regulated in such a manner so as to provide only consistently therapeutic medicinal marijuana to patients. The Department of Health Services has already contemplated requirements for clean and safe conditions as well as inventory control and product testing. Yet §R9-17-307(C) seems to act contrary to these well thought out and necessary provisions. Draft Rules §R9-17-307(C) requires a dispensary to cultivate at least of 70% of the marijuana it provides to qualified patients and designated caregivers. It also limits the amount it may receive from other licensed growers to 30% of their output, and limits the percentage of their total crop that they may provide to other dispensaries to 30%. This makes little sense when related back to the State's interest in delivering a consistently high quality product to sick patients. It also may create a security risk in the sense that the more cultivation facilities the more difficult it will be for the State to make sure the operations are in compliance on every level. We feel that the language of that rule should be deleted, permitting holders of Dispensary Registration Certificates to be able to grow and supply to other Certificate holders who may not have the facility or the know how to adequately cultivate a quality medicinal plant. This would make the State's regulatory task easier and less costly and make marijuana production more secure.

I think improvements on patient Records safety and confidentiality is Very much needed here. Also I think that the way and the tools (map quest, Google maps, Bing etc.) that you use in determining if a patients lives 25 miles to a Dispensary and has the permission to grow his or her own medicine needs to be lined out here. The last and finale thing I believe that needs to be addressed is the $150 fee. I do think that there needs to be something in it to waive it for low income people and people on Social Security because this is what the law was made for, "the Sick". Many of the sick are Under employed or UN employed making it a burden and unreasonable to charge a sick person to have the right to buy there medicine.

The rules will be improved by deleting §R9-17-307(C). This section ensures that the maximum number of cultivation facilities will operate in the state, and allows registered patients who grow without being monitored by the State to supply to dispensaries. This has many unintended consequences: § Creates more potential targets for crime § Increases the amount of DHS resources needed to effectively oversee the operation of these facilities § Makes quality control for purposes of drug consistency and safety logistically impossible · Makes it more difficult to obtain the specific type of medicine needed from across the state Deleting §R9-17-307(C) will have the following benefits: § The oversight of fewer cultivation facilities by DHS reducing the burden on already limited resources § There will likely be fewer potential targets for criminals looking to get their hands on marijuana across the state § Quality control will be drastically easier thus the medicine will be safer § Multiple dispensaries can carry the same product originating from single source, giving patients better continuity § Reduce the chances of medical marijuana ending up in the wrong hands by eliminating the need for cultivators to dispose of product they cannot sell to patients

The dispensary cultivation rules need to provide for additional production sources. Licensed growers and facilities could specialize in production whereas a dispensary is a business, not a farm.

1. There should be specifics about the selection process - You have put a HUGE financial risk out there, by not specifying the selection process, yet requiring a huge blind upfront expense. This seems like overstepping your bounds. 2. The rules for a patient card are WAY too stringent. I understand the fear of abuse, but DEA tells us that the most abused drugs in this country are Pharmaceuticals! Until all patients of all doctors are required to go through these extraordinary hoops to get truly dangerous (read: deadly) prescriptions the double standard seems illegal at best and contrary to the peoples will in passing 203 at the very least. 3.The twice a year window for petitioning new conditions is unreasonable. 4.The concept of a medical director is a reasonable one, but the stringent requirement is unreasonable. It assumes a medical emergency or urgency that can an never will happen in the real world. Do this for all pharmacies, where the truly dangerous drugs pose a real risk! As many as

150,000 people a year die from prescription meds. ZERO - none- die from marijuana.
Section R9-17-308: Re: Obtaining a Dispensary Agent Identification Card. (Also under Section R-0-17-107 sub-section F) • Which government issued identification documents will be required for qualification? o Is it mandatory for an applicant to also submit an Arizona Identification Card if the applicant has an Arizona Drivers License? o Please list all required identification documents that must be supplied by each Agent. • What documentation is needed to confirm applicant's Arizona residency? o Will state or federal tax returns suffice for demonstrating two years of Arizona residency? o Will evidence of mortgage, rental/lease agreements, property ownership or utility bills suffice for demonstrating two years of Arizona residency? • We suggest that non-naturalized, documented permanent residents of the United States qualify to apply for a Dispensary Agent Identification Card. • We suggest that a qualified person be allowed to serve on the management board of the Dispensary without having a Dispensary Agent Identification card. Perhaps modify the rule to say that only persons with valid Dispensary Agent Identification Cards can handle the Marijuana, but persons can serve on the board. Example, a dispensary may want to have a person on the board for their expertise in business, but not have that person be involved in the cultivation/handling/sales of Medical Marijuana. (Also mentioned in R9-17-307 sub-section4) • We suggest that non-naturalized, documented permanent residents also be permitted to provide expert advice concerning cultivation. Section R9-17-102 • We suggest that 90% of the $5,000 Dispensary application fee be refundable if the application is rejected by the Department. The remaining $500 will be kept by the department to cover the actual expense of researching applications, etc. Section R-9-17-301 • If prop 203 specifies that Dispensaries can only be non-profit entities, why are individuals eligible? Section R-9-17-302 • Section A: Why does every principal officer or board member need to submit a separate Dispensary Certificate Application? Shouldn't it be one Dispensary Certificate Application with information of all principal officers and board members included in it? • Section B-1 o We suggest that an applicant should not be disqualified for having one late child support payment, per year or disqualified for payments that have been delayed due to clerical error, holidays or other causes beyond the control of the payer. o Is having a Medical Director mandatory or optional? o Do the Cultivation Site and Dispensary Location have to be separate? • Section B-5&6: RE: Zoning: What happens to the validity of the Dispensary Registration Certificate, if at the time of application or after the Certificate is issued, the city changes its regulations limiting or forbidding the cultivation and sale of medical marijuana? • Section B-15: Is having a registered pharmacist on-site, on-call or available, a requirement or optional? Section R9-17-303 • Can a dispensary have more than one location/branch? o If yes, can each location be registered under the same Dispensary Registration Certificate? o We suggest that up to five branches be allowed under the main Dispensary Registration Certificate, provided each location meets the general qualifications for certification. MISC: • Is it required to have a signed lease already in place before applying for a Dispensary Registration Certificate, or would a conditional lease suffice? o We suggest, that given the complexities of the application process, applicants should be allowed to submit a conditional lease that would specify that the building will be leased if the Dispensary Registration Certificate is granted. • Can a Dispensary sub-lease part of the Dispensary to a company that sells related products? We suggest that this be allowed. • We suggest that there should be a provision in the rules that mandates that all Medical Marijuana sold in Arizona, must be grown in Arizona.
This definition id not practicable for cultivation facilities and is inappropriate for dispensaries or even their product storage areas. Only the storage rooms need strong enclosures such as a safe. A dispensary should have security, but this draft rule goes way too far. Differentiating the the levels strength of the building materials according to the individual uses instead of lumping all needs for "enclosed" into one form would be more effective and less costly.

Re R9-17-302: I am a commercial Real Estate Broker and I dont agree or understand how an applicant for a Dispensary can provide an address showing ownership or a fully executed Lease unless they are approved for the Dispensary. Landlords/Owners want a 3-5 year commitment from a Tenant that could cost $4-$5000 per month the Tenant would legally and financially for responsible for a building he would not have any use for unless he were approved. Some clarity as to the business ownership rules.

1. A patient must pay $150 each year for an identification card, and a designated caregiver, $200. There does not appear to be a sliding scale or lower cost card available for low-income patients, as most other states have. I would suggest reducing the fee for patients receiving SSI, SSDI, Medicaid, or other federal/state benefits. 2. A dispensary may provide only 30% of its cultivated marijuana to other registered dispensaries and may acquire only 30% of its own marijuana supply from other registered dispensaries. This is very problematic and not in the best interests of patients, as it will likely create acute shortages in rural areas and drive costs up. Those patients within 25 miles of a rural dispensary unable to meet demand will have no secondary option for safe access to their medicine. Please create an open wholesale relationship between dispensaries. This will assure consistent supply to rural Arizona, easy access for all qualifying patients, and lower costs due to increased competition of organizations trying to meet demand. 3. A patient's Arizona physician must either 1) have been treating that patient for the debilitating medical condition for at least a year that included at least four visits, or 2) have taken primary responsibility for the care of the debilitating medical condition after compiling a medical history, conducting a comprehensive exam, and reviewing medical records. This provision is stricter than in most of the medical marijuana states, but does not appear designed to prevent a seriously ill patient with a demonstrable debilitating medical condition from getting a written certification. It may make it impossible for some veterans to qualify, because Veterans Administration Hospital doctors do not issue recommendations. Please consider modifying this restriction to make it easier for such parties to gain access to their preferred form of medication.

R9-17-101 item 15 & 16 This clause seems to be intended to make the acquisition of medical cannabis a difficult, costly and timely proposition. This would seem to be a clever method by which to counteract the will of the voting population. R9-17-102 Prop 203 requires a fee $5000 for the license fee and NOT for a NON REFUNDABLE registration FEE. Is this even legal? Does it not amount to a very expensive pay to play lottery. · The Draft does not clearly define the Registration and licensing process. Is this a first come first serve basis? The proposed registration process clearly places an enormous financial burden on the applicant without the slightest assurance of a clear, fair, honest and straightforward process. One suggestion might be some type of Conditional Registration subject to final registration prior to licensing. Item 5.a. The registration fee for qualifying patients is financially prohibitive for many potential patients and again this clause seems to be intended to make the acquisition of medical cannabis a difficult, costly and timely proposition. This would seem to be a clever method by which to counteract the will of the voting population. Item 6.a. The registration fee for renewing qualifying patients ID cards are financially prohibitive for many potential patients R9-17-302 Item 1. g. Medical dispensary's should not be required to place on payroll and employee a medical director. The patient is already under the care and supervision of a physician. Where does the authority originate that mandates this requirement? Item 15. Making a determination as to the ability of the facility to adequately supply medical cannabis to the community should not be based on a decided factor of any of the listed a,b,c or d criteria. Item 16. A registration fee is not appropriate. R9-17-310 A, B, C & D The requirement of a Medical Director is over restrictive and only adds to an over regulated burden to ownership. Where does the authority originate that mandates this requirement? R9-17-313 Item 3.a. The inclusion of a documented watering schedule is ultimately over burdensome subjection the site management to unrealistic oversite. R9-17-107 Time Frame · Under this heading letter B states that the registration packet for a dispensary is not complete until the applicant provides the Department with written notice that the dispensary is ready for inspection by the department. This

creates a huge problem for the initial applications. Since there are a limited number of registrations to be distributed, it is evident that not all qualified applicants will be granted a registration. Therefore it is unduly cumbersome and expensive to have a completed facility ready for inspection when there is no guarantee that even if all rules are complied with a registration will be granted. A registration packet should be deemed completed subject to the inspection, therefore the entity will Have the necessary time to complete the plans submitted to the department knowing that if they comply with the rules they will be granted the registration. · There is no defined method as to how registrations for dispensaries will be granted. This needs to be clearly defined, and again the application process should be subject to final inspection of premises, instead of demanding that the facility be ready for inspection hoping they will be one of the few registrations granted. Additional Questions: · Who is responsible for the development of software for validation of user sales reporting? If facility operators are to be made responsible for development when will operators be made aware of the types of county systems necessary for interface? · Are sales subject to a use tax or sales tax? · Can grow facilities be located in a separate county from the dispensary primary location?
Title 36 id not say “business days” and that is what the draft rule implies. Calendar day should have the same meaning as it does in most other Arizona regulatory programs. A day is a day.
---I can't medically wait a year with out it. ---I can't entrust my pre-existing 'disabled' mental health to a Dr who specializes in MedMJ treatment. ---On disability, there is NO way for me to afford $150 every year for a card. ---Because I don't know/trust anyone...how do I find a deliverer if I can't pick up? ---If I live more than 25 mls from dispensary, how do I get my medicine? It's against policy rules to grow a regular grass lawn in the retirement community I live in. Plus I can't even grow a tomato plant successfully. If Arizona can't compromise on needs of the people, why have the law? If Arizona becomes to tough on people needing MedMJ for medication, we will all continue to do it unlawfully. That's really all there is to it. I propose a MedMJ leaf on my general "Health Insurance Card." or Medicare Card. That way my Dr medically approved the care I need through health insurance.
3. ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rule making be implemented “without imposing an undue burden on nonprofit medical marijuana dispensaries....” 4. ARS 28.1 Section 2 “Findings” of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. 5. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. 6. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. 7. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require “ongoing” care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient,

physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not (or cannot afford) to seek other medical care at all (whether prior or subsequent to application). 8. R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. 9. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. 10. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. 11. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. 12. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. 13. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information 14. R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. 15. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. 16. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. 17. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. 18. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. 19. R9-17-

313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. 20. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. 21. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. 22. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse. ADDITIONAL RECOMMEDATIONS: 23. SURETY BOND: Clarify the purpose, the type, the amount and the third party beneficiary, of the surety bond, or eliminate its reference from the rules. 24. NON-PROFIT ENTITY: Clarify the need to establish a non-profit entity. Title 36 only requires an applicant to operate the dispensary under a non-profit “basis”. Can an applicant establish a LLC or other entity so long as his/her bylaws comply with Title 36? 25. 70% COOPERATIVE GROW: Clarify if a group of dispensaries can form a cooperative to grow their medical marijuana under one roof, so long as the facility is in compliance with Title 36 and the AZDHS rules. 26. SEEDS: Please clarify where a dispensary owner can purchase his initial seeds. 27. LANDLORD RIGHTS: Please clarify landlord rights with respect to entry and inspection of a dispensary/ cultivation facility. (Assuming the landlord is not a registered agent of the Dispensary). Additionally, please clarify access by a repair service to enter upon the restricted areas of a dispensary/cultivation to make necessary repairs. 28. TWO STAGE APPLICATION PROCESS: R9-17-302 Applying for Dispensary Registration Certification; we believe the proposed rules regarding the application process are inherently unfair and favor the wealthy. The average person who may otherwise qualify would be reluctant to invest hundreds of thousands of dollars in a dispensary application without knowing if they will get a license. In order to equalize the application process we believe AZDHS should adopt a two stage application process as follows: 1. Review the principals and legal entity first. Perform whatever background checks AZDHS desires, including FBI and all the other requirements as set forth in the proposed rules relevant to the principals and legal entities. 2.Issue a conditional License to the 125 most qualified individuals subject to approval of the facilities. (dispensary and cultivation sites) 3.The conditional license would require that the applicant to complete the build-out and/or construction of the facilities within 90-120 days. 4.Thereafter, the conditionally approved applicant would submit the second half of his application (Facilities) for inspection and approval. 5.The second half of the application must meet all the requirements of the proposed rules relevant to the facilities. 6.Provided the applicant meets all the facility requirements he/she would then be issued a Dispensary Registration Certificate 7.This system allows for fairness across all demographic and financial groups. It would not preclude individuals simply because they are not millionaires, and would allow those that are chosen to obtain the financing they need to complete the project. Fairness and transparency requires AZDHS to adopt this application process or similar one.

204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority

to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application).
Section R9-17-201has too many vague references as to what constitutes a medical necessity! This was one of our biggest problems in Washington State. As a former nursing professional, one of the most widely abused sections of our medical marijuana law was the "Chronic Pain" category. There is no scientific evidence to prove that medical use of marijuana helps with pain management other that the intoxicating effects makew you forget you are in pain! Because the "pain" Category had so many applicants, it became apparent that unauthorised use and access to medical marijuana was running rampant.
Four visits and one year to be able to get a recommendation is too long. And having to use that doctor for my management of my illness is not possible. I need to go to multiple doctors to treat my condition and would rather see one doctor for my arthritis and one doctor for treatment of the chronic pain. I also think that $250 is too expensive. I also believe that Rheumatoid arthritis should be added to the list of treatable conditions. Although I do have severe chronic pain, it will be more difficult to get my recommendation as most rheumatologists do not believe in this line of treatment.
I made a comment a few days ago about having card holders (patients) whatever..... to have the right to grow their own plants if they are in the 25 mile zone for dispensaries... only two plants; one in vegetative and one in bloom.... so that someone with knowledge of cultivation can take care of themselves and save massive amounts of money on their medicine in a horrid economy. I've been thinking of my proposal further and know that trafficking is a concern (for good reason; I don't care for criminals either) so how about if you would like to cultivate in the 25 mile zone you give up your rights for going to the dispensary to purchase prepared cannabis? This way no one person ends up with far too much. A patient having only one plant in bloom at any given time would eliminate the selling off of extra due to the fact that it would be difficult to produce more than one would consume. I have seen in other states where card holders are allowed to have 12, 18 plus plants and even I feel this is absurd for a single consumer and I'm 100% behind cannabis reform. Some people may make the argument that you have so many plants due to the fact that only the female plants produce cannabis buds; well one can purchase feminized seeds which only produce female plants and that fact eliminates the argument. I would even be comfortable with language in the "rules" that clearly state that if you are found with more than you are allowed then you lose all privileges and the full weight of the law lands on the head of the rule breaker. The people whom I've spoken to like this option and would never jeopardize the privilege of what we are being given and have been hoping to happen for so long. Thank you for your consideration.
The interests of individual citizens who own firearms are of utmost concern. Therefore, the qualifying patient registry identification card must be eliminated as a requirement. RATIONALE: It will remain illegal for an individual to possess and use marijuana under federal law (21 USC §811). In Gonzales v. Raich, 545 U.S. 1 (2005), the United States Supreme Court held that the federal government has the constitutional authority to prohibit marijuana for all purposes. In a 6-3 opinion delivered by Justice John Paul Stevens, the Court held that the commerce clause gave Congress authority to prohibit the local cultivation and use of marijuana, despite state law to the contrary. Any individual who purchases a

firearm from a federally licensed firearms (FFL) dealer must complete a BATFE Form 4473. Question 11e, which is a YES or NO question, reads as follows: "Are you an unlawful user of, or addicted to, marijuana or any depressant, stimulant, narcotic drug, or any other controlled substance?" This puts the potential purchaser of a firearm in a quandary. The individual purchaser can neither answer YES nor NO to BATFE Form 4473, question 11e because, 1) Lying on this form is a felony and can be punished by up to five years in prison in addition to fines and 2) Answering YES will result in a denial of purchase order from the National Instant Criminal Background Check System (NICS). This will effectively deny the individual right to keep and bear arms for anyone who submits an application for a Patient Registry Identification Card. Furthermore, filing an application for the Patient Registry Identification Card will abridge those rights conferred in the United States Constitution, Articles in Amendment, Amendment 5, especially self-incrimination, among others. Additionally, in order to prevent an occurrence in Arizona like what happened in Oregon, rules must be written and implemented that prohibit the declination of an Arizona Concealed Carry Weapons permit based solely on ones application and/or issuance of a Patient Registry Identification card and/or the purchase of medical marijuana from a dispensary.

A funds verification from a bank will also prove financial ability if it is supported by a cash flow projection.

A full audit is very expensive and time consuming. This will increase patient costs in the long run. A review or compilation would accomlish the same without increasing costs to patients all that much.

The draft rules must be discarded in their entirety and, in an open and honest process, new regulations should be drafted to the advantage of the suffering, dying, and good citizens of Arizona. Among the serious problems of the current proposals are the following: ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is

dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information. R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. 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The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. Arizona's pharmacies dispense drugs that are very toxic, yet are not required to have medical directors on-site or on-call. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. 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Be mindful of the economics here. If you spend more money on enforcing what you take on as your mission to keep marijuana from marginally qualified users---rather than setting up a supply system for 100% qualified patients---you will defeat the purpose of the initiative and drive our state even more into debt. Let the alloted number of clinics open. Then take complaints about possible problems. Reconsider how you will implement the micromanagement called for: 24/7 video monitoring, soil types, watering schedules, weights of items offered for sale, etc.
why are nurse practitioners excluded from recommending/prescribing medical marijuana or any healthcare provider that currently can write for medication. all rx's have to be aprpovedby AZDHS so why limit those who can prescribe?
az state gverment has onc e again ignored the will of the people and ried to implement there own agenda with prop 203 , all career poloticians and appointed officials should remember that prop 203 brought more votrs out than the govoner or senate seats that where being votd on the same ballot , the regulations that hve ben proposed for dispensaries and grow facilities are so redicoulos and over the top that it would cost some one potentially 50,000 or more just to apply for the lisc. and than to b relistic anoth 75000$ tooperate for the first 3 months you are once again trying to ignore the wishes of az voteres much like the state did in 1996 and 1998 either someone at azdhs is takeing a bribe from the few wealthy and elites that have popped up tryng to control this industry "azmma" or your trying to regulate this out of exisistance .it is outlandish to think that a non profit would spend this kind of money to get up and running and even more ridiculous to think that anyone individual or corpraton would spend this kind of money unless they had figured out a way to profit from it on a level equal to there investment , worse yet and even more suspicius is the fact tha azhds has not released any criteria for witch they will judge potential owners . For an orginzation that is supposed to represent responsible medicine in this state as well as patient care and protection the regulations you have put forth tread all over the normal standard of doctor patient reationship , and again seem to be focused on stopping doctors from prescribeing and patients from recieveing medical canabis, for all the bluster about patient protection there is not one line in azdhs regulations that deal with quality or saftey of the product being grown and distributed to patients that in many cases would be immuno suppressed , when just the nature of growing any agricultural product lends itself to exposure too pesticides , fungus , bacteria,and mold . the product being produced is not a tomatoe it can not be washed off after harvest ! The most rediules part of all this is that azdhs has not come up with a system that is self sufficient the amount of money generated from lisc. applications , renewals ,and medical cards does not add up it is not enough revenue to police and montor 125 potential disp. ,and grow facilites as well as a potential 50 to 150,000 patients ,
Eliminate the requirement for a physician-patient relationship to mean there has been contact for at least a year, with at least four visits dealing with the condition for which the patient is seeking marijuana. Eliminate the requirement whereby a patient can get a recommendation from a doctor without any prior visits if that physician conducts a comprehensive medical history and physical exam and agrees to take on the primary responsibility of managing the person's ailment. Eliminate the requirement for dispensaries to provide detailed information on cultivation, including the type of soil used and the watering schedule; Eliminate the requirement for dispensaries to have 24/7 video

monitoring by the health department; Eliminate the need to spell out the weight of cookies and other products into which marijuana was infused; Broaden the limits on who can be a medical director of a dispensary.

Have initial dispensary fees lowered to help entry into the field and small ma and pa operations to get started. The fee then can be raised to continue, hopefully the second year so people can have the opportunity to earn enough to pay the fees. Or possibly some type of fee exemption on dispensaries. Something to help the disadvantaged people to open and operate a dispensary.

ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-

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If you want to reduce your suffering and your costs, you must speak out now and also at the public meetings I have listed below. The good news: As best I can tell, the AzDHS does NOT have the authority to enact the cruel and unreasonable package of regulations they propose. Obviously, I am not an attorney, so we are soliciting the input of qualified attorneys. Because I am a physician, I am restricting my comments here to the matter of patient-physician relationship. Others with expertise in dispensary and caregiver matters will share similar analysis and commentary concerning the draft regulations for dispensaries and caregivers. I have attached the AzDHS Timeline. Please familiarize yourself with the Arizona Medical Marijuana Act (AzMMA): http://stoparrestingpatients.org/home/initiative If you pay special attention to Section 36-2803 "rulemaking," you will notice that the AzMMA does NOT give authority to the Arizona Department of Health Services to define-or redefine-the patient-physician relationship and does NOT

give the authority to amend the AzMMA language, e.g., adding "ongoing" to "patient-physician relationship." The Arizona Voter Protection Act specifically DENIES authority for such usurpations. Please note that even the Director of AzDHS questioned his own authority to do what he proposes: http://directorsblog.health.azdhs.gov/?p=810 See also: http://blogs.phoenixnewtimes.com/valleyfever/2010/11/prop_203_legal_weed_will_be_av.php Next please familiarize yourself with the draft regulations: http://www.azdhs.gov/prop203/documents/Medical-Marijuana-Draft-Rules.pdf Then please participate in the public comments online and in person: http://azdhs.gov/news/2010-Alll/101217_ADHS-Med-Marijuana-Release-and-FAQ.pdf Please plan to testify. Please also mobilize other suffering patients to comment online, in writing, and to testify at the Public Meetings: Phoenix, February 15, 2011, 1PM, 250 N. 17th Avenue Tucson, February 16, 2011, 1PM, 400 W. Congress, Room 222 Phoenix, February 17, 2011, 1PM, 250 N. 17th Avenue Some specifics. The AzMMA requires this: 18. "WRITTEN CERTIFICATION" MEANS A DOCUMENT DATED AND SIGNED BY A PHYSICIAN, STATING THAT IN THE PHYSICIAN'S PROFESSIONAL OPINION THE PATIENT IS LIKELY TO RECEIVE THERAPEUTIC OR PALLIATIVE BENEFIT FROM THE MEDICAL USE OF MARIJUANA TO TREAT OR ALLEVIATE THE PATIENT'S DEBILITATING MEDICAL CONDITION OR SYMPTOMS ASSOCIATED WITH THE DEBILITATING MEDICAL CONDITION. THE PHYSICIAN MUST: (a) SPECIFY THE QUALIFYING PATIENT'S DEBILITATING MEDICAL CONDITION IN THE WRITTEN CERTIFICATION. (b) SIGN AND DATE THE WRITTEN CERTIFICATION ONLY IN THE COURSE OF A PHYSICIAN-PATIENT RELATIONSHIP AFTER THE PHYSICIAN HAS COMPLETED A FULL ASSESSMENT [NOTE: "assessment," singular, not plural; 1, not 4] OF THE QUALIFYING PATIENT'S MEDICAL HISTORY. So, one full assessment, specify the qualifying condition, sign, and date-done! Without the authority to do so, Az DHS proposes: R9-17-202 5e. A statement, initialed by the physician, that the physician: i. Has a professional relationship with the qualifying patient that has existed for at least one year and the physician has seen or assessed the qualifying patient on at least four visits for the patient's debilitating medical condition during the course of the professional relationship; or ii. Has assumed primary responsibility for providing management and routine care of the patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the patient's medical record maintained by other treating physicians, that may include the patient's reaction and response to conventional medical therapies; Key points: • Any Arizona physician may in a single visit prescribe "speed," e.g., Adderall, to a kindergartener-without 4 visits spread out over 1 year any Arizona physician may prescribe to a kindergartener a drug that can kill that child by heart attack, stroke, seizures, or other "side effects." • Cancer, HIV, Hepatitis C, and ALS patients often do not have 1 year to live. • The patients that do live are cruelly being told to change doctors or suffer for 1 year. • Deadly and addictive drugs such as the opiates are prescribed in a single visit by Arizona physicians and, despite the best efforts of physicians, some of those deadly and addictive drugs are illegally diverted, but that does not cause the AzDHS to demand 4 visits, 1 year of visits, or that the pain specialist assume primary care of the patient. • Marijuana is 100% safe, gives patients good relief, and cures some conditions-Marijuana is not deadly and is not addictive. • The alternative offered by the AzDHS to avoid 1 year of suffering, the cannabis specialist takes over the primary care of the pt's qualifying condition, is done nowhere else in medicine-Nowhere else in medicine does a specialist take over a patient's primary care. • The AzDHS does not have the authority to define or re-define the patient-physician relationship or the number of doctors visits, or the length of time for those visits-that infringes on the patient's choice • The draft regulations are cruel and unreasonable. We still believe that an evaluation and a signed physician recommendation stating the patient's qualifying condition currently gives an "affirmative defense" in the event of a legal encounter at least until the final regulations, not merely the draft regulations, are announced by the AzDHS. Once the final regulations are promulgated, we will, of course, abide by them. Until then, we are still making recommendations to qualified patients. If the AzDHS succeeds in forcing 1 year and multiple visits upon patients, it is to the advantage of qualifying patients to start the process as soon as possible.

Allow all patients to be able to grow their own since the dispensaries will not be able to provide enough

of the medicine to it's patients...no to finger printing..have discreet signs on dispensaries to discourage arrogance. No access of medical marijuana to people under 18 years. Allow out of state patients from legal states to purchase in Arizona. Allow delivery to patients. And please don't be paranoid about med. Marijuana. Everything will be alright.

1. The Definition of Calendar Day: The exclusion of weekends and holidays makes the 14-day period nearly 3 weeks, which is not fair for patients. The pharmacy doesn't exclude weekends and legal holidays on a 30-day prescription. 14 days should be 14 days. Extending the 14 days to 3 weeks by excluding weekends and holidays only encourages smoking. While smoking it is good for immediate effects (especially for chemotherapy patients), those with chronic conditions can often better manage their issues through cooking their medical marijuana, which has the added benefit of eliminating any concerns due to smoking, but it takes more product. 2.5 ounces every 3 weeks is insufficient for a patient with a chronic condition who prefers to cook with marijuana instead of smoke it. 2. The physician-patient relationship: Requiring a one-year patient relationship at first seems fairly reasonable. After all, most of these patients are dealing with chronic conditions that have affected them for a number of years, and I understand that this may be a measure to limit the number of doctors who plan to make their living off writing hasty recommendations. However, this rule in inequitable to a large population of patients. For one, this excludes cancer patients altogether. Cancer patients meet their oncologist/radiologist after they've been diagnosed, and waiting a one-year period with a new doctor could mean the difference between life and death. At the very least, it almost guarantees that these patients will not have access to marijuana for nausea and pain during treatments. A large second group of patients are veterans of our armed forces. The VA is the primary care facility for many veterans, but VA doctors are not yet allowed to recommend marijuana, and so some of our most honorable patients in need would be denied effective medicine, at least for the first year of developing a new patient-doctor relationship, not to mention the increased costs of doing so when these veterans are used to having their healthcare paid for as a result of their service. Furthermore, the rules require the recommending doctor to sign a statement that s/he "has assumed primary responsibility for providing management and routine care of qualifying patient's debilitating medical condition." So again, most veterans who rely on the VA are out of luck if they need to find a doctor to assume primary responsibility for the patient's condition. Also, to be honest, many doctors are not willing to write recommendations. As a qualifying patient, I have discussed this issue with my doctors on several occasions during the past year, and they are scared of either increased malpractice insurance rates or harassment by the government or medical governing boards. Medical marijuana is a good option for many, but it is still against federal law and (mistakenly) classified as a Schedule I drug; doctors are fearful of repercussions. Please, please, please do some outreach to legimate, practicing doctors to let them know that AZDHS supports patients' real doctors in their right to recommend marijuana to patients who could benefit. 3. Public Place: This definition should be slightly altered. For one, it includes all public places, including bars, entertainment venues, common areas of living complexes, parks, parking lots, etc. For one, medical marijuana use should only be excluded in certain places when it is smoked. As long as an individual does not get behind the wheel, as with alcohol, consuming marijuana in a form other than smoke has no effect on anyone else and should not be limited to a person's private residence. Further, where tobacco (a far more harmful substance) smoking is allowed (parks, outside smoking sections for bars and entertainment venues, etc), marijuana smoking should be allowed for those with proper ID cards. 4. Fees: 1) $5000 for registration of a dispensary does not seem unreasonable, but how is the application process going to work? Do you expect 1000 applications for 125 licenses, and what happens to the extra registration fees? Do they get refunded to applicants who are not accepted, or will you use those extra fees to pay for comprehensive reviews of the applications so that the most qualified applicants are chosen? Or do you stop accepting applications at 125 and take a first-come, first-served approach, which could result in unscrupulous business practices or inexperienced businesspeople? 2) I think the initial fees for obtaining registry identification cards for patients, caregivers, and agents are fine, but the annual renewal fees are excessive. The annual renewal fees should be nominal, at least for the patients, as many are on fixed income. 5. Applying for a dispensary registration certificate: The

application must include a physical address. That is a big investment--nobody should have to sign a lease agreement to secure a location before applying. I understand that the address will be relevant before the registration is issued, but this rule excludes most people from having a chance to apply for a dispensary. This rule demonstrates why a business plan pre-application screening would be useful so that only the people who are going to be given registrations would have to secure a facility, and not all applicants. I am not necessarily opposed to the $5000 application fee even for those who are not chosen because I hope the overages will go back into medical marijuana research and education, but requiring applicants to also have a place secured goes too far. Plus, nobody is going to lease a place out to somebody (who tells the truth about why they want the business) who has a 1 in 10 chance of getting the dispensary registration certificate. 6. A dispensary shall cultivate at least 70% of the marijuana it provides to patients/caregivers: This rule will make it more difficult for patients to get the strains that work more effectively for them. I guess it would be hard for dispensaries too if they had a bad crop and couldn't get product from anyone else for several months, but I think of it more as a patient issue. Patients should not have to drive all over town just to find the strains that work best for them. The best (patient-friendly) medical marijuana dispensaries have a wide selection of product and a knowledgeable staff. I definitely think it's a great idea to keep all marijuana cultivation and production in Arizona, but patients need options.

I would like to see more about how the patient and/or caregivers are protected by the law. Are they protected from having their homes, cars, bank accounts taken away? Will we be subjected to house checks or arrest even if we are in compliance? You could simplify the draft without so many sub-catagories and repitition, and a better idea of where we are to obtain cards, photos, and registry ID cards as well as the Dr. recomendation forms.

pricing,card pricing,smoking areas and growing. theres no protection for the patients when it comes to pricing. it needs to be a simple system a flat monthly fee. a few of us believe a $100-200no more a month should cover 5oz of medical marijuana. then you wont see so many people appling for dispensary licenses. there should be cost in the system but a $150 a yr for a card is outragous! im on medicare and believe patients who really need this are like myself on fixed incomes and need the medicine should get price breaks on application fees. $50-75 would be reasonable and thats still to high.smoking areas need to be opened just a little bit. outdoors like camping , fishing , hiking basically anything outdoors and hotels. the patient should be discreet. remember its medicine. and finaly growing. if the patients choose to grow they should be able to even if they live within 25miles of a dispensary. it could be theraputic for patients and give some of them something to do.

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I feel that the Patient ID Card fee of $150 is too steep. These are patients with serious illnesses and limited income and need to have affordable fees in order to participate. These regulations require patient to have a lengthy relationship with the physician who recommends medical marijuana. Some of us will not be able to get recommendations from our primary care physicians. We must not create a burden to sick patients receiving a medical marijuana recommendation. I urge the ADHS to adopt no visit minimum for a medical marijuana recommendation. Requiring dispensaries to grow 70% of their medicine restricts dispensaries from diversifying their sources and providing patients with a wide variety of strains and organic medicine.

If you pay special attention to Section 36-2803 "rulemaking," you will notice that the AzMMA does NOT give authority to the Arizona Department of Health Services to define-or redefine-the patient-physician relationship and does NOT give the authority to amend the AzMMA language, e.g., adding "ongoing" to "patient-physician relationship." The Arizona Voter Protection Act specifically DENIES authority for such usurpations. ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including

therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the

department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse.

AZDHS and MPP Acting in Collusion to limit access to Dispensary Applicants. Monopolization abuses outlined in letter to Arizona Heath Department. This is the formal response from the Arizona Association of Dispensary Professionals , (AZADP), to the Arizona Department of Health Services, (AZDHS) concerning the implementation of the Arizona Medical Marijuana Act. The AZADP is an organization comprised of over 4600 members. AZADP membership includes concerned dispensary candidates, individuals who believe they are qualifying patients, Physicians and other individuals and entities involved in the Marijuana industry. While we want to believe Mr. Humble when he states that, (EXHIBIT A), "Fairness and Transparency are the keys to effectively implementing the AZ Medical marijuana Act", the evidence contained herein suggest otherwise. We believe that the AZDHS has been influenced by and is conspiring with other organizations, namely the Marijuana Policy Project, (MPP) and their recently established association, the Arizona Medical Marijuana Association, (AzMMA), to create an elitist and monopolistic program where only the wealthy influential, informed sponsors of MPP will qualify for one of the 125 licenses. We believe that the following evidence will show that the AZDHS in collusion with MPP are intentionally developing program rules that are so complicated and costly so as to preclude otherwise qualified applicants merely on the basis of wealth and influence. We believe it is the intention of MPP to control the marketplace. Accordingly, we submit the following: Citations: Arizona Medical Marijuana Act, hereinafter referred to as "TITLE 36" Arizona Department of Health Services, hereinafter referred to as "AZDHS" Marijuana Policy Project hereinafter referred to as "MPP", a national political action committee who sponsored Proposition 203 in Arizona. MPP has a local chapter in Arizona. Arizona Medical Marijuana Association hereinafter referred to as "AMMA". An association recently established by MPP. Arizona Association of Dispensary Professionals hereinafter referred to as "AZADP". An independent association comprised of concerned citizens. Arizona Voter's protection Act hereinafter referred to as "AVPC". A 1998 voter approved initiative petition amending the Arizona Constitution, to revoke the government's power to amend an initiative measure approved by a majority of the votes cast thereon, unless the amending legislation furthers the purposes of such measure. (AZ Cons. Article 4 Section 1(6)(c). Regulatory Bill of Rights, (A.R.S 41-1001.01) hereinafter referred to as "TITLE 41". An Arizona law to ensure fair and open regulation by state agencies, limiting a state agencies rule making ability to subject matter listed in the specific statute and provides for citizens right to file a complaint with the States Administrative Rules Oversight Committee. Affirmative Defense, (A.R.S. 36-2802), hereinafter referred to as "ARS36-2802". Qualifying Patients and Caregivers mat assert medical purpose as a defense to any prosecution of an offense involving marijuana. Sherman Antitrust Act: To establish a violation of The Sherman Act, Monopoly Power may be defined as the power to fix prices to exclude competitors, or to control the market in the relevant geographical area in question. Prefatory Statement:
AZADP was established as a direct concern of so many individuals who are alarmed at the direction the AZDHS is taking in their rule making progress. Prior to the election some of our members where involved with MPP and provided us with internal documents generated in the course of MPP's campaign operations. These documents will be produced herein and used as evidence to support our arguments. In September, 2010 MPP established an advisory committee. According to the local Campaign Manager for MPP, [redacted], this Advisory Committee was established at the request of AZDHS. Presumably, AZDHS was concerned that should the voters approve Prop 203, their understaffing and budget cuts would curtain their ability to complete the rule making process in the time allowed under the law. (120

days). According to [redacted], AZDHS asked MPP if they could assist AZDHS by preparing some proposed rules for consideration by AZDHS. "A blueprint to help AZDHS start the process". MPP agreed to assist AZDHS and established the Advisory Committee, also known as the "Roundtable". MPP invited 12-14 of its members to join the Roundtable and create proposed rules for consideration by AZDHS. Presumably most of the members on the Roundtable were either dispensary candidates or have other business interest in the medical marijuana industry. The members of the roundtable were divided into "task forces" each given a specific assignment. (EX: Cultivation rules, testing /quality control, security, applications, qualifications, etc). The roundtable participants also worked together to develop and establish the MMP Association, "AzMMA". It is no coincidence that the acronym for MPP's Association and Title 36 are identical; "AzMMA". MPP took ownership of Title 36, and intended to impose its own agenda on the people of Arizona. MPP's stated agenda was to limit the competition and to assure that as many of their own members as possible received dispensary licenses. During the weeks leading up to the election, the Round table became fractured. Some of the members realized the true agenda of MPP and resigned from the group. Let us first understand that MPP is funded and sponsored by very wealthy individuals and organizations. The following evidence will show that MPP invested over half a million dollars of its money to secure an elitist program designed to solely promote the interest of their sponsors. The agenda of MPP is to make the dispensary application process as difficult and expensive as possible to preclude all applicants except the well informed wealthy members of MPP. As evidenced by the attached internal memorandum (EXHIBIT "B"), MPP, in the process of establishing it's Association , recommended that, " AZDHS implement dispensary applications and licensing standards that are rigorous enough to deter trivial applications, but that do not unduly impair the ability of serious applicants to operate successfully". It would be a serious conflict of interest to allow a Association comprised of wealthy future dispensary owners to determine what a "trivial application" is, but that is exactly what they moved on to do. Contained within the same documents MPP makes the following recommendations to AZDHS; Would require applicants to provide proof that they have obtained dispensary and /or cultivation facilities that meet the requirements of the ACT and local zoning. Requiring that the applicant provide a business plan demonstrating that the licensee will be operational within a specific time frame. Requiring the applicant provide proof of financial competency through a BOND or other means. Requiring that the applicant demonstrate medical expertise by having physicians or pharmacists on staff or engaged as consultants. Contrary to the assertions of Mr. Humble, (EXHIBIT A), clearly these MPP proposals have had significant influence on AZDHS, since all of them are incorporated into the AZDHS proposed rules. Additionally, these proposed rules, should they be adopted, will further the agenda of MPP by adding momentous increases to the cost of obtaining a dispensary license for the following reasons: Section 36-2804, of Title 36, among other requirements, necessitates an applicant to provide AZDHS with a "Physical address of both the Dispensary and Cultivation center, and a sworn statement that the applicant is in compliance with local zoning requirements. This in and of itself creates a significant expense to an applicant, since they will have to secure a physical location without ever knowing if they will qualify for the license. However AZDHS has added a significant additional expense to the cost of the applicant by requiring a Certificate of Occupancy. This adversely changes the intent of Title 36. Under proposed rule R9-17-302, B-5 AZDHS is requiring an applicant, as part of the initial application process, to produce a Certificate of Occupancy This would require a applicant to not only secure a location for his/her dispensary and Cultivation center, but build-it-out as well at a cost of hundreds of thousands of dollars, all at risk, since all is done without any assurances that they will obtain a license. This rule alone will serve to eliminate all but the wealthiest of applicants. At the request of MPP, (See EXHIBIT C), AZDHS's proposed rules regarding business operations are outrageously over-regulated. We recognize the need to maintain strict business operations, but the proposed rules are simply overkill, intended to play into the hands of MPP's agenda. (More on this below). There are no provisions in Title 36 that requires an applicant to produce a Bond. According to statements made by MPP all applicants with less than a million dollars of cash liquidity are considered "Trivial" and should be required to post a two hundred thousand dollar bond.(See Exhibit D). While there is no clarity or designation as to the purpose, type , amount or third party beneficiary of said bond, AZDHS has nevertheless, under proposed rule R9-17-302,15-D,

and as part of the initial application , asks the question, “Whether the dispensary has a surety bond and , if so, how much?” While we have sought clarification from AZDHS on this point, none has been provided. Attention must also be given to the availability of said bond. Because of the unique nature of the medical marijuana business model, obtaining such a bond might be impossible or extremely costly. Under federal law Medical Marijuana Dispensaries are considered a criminal enterprise; consequently, most if not all insurance companies would consider a request for a bond a very high risk. Therefore, potential applicants may be denied a license merely because he/she is not a millionaire. The prompting by MMP to have a medical director on the staff of each dispensary is not necessarily a bad idea. Unfortunately, AZDHS, at the urging of MPP has taken the Medical Directors position to place where no Doctor will go thereby making it impossible to comply with this rule, unless you are wealthy enough to afford a full time Doctor on your staff. A medical director retained to provide assistance in developing the medical aspects of the program for a Dispensary is a welcomed idea; however, to have the Medical Director interact with patients or develop any materials for use by patients could be considered interference in a patient-physician relationship. All qualified patients of a dispensary must have a recommending, primary doctor to obtain their registration card. Any log books, rating scales, or guidelines for patient’s self-assessment, as set forth in AZDHS proposed rule R9-17-310-2, may create a conflict of interest for the medical Director. This again plays into the main scheme of MPP. We are deeply concerned about the AZDHS’s plans concerning the selection process. As you will note AZDHS’s proposed rules are silent on this matter. On October 29th 2010, Director Humble wrote on his blog, (Copy Attached EXHIBIT E), that he had three choices before him, He asserted that method 3, (Evaluate the complete application using some kind of objective criteria), is probably the best because we’d be able to select the best qualified applicants. Humble went on to say, “ An Interesting twist on method 3 would be to send the completed (And blindfolded) applications to a 3rd party (e.g. a consulting law firm) and ask them to score the applications for us. It is perhaps more than coincidence that just prior to that Blog entry, MPP sent AZDHS a proposal to use their new Association (AMMA) as an Application Review Board. (SEE EXHIBIT F). This is the most outrageous conflict of interest we have ever heard of. A group of weathly potential dispensary owners, reviewing their own applications! We demand that AZDHS immediately disclose their selection process. We further suggest, in fairness, and in compliance with AZDHS proposed rule R9-17-319, a, 2, g, that any member of the MPP roundtable be excluded from consideration of a dispensary license. We would further ask that Director Humble make a full public disclosure as to whether or not any member of AZDHS has had any contact with MPP, AMMA or any representative or agent of said organizations. As most people know, MPP staff actually wrote Prop 203, now the Arizona Medical marijuana Act. Title 36. What most were not aware of is the fact that under section 6 of Title 36, AZDHS compliance under A.R.S 41-1001 is waived. Title 41, The Regulatory Bill of Rights, is an Arizona law to ensure fair and open regulation by state agencies, limiting a state agencies rule making ability to subject matter listed in the specific statute and provides for citizens right to file a complaint with the States Administrative Rules Oversight Committee. Any reasonable person would have to cast a sinister eye on MPPS reasoning in exempting AZDHS from compliance with these provisions. This exemption eliminates the public’s ability to object to the abusive behavior of the AZDHS. Point by Point Objection to AZDHS Proposed Rules:
1. Medical Director Definition: Should change to include any Doctor who is permitted under Title 36 to recommend Medical Marijuana. 2. Ongoing Definition: this is merely an attempt on the part of AZDHS to create an artificial bottle neck, choking off a potential revenue stream for struggling new dispensary owners. This is an unfair, abuse of authority on the part of AZDHS, intending to further the agenda of MPP. This rule is intended to dissuade marginal (“Trivia”l) applicants from submitting applications. AZDHS should rely on the recommendation of a Arizona licensed Physician, regardless of the relationship period, so long as the recommending physician complies with the provisions of Title 36, or until such time as there is evidence of fraud. 3. ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rule making be implemented “without imposing an undue burden on nonprofit medical marijuana dispensaries....” 4. ARS 28.1 Section 2 “Findings” of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana.

Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. 5. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. 6. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. 7. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require “ongoing” care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient’s care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department’s regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients’ rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not (or cannot afford) to seek other medical care at all (whether prior or subsequent to application). 8. R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. 9. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients’ parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. 10. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. 11. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. 12. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. 13. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients’ rights to choose other providers or sources of information 14. R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. 15. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. 16. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-

307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. 17. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. 18. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. 19. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. 20. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. 21. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. 22. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse. ADDITIONAL RECOMMEDATIONS: 23. SURETY BOND: Clarify the purpose, the type, the amount and the third party beneficiary, of the surety bond, or eliminate its reference from the rules. 24. NON-PROFIT ENTITY: Clarify the need to establish a non-profit entity. Title 36 only requires an applicant to operate the dispensary under a non-profit "basis". Can an applicant establish a LLC or other entity so long as his/her bylaws comply with Title 36? 25. 70% COOPERATIVE GROW: Clarify if a group of dispensaries can form a cooperative to grow their medical marijuana under one roof, so long as the facility is in compliance with Title 36 and the AZDHS rules. 26. SEEDS: Please clarify where a dispensary owner can purchase his initial seeds. 27. LANDLORD RIGHTS: Please clarify landlord rights with respect to entry and inspection of a dispensary/ cultivation facility. (Assuming the landlord is not a registered agent of the Dispensary). Additionally, please clarify access by a repair service to enter upon the restricted areas of a dispensary/cultivation to make necessary repairs. 28. TWO STAGE APPLICATION PROCESS: R9-17-302 Applying for Dispensary Registration Certification; we believe the proposed rules regarding the application process are inherently unfair and favor the wealthy. The average person who may otherwise qualify would be reluctant to invest hundreds of thousands of dollars in a dispensary application without knowing if they will get a license. In order to equalize the application process we believe AZDHS should adopt a two stage application process as follows: Review the principals and legal entity first. Perform whatever background checks AZDHS desires, including FBI and all the other requirements as set forth in the proposed rules relevant to the principals and legal entities. Issue a conditional License to the 125 most qualified individuals subject to approval of the facilities. (dispensary and cultivation sites) The conditional license would require that the applicant to complete the build-out and/or construction of the facilities within 90-120 days. Thereafter, the conditionally approved applicant would submit the second half of his application (Facilities) for inspection and approval. The second half of the application must meet all the requirements of the proposed rules relevant to the facilities. Provided the applicant meets all the

facility requirements he/she would then be issued a Dispensary Registration Certificate This system allows for fairness across all demographic and financial groups. It would not preclude individuals simply because they are not millionaires, and would allow those that are chosen to obtain the financing they need to complete the project. Fairness and transparency requires AZDHS to adopt this application process or similar one. IN CONCLUSION: Taken in totality, it appears that AZDHS is working in collusion with MMP to make this application process as difficult as possible, beyond what is fair and reasonable. What was alleged to be “fair and transparent”, has now become biased and opaque, demanding a comprehensive review and explanation. The sole agenda of AZADPs is to assure the success of the Arizona Medical Marijuana Act. To bring the dispensaries out of the dark corner of society into the main stream of America. We understand that to accomplish that we need to change the image, we need to exceed the highest standards, and we need to conduct ourselves and our businesses with the utmost professionalism, always in full compliance with the law. While you allege that “nobody outside the department is involved in the development of your informal draft rules”, it appears that is not correct. The fact remains you may not know if MPP is communicating with your underlings. The answer to your problem is to embrace ALL these organizations rather than create the illusion that you are NOT being influenced by some. You may want to establish a round table of your own, invite all the organizations, associations and industry leaders in Arizona including MPP, to offer and exchange ideas. That way nobody feels left out, and you perhaps may even learn a few things. We would welcome the opportunity to assist you in organizing a round table of industry, leaders. In the alternative we hope you will make a full disclosure of your involvement with MPP. Sincerely, [redacted] [redacted] [redacted] once again, i have to agree with what has been addressed here. your intentions were good, but the consequences were not well thought out. if these members of your committee who helped you draft the rules are given licences, there's a definate conflict of interest, if not collusion. i think he's making the point that the collusion would be in the actual rules, gearing this to exclude wealthy or experienced to be included for considersation is not fair. this should be considered as an open market, not tailored to more affluent or experienced contenders. if a dispensary fails, it's not the state's problem. in light of how your expertise has been obtained, you're now treading on thin ice. why didn't you seek advice from other states agencies for help with drafting rules and the problems they've encountered? Why is there only a two year residency requirement? two years is obviously convenient for outside markets making a presence here when the petitions first started, two years ago. make it at least three years, i'd love to see a five year residency requirement, so citizens know we're not going to accomodate some of the members of your counsel and outsiders, and promote arizona citizens to create business. remember, these states are boycotting our state over sb 1070, and their residents and businesses do not deserve this opportunity. keep it local. please rethink some of the conditions of this draft to avoid problems. make it fair. the little guy should be fair game if willing to play by the rules. Everyone should have a fair chance, and the violators get closed down. all these rules mean nothing without the regulators. this is not the smartest business for people to get into to begin with. never mind the social non exceptance, but the IRS allows no tax deductions for an illegal product business and, are going to be subject to IRS audits if successful. all doctors should be able to write prescriptions. the language now makes it seem that only doctors would be opening dispensaries in a sense. and you're hurting the patient by having to switch drs. this is wrong. why not have a public hearing with all interested before the final draft is completed?

Page 4, number 16: definition of "ongoing" physician-patient relationship is excessively restrictive, to the point of being crippling for a high percentage of patients. Under subsection 16.a, only the patient's primary care provider (PCP) will qualify to meet the 1 year, minimum 4 prior visits for the debilitating condition. If a patient's PCP does not believe or want to recommend medical marijuana, the patient is

out of luck and will have to forgo a potentially beneficial treatment, or purchase the marijuana off the street from a drug pusher. Under subsection 16.b, only the patient's specialist will be able to recommend medical marijuana. Cancer is the domain of oncologists, glaucoma of ophthalmologist, HIV and AIDS of infectious disease specialists, Crohn's disease and Hep C of gastroenterologists, MS, ALS and seizure disorders of neurologist. This may result in non-specialist taking over the care that should be reserved for specialists, resulting in a lower quality of care. Personally, as both a cancer and hep C patient whose onclolgy and hepatology doctors are not willing to recommend medical marijuana, should I ever find it necessary, I would be out of luck and would have to go find new doctors who are willing to make a medical recommendation for medical marijuana. This is not only unfair, it will disrupt ongoing patient-physician relationships and possibly exclude the majority of patients who otherwise would qualify for medical marijuana. Any patient who receives their care from the Veteran's Administration would have no access other than to purchase pot illegally under the current rule.

I don't understand why you have to see a doctor in Arizona for an "ongoing" medical condition. The requirements seem a bit rash. Not every doctor is going to agree to recommend cannabis to their patients, even if there patients have legitimate claim. About less than half of doctors in Arizona will be willing to put their license on the line for their patients/agree with medical marijuana. maybe less than that, because thats about the ratio of doctors that agree with it in California. Usually "pot docs" are specialists, that leave their field/or use their prior field of expertise to evaluate medical marijuana patients. How does any patient know their doctor will prescribe them cannabis unless the physician has advertised himself as a pot doc? This is why I think the law about having a medical condition with the same doctor, and four visits is rash. There needs to be verification of a chronic condition through a M.D., but some people will be left in the cracks for a year if you write the draft this way. Also, how are the cultivation sites supposed to be up and running if pot isn't technically legal in Arizona, yet? Doesn't this requirement give an advantage to criminals who are already running illegal grow operations. How is the cannabis supposed to be available for the dispensaries to open? I'm unclear of how this is supposed to work after reading the draft. I live in California, and am a medical marijuana patient. I also attended Oaksterdam University, cannabis college, so I know a lot about the laws about dispensaries in California. Most pot docs in California suggest growing your own medicine, so you know whats going in to it. So, I don't think there should be a limitation for small personal grow operations for medical marijuana patients. California supreme court ruled that SB 420 (put limits on cannabis amounts) was unconsitutional, since the law can't tell you how much medicine you can have. That should be up to you and your doctors discrection and advise. 99 plants and 3 pounds should be the limit. Thats the Humboldt County limit, and general limit for California patients. However, without a 420 SB expemption from your doctor you can only grow 6 plants and have a half pound. Why do you have to have driver's license issued before 1996? That means you can't get a card if you are younger than 30 approximately?An Arizona Driver's License should be sufficient, or an ID card from the State.

ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic

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R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. 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1. To eliminate unscrupulous doctors abandoning legitimate practices, in lieu of specializing in providing marijuana cards or becoming full-time out-of-control "Pot Docs" as experienced in other medical marijuana states; The following language should be stricken from the rules: " OR -Has assumed primary responsibility for providing management and routine care of the qualifying patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the qualifying patient's medical record maintained by other treating physicians that may include the qualifying patient's reaction and response to conventional medical therapies: R9-17-101 (16) (b) R9-17-202 (G)(13)(e)(i)(2) . R9-17-204(A)(e)(ii) R9-17-204(B)(4)(f)(2)

ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic

drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. 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Two suggestions are: 1. Marijuana dispensaries should only be allowed to dispense marijuana in foods. Raw marijuana and marijuana to smoke is loaded with carcinogenic chemicals and toxic metals. This should not be allowed. 2. Doctors who dispense marijuana should be limited to about 50 patients only. The reason is that in other states, a handful of doctors make all their money dispensing prescriptions for marijuana. This amounts to abuse and should not be permitted. Thank you.
[redacted]

I think the draft rules can be improved by removing the fees for changing the location of a dispensary and a dispensary's cultivation site. Changing the fee for a qualifying patients registry identification card and renewing a qualifying patients registry identification card from $150 to $50 or less. Allowing a doctor to determine from patient/doctor relations what is and is not a debilitating condition for the patient disregarding any other necessary proof of such or a required time establishment of a doctor/patient relationship, however, documented to prove patients improvement in condition. Removing all possibility of public comment on a patients particular request in regards to adding a debilitating medical condition. Removing the requirement for such an extensive electronic monitoring system and the granting of remote access to a dispensary's electronic monitoring system. The minimum amount a dispensary must cultivate reduced from 70% to 30% with an allowable 70% to come from a dispensary's cultivation site. Allowing a medical director or medical directors to determine for themselves how many dispensaries they are able to effectively cover.

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I AGREE WITH THE FOLLOWING: ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to

application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. 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i have commented before,,, if there is any search of patients in numbers that would allow increases in estimations the dhs needs to look at all lymphadema patients. i don't understand the complications or needs of "medical approval" i can assert the following is correct; What are the sources of this physical pain from lymphedema? 1. Compression of and to nerves from the swelling 2. Increased pressure and compression of nerves from fibrosis 3. Chronic inflammations that are all to often with lymphedema 4. Cellulitis, lymphangitis and other infections 5. Over exertion of areas of the body as it attempts to cope with the excess strain and weight over an oversized limb 6. Wounds and those weeping sores we all get from time to time
Define the plant better. Example seedlings are not a mature product, would not be of any use as medicine. I like to view it as an apple tree, only the fruit when it is mature is of value to human consumption. With the marijuana plant the bud is the usable medical fruit, must be mature and have THC crystals for medical potency. Let those with medical cards, and valid reasons grow their own medical plants. Some of us can not obtain our medicine through a dispensary. I have seen patients with Oregon medical marijuana cards that could not get out of bed they were so sick. Terminal cancer, wasting syndrome, blindness, ect... Each patient should be able to smoke, eat, or ingest the marijuana through the managment of their own physician. How can a dispensary worker perscribe what is the right treatment for a cardholder without totally knowing the persons medical condition? That should be up to the physician! Also know that most growers do not start with seeds, they use clone's, these are cutting from mature female plants. This method insures that you are using the same strain, the plants will be female, and your chance of succesful grow results are better.
Stop making asinine rules to please the "NO" voters. They lost... Don't interfere with the doctor patient relationship. Specialists can't be required to be each patients primary doctor. Don't require more security than a standard doctor's office is required to have, that stocks opiate pain medication. Cannabis is safe and impossible to overdose on, opiates can be deadly. Criminals like to steal opiates just as much as Cannabis. AZDHS is opening up the state to countless, very expensive lawsuits with these horribly restrictive rules. I think the fine state of Arizona can find better things to spend it's tax dollars on.
I read news today that ADHS has an arrangement with one of the rich prospective dispensary companies. If this is true I am deeply disappointed. My hope is that marijuana will be able to be grown by dispensaries at a low cost where there is fair competition among all potential dispensary owners. Marijuana prices need to be low for the handicapped. An 8 foot fence is unnecessary. A Dr. on call for a dispensary is absurd. These will drive up the costs for the disabled consumer. Please keep costs down. Please have lower fees for the patient. Please make it so a patient can see any doctor for the yearly medical marijuana recommendation. If the doctor is writing bogus recommendations, fine the doctor but don't make it hard for the patient. You can go undercover if you believe a doctor is writing bad recommendations.
Modifying the 70%/30% growing terminology. It seems counter-productive to have 124 dispensaries having to grow most of their own product. There already exists a number of qualified growers who would/could produce reproducible, high quality product. They could be required to associate & supply 100% to a given dispensary, but be able to sell excess to other dispensaries.
A dispensary may provide only 30% of its cultivated marijuana to other registered dispensaries and may acquire only 30% of its own marijuana supply from other registered dispensaries. This is very problematic and not in the best interests of patients, as it will likely create acute shortages in rural areas and drive costs up. Those patients within 25 miles of a rural dispensary unable to meet demand will have no secondary option for safe access to their medicine. I would like DHS to create an open wholesale relationship between dispensaries. This will assure consistent supply to rural Arizona, easy access for all qualifying patients, and lower costs due to increased competition of organizations trying to

meet demand. Additionally, we are looking into offering a Dispensary only facility and purchasing all medicine from other growers/ Dispensaries. This model works very well for Harborside Health Center in Oakland CA. From what we understand, it is one of the premier facilities in the United States. A patient's Arizona physician must either 1) have been treating that patient for the debilitating medical condition for at least a year that included at least four visits, or 2) have taken primary responsibility for the care of the debilitating medical condition after compiling a medical history, conducting a comprehensive exam, and reviewing medical records. This provision is stricter than in most of the medical marijuana states, but does not appear designed to prevent a seriously ill patient with a demonstrable debilitating medical condition from getting a written certification. It may make it impossible for some veterans to qualify, because Veterans Administration Hospital doctors do not issue recommendations. Will a Dispensary be required to have a lease on a proposed location prior to receiving certification, or will a LOI with a Landlord suffice? Also, is there a square footage requirement of the maximum allowable size of a Dispensary, or is this up to each Licensee?
Overall, the draft seems overly concerned on imposing restrictions. This limits the ability of qualifying patients to acquire effective medication. Also, it appears that the rules do not respect the professional opinion of doctors who would choose to recommend cannabis to their qualified patients. Specifically, this can be improved by eliminating the requirement that a patient be in the primary care of the recommending physician for one year. This needs to be eliminated because patients are sometimes in the care of multiple physicians. While it is the patient's responsibility to discuss any medications they are taking with each of their physicians (in order to prevent prescribing drugs that may cause harmful drug-drug interactions), each physician should be respected under the law to make a recommendation if they feel it is necessary. Additionally, the one year requirement ensures that qualified patients will have to endure otherwise avoidable suffering in order to fulfill a bureaucratic requirement. Again, though a physician may feel that a recommendation for cannabis would benefit their patient, they would be hamstrung by an arbitrary rule. In short, if a physician is to be allowed to recommend cannabis to his/her patient, that recommendation should be able to be made solely at the discretion of the recommending physician and not subject to arbitrary rules that are inconsistent with a doctors ability to prescribe other medications that often are addictive, toxic, or both. Finally, the requirement that a patient see their recommending physician at least four times during the course of the one year requirement will impose an unfair burden on low-income patients. Strike all references to the one year, four visit requirement from the rules in order to improve this draft. I suspect that failure to do so will precipitate legal action from interested parties against DHS in order to solve this matter through the courts.
More explanation needs to be given to what a NONPROFIT MEDICAL MARIJUANA DISPENSARIES is exactly. The word non-profit is not explained enough.
Section 6 - the AZDHS waives title 41. This appears to have only sinister motivation. This is not a reasonable clause. I urge title 41 to be complied with
The application selection process is unclear. The hope is that the department provides licences to the most viable submissions. The best applications not just first come first serve or lottery. This opens the door to applicants that should not be involved for whatever reason. I hope the department clarifies this based again on best applicants not only on complete applicant applications. Lets get this right to begin with!
R9-17-202 e.i. A one year relationship is a loop hole to push back the time it takes to get medical marijuna to over a year starting from april/2011 so by april of 2012 a person would then qualify. by then it is time to vote again.. This is not a good rule unless your against the M.M. law

One year relatitionship with your Doctor is not right. You can not change Doctors and qualify, If a Doctor leaves the area you then do not qualify, I have had a diagnoasis for 3+ years. I have not had the same Doctor for a year. They either leave, or I feel they are not doing there job.so I change Doctors, as allowed by ahcccs.I feel a Doctor should know weather a person needs it or not.Period..He has all the records about the patent. I feel this needs to be changed to any licenced Doctor in Arizona,other wise you do not trust the Arizona Doctors.

[redacted] has made two excellent recommendations, which I support: "1. Marijuana dispensaries may only dispense marijuana in food, in capsules or as suppositories, but never in its raw form or in any other form that can be smoked. Marijuana smoke contains dozens of carcinogens and research links pot-smoking to several types of cancer and respiratory problems. An extensive description of the research can be found at my website, http://edgogek.com. 2. Doctors who recommend medical marijuana can have no more than 30 active medical marijuana patients at a time. This is the same as the rule for buprenorphine. The reason for this rule is that, in other states, almost all the marijuana is recommended by a handful of doctors who set up marijuana practices and earn their living handing our recommendations to anyone who pays their fee. A 30-patient limit will stop these pot doctors. "

ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or

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The state proposes to charge patients $150 for a medical marijuana card, and caregivers $200, annually. For a patient who cannot travel and whose spouse is the caregiver, this amounts to $350 a year. Add to this the substantial cost of the medicine itself and you end up with a law that fails to serve the public as it was intended. The public interest demands that these charges be significantly reduced especially for stage IV cancer patients as they are in critical need. Otherwise many cancer patient/caregiver couples will be forced to choose between eating or having a medicine that has been shown to actually fight cancer along with improving the lives of cancer patients.

Trash them and start over again. Treat this exactly like you would any other new drug that comes on the market for patient use as prescribed by a doctor.

The fees for changing locations is way too high. This is likely to happen frequently for many reasons at first. These fees should cover paperwork costs only. There needs to be a method of appeal for any and all refusals and non-conformance. A complaint system needs to be designed and implemented 90 days time-frame for applying and changing locations for dispensaries seems excessive - how about 45 days overall, 15 days for administrative completeness and 30 days for review (or vice-versa). Chronic and debilitating anxiety or depression needs to be included in the debilitating disease section. There needs to be provisions for temporary substitute caregivers. There are many reasons why a caregiver may need to be absent for a short period of time (up to 30 days) R9-17-302 B-1-f-ii through vii Information about these issues of an applicant is irrelevant and an unnecessary invasion of privacy. R9-17-302 B-1-g A dispensary does not need a medical director. There are 2 kinds of information that a patient needs. 1. They need to know if MM can help them and ease the suffering and pain and if so, what are the side effects of the various methods of ingestion. This kind of educational information should be explained by the prescribing physician. 2. The patient needs to know the relative effects of the specific strain of MM that is available at the dispensary. This is the only information that a dispensary should have the authority to convey. R9-17-302 B-3-c-i Social Security cards should not be used for identification purposes Video cameras should not be mandatory - you are going to scare away patients and they do not provide any real security. Panic buttons should not be mandatory

Provide the locations of natural and artificial lighting???? this is going way too far. You are being excessively intrusive The dispensary's by-laws containing provisions for the disposition of revenues and receipts. Again - useless and invasive information that will probably be incorrect after the first week of real world operations. Why are you increasing your workload and decreasing efficiency? A business plan demonstrating the on-going viability of the dispensary as a non-profit organization;. See the above paragraph. With the current restrictions on facility sizes, the requirement to grow 70% of the MM sold is not reasonable. A patient being required to buy all the MM they use if they live within 25 miles of a dispensary is not reasonable. MM is not covered by any insurance. Dispensaries do not carry all strains and types of MM. There are many patients who must consume 4+ ounces a week. Even at the cheapest rates, this comes out to $5000 per month or more. 25 miles can be a long long distance when you can't drive and MM is not allowed on public transportation. Patients should have the choice of buying and/or growing. The 5 ounce per month limit is ridiculously low for many patients. Patients who must consume their medicine internally must consume many times the amount that a smoker needs, up to the equivalent of 2 ounces per day in edibles or oils. There needs to be provisions for easily attainable exceptions as recommended by the physician. R9-17-306 Inspections B. A dispensary shall provide the Department with authorized remote access to the dispensary's electronic monitoring system. - A warrant-less intrusion and an invasion of the privacy of patients and staff. Do you have access to the electronic monitoring systems of pharmacies and doctors offices? No - you do not and you should not have access to these systems either. R9-17-307.A.1 b. Business records, including manual or computerized records of assets and liabilities, monetary transactions, journals, ledgers, and supporting documents, including agreements, checks, invoices, and vouchers; - Again, a warrant-less intrusion and an impediment to business. The Department of health has no use for this information and keeping the information private and secure is a risk to the business and to the Department of Health - an invitation to law suits. R9-17-307.A.1.e - this section is needlessly complicated and open to any interpretation of anyone who reads it. Pharmacies are not required to track patients at this level and dispensaries should not be so required. R9-17-307.A.3 - This single requirement will keep more dispensaries from opening than any other regulation described here. Doctors are VERY expensive and a doctor, under the rules laid out here, can only be a medical director for 3 dispensaries. No doctor in his right mind is going to deliberately open himself up to the kinds of malpractice suits that this requirement will generate. Requiring this section will also open the Department of Health to the sue happy lawyers that are going to jump all over this. As a taxpayer, I do not want to have to pay for the resulting court battles. A dispensary does not need a medical director. There are 2 kinds of information that a patient needs. 1. They need to know if MM can help them and ease the suffering and pain and if so, what are the side effects of the various methods of ingestion. This kind of educational information should only be explained by the prescribing physician. 2. The patient needs to know the relative effects of the specific strain of MM that is available at the dispensary. This is the only information that a dispensary should have the authority to convey. R9-17-307.C - With the cities trying to regulate dispensaries out of existence and restricting growing space to ridiculously small spaces, the 70% rule is not reasonable. No dispensary with more than a few dozen patients can possibly grow enough medicine to properly support the patient's needs. R9-17-310. - This single requirement will keep more dispensaries from opening than any other regulation described here. Doctors are VERY expensive and a doctor, under the rules laid out here, can only be a medical director for 3 dispensaries. No doctor in his right mind is going to deliberately open himself up to the kinds of malpractice suits that this requirement will generate. Requiring this section will also open the Department of Health to the sue happy lawyers that are going to jump all over this. As a taxpayer, I do not want to have to pay for the resulting court battles. A dispensary does not need a medical director. There are 2 kinds of information that a patient needs. 1. They need to know if MM can help them and ease the suffering and pain and if so, what are the side effects of the various methods of ingestion. This kind of educational information should only be explained by the prescribing physician. 2. The patient needs to know the relative effects of the specific strain of MM that is available at the dispensary. This is the only information that a dispensary should have the authority to convey. R9-17-312. - If I were a patient, this section would strike me as Big Brother raised to the highest level of deliberate

interference and over-control. I can't think of a single reason for gathering the enormous amount of information you are asking for, except maybe to compile a list of people to arrest at some later date. The only piece of information that makes any sense is the verification of a person's identity and registration card. R9-17-315.C - This is ludicrously invasive and obtrusive. It is deeply offensive. None of this section should be mandatory. Business people will protect their business as necessary - you do not need nor should you have the authority to over-control a legitimate business. R9-17-319.B - Over controlling again. These requirements have nothing to do with the proper administration of a business. As a general comment on the many documents and items of private and sensitive information that the Department of Health is requiring from law-abiding citizens. How and where is this information stockpiled. What security methods are being used to prevent un-authorized access and what methods are being used to insure that this information is not abused. What guarantees are you issuing to ensure patient confidentiality and the safety of the dispensary workers and to the businesses involved. I don't know why you still think of these dispensaries as drug pushers and patients as illegal drug addicts but it is glaringly obvious that you do consider them as such. These patients are people who are in great amounts of pain and discomfort. They need relief from these symptoms, not deliberate hindrance, red tape, intrusive behavior and the attitude that this stuff is something that you should be sneaking out behind the garage to do. Taken as individual requirements, the draft rules, for the most part can be logically be posited to be applicable. Taken as a whole however, they provide an excuse to deny pain relief and surcease of suffering to thousands of good people. Dispensaries are legitimate businesses and should be treated as such. These establishments are very close to pharmacies and should be run and regulated similarly. The over-regulation that is put forth by these draft rules will guarantee that the only entities that are capable of running a dispensary are the big corporations and drug lords from south of the border. It also invites corruption and bribery. The costs and obtrusive regulations required by this draft is such that good business people of high morals and good will are excluded from involvement in this endeavor to help relieve the suffering of many, many persons. The only entities able to comply and who also have the monetary resources are big corporate and drug lords. These are the last people we want in charge of any of this. As you know, Over-regulation is an open invitation to corruption, both in the private sectors and for the government overseers. I wonder why you are deliberately constructing such a scenario.

Marijauna smoking should be limited to places where cigarette smoking is allowed. Marijuana smoke has the same cancer causing tars as cigarettes. Public employees should not be allowed to smoke marijuana as it may impair their judgement and there is no way to measure that. Physicians should be limited to the number of patients for whom they are recommending marijuana so it doesn't appear a physician is making a practice of being a prescriber.

The draft rules can be improved by simply following the law as stated in prop 203 ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." As written the rules are placing undue burden on the dispensaries and on the patients themselves.

Cancer, HIV, Hepatitis C, and ALS patients often do not have 1 year to live. The patients that do live are cruelly being told to change doctors or suffer for 1 year. How can the draft rules be improved? REMOVE THIS CRUEL 1 YEAR, 4 VISIT RULE

See below section of what has been left out

ARS 36-2803.4 of the AMM Act requires that the ADHS rule making be "without imposing an undue burden on nonprofit medical marijuana dispensaries". ARS 28.1 Section 2 "findings" of the AMM Act requires the Dept to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijunana. AZ pharmacies and phsician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet AZ pharmacies and physician offices are not required

to have 12 foot walls, constant on site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the dept. R 9-17-101.10 is an undue and unreasonable burden, 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17 101.15 is unreasonable and usurps authority denied to the dept, It violates the 1998 AZ Voter Protection Act. The dept does not have the authority to deny the involvement of naturopathic and homopathic physicians as defined by ARS 36-2806.12.

Selection of Doctors who will Prescribe Medical Marijuana. I can tell you as a two time breast cancer survivor my doctors would never prescribe it even though they know it works because they are afraid of the DEA contracts they have signed. They would lose their license to practice. Therefore, we should have doctors who SPECIALIZE in Medical Marijuana and fully understand the dosages, edible versus smoke, etc. They would be protected by the State to ensure their licenses would NOT be in jeapardy. I am not in favor of requriing these potential dispensaries to secure leases, buildings, and be set up ready FOR INSPECTION BEFORE the application is approved. Please explain why this is? Isn't a legitimate corporation licensed with the State of Arizona and a business plan provide sufficient documentation (as well as required documentation on principal officers, etc.) versus forcing me as a potential dispensary owner to commit to a lease, hire employees, perform build-out or tenant improvements, all before knowing if we are approved?

The law is discriminatory regarding the rules and regulations related to prescribing and dispensing of medical marijuana. This law as is, is cruel and unusual and contradicts even the states regulations in the prescribing narcotics and other controlled substances. The individual needing medical marijuana will be jumping through "hoops" creating an atmosphere of frustration and discrimination in regards to this population. It is the intent of this law to alleviate symptoms that are difficult to control and manage. The law now creates a new set of problems and difficulties in obtaining the ability to receive medical marijuaa. These problems may lead those who want and need the medicine to pursue a prescription by the same means as before this law was inacted. We do not need illegal providers coming to the rescue of those patients who are denied a prescription unfairly or those who are unable to navigate the stringent and discriminatory system that is difficult for the average Arizonans capacity to understand the rules or figure out the particulars. Primary care physician rules are ludicrous and need to be changed as to accomodate those seeing specialists etc. The rule of seeing a physician at least 3 or 4 times a year is discriminatory and is not necessary since there are not other medications that have the same rules. One can obtain a drug from a licenced doctor in one visit when deemed appropriate. The provisions of the act are discriminating against patients such as military personnel suffering grief, PTSD and other disorders both mental and physical that effect the quality of one's life. Must one attempt suicide rather than be precribed a medication which may enhance or improve quality of life? This most definately defeats the intent of this law. Again, these abusive and unfair regulations will lead to illegal activity that is prevalent in our state. One can buy liquor at anytime and almost anywhere and go out and drive drunk and kill people or themselves. Although this does not actually pertain to the law at hand but it highlights the upsurdity in most of the language in this law.

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There is No mention of the Limit of Dispensaries that will be issued to one particular group and/or individual. Californians are expecting to monopolize Arizona since they have big bucks.
The response just filed by the Arizona Association of Dispenary Professionals says it all. This process has been designed to obstruct all but the most wealthy applicant. It appears to be rife with collusion between the AZDHS and the MPP and their agents. There is no transparency to the process. Fees are outrageous and non refundable
1.Restrict the number of applications for dispensaries to one applicant per person or persons, that way big monies, i.e. corporations cannot apply for multiple applications in multiple cities. Also restrict applicant's for dispensaries to be limited to the city they reside in. 2. (Draft Rules R9-17 –102 – Prop 203 –36-2803) The dispensary registration fee of $5,000 is way too much not to be refundable: remember this is non-profit. Why don't you have an application fee of $1,000.00 upon approval an additional $4,000.00 will be required and if denied the $1,000.00 is non-refundable; that sounds more reasonable? 3. (Regarding A Dispensary Administration- Draft rules - Page 34 –Paragraph C 1 thru 5- R9-17-307) The draft rules states a dispensary must cultivate at least 70% of its Medical Marijuana. The other 30% may be acquired from another dispensary. This is great however its going to take at least four to seven months to even have any medical marijuana ready for medical distribution due to growing time and depending on medical strains such Sativa and Indica whether growing indoors or out. Regarding the 12 plant limit as stated in the rules; you will need 12 plants in the flowering stage, 12 plants in the vegetation stage in order to keep up with the medical demand and 12 plants in the cloning stage to assure the same quality strain can be duplicated. So the rules should read 36 plants total with the 3 stages implemented i.e. (12 plants in flowering stage for harvest, 12 plants in vegetation stage for growing, 12 plant in clone stage from the mother plant to insure same quality) with a total number being 36 plants in the stages listed above. 4.In Proposition 203- Page 83 – Analysis By Legislative Council (which is what we voted for) it states under qualifying patient is defined as a person who has been diagnosed by a physician (a doctor of medicine, osteopathy, naturopathic medicine or homeopathy. In the draft rules you only list, a doctor of medicine or its successor or a doctor of osteopathic medicine who holds a valid and existing license to practice. What happened to naturopathic or homeopathy doctors it seems they were left out of the draft rules? 5. Draft Rules – Definitions R9-17 –101 item 15 – Medical Director Paragraph A Should be deleted completely as it's discriminatory toward patients, we do see the or at the end of paragraph stating or physician assumes primary responsibility. However Insurance will not allow patient to change providers or MD may not be allowed to prescribe under their current contract or beliefs. Terminal patients may not have the time to establish the relationship necessary etc.
Allow for post traumatic stress disorder
The draft rules can be improved by removing certain sections of the draft that appear to be arbitrary and capricious in its attempt to restrict the freedoms of patients and physicians rights: The following

sections should be removed: R9-17-101(16) , R9-17-101(17), R9-17-202(F)(e,f,g,h). [redacted]
Our veterans should be eligible for medication, but are not currently issued recommendations by their physicans. It should be rewritten to allow veterans the ability to qualify. Dispensaries should have free trade among locations if necessary. This will discourage shortages and price gouging in rural areas and across the board.
if you are trying to provide and track quality of the medicine, why are you requiring each dispensary to grow their own and limit what they can sell, this is going to result in 120 mom and pop growers which will be a lot harder to track than a few well qualified, growers .
The language and format of the draft rules document are a bit cumbersome and could be simplified. It would be helpful to have a separate page defining all of the Arizona Revised Statutes that are referenced in the document. Expanding the definitions included, such as adding "divert", "department provided format". Please clarify whether the 'physician statement' regarding a patient's recommendation will be a AZDHS provided or a free hand written statement with the required information. Address the rules and regulations investors or lenders may or may not be subject to.
Remove the timelines for Physician relationships and remove the 25 mile restriction on patient cultivation. The timelines are unrealistic in the current medical/financial conditions. Most people, including Physicians, move frequently for various reasons. These moves and other changes interrupt the relationship timelines through no fault of the patient. The 25 mile cultivation restriction forces patients to purchase and transport expensive medication from dispensaries that could otherwise be safely and securely cultivated in a controlled environment. Patients should have the choice to cultivate their own medication regardless of their location as long as they follow all security regulations. There are no mileage restrictions on any other medication so there should be none on this medication.
There are zoning requirements being enacted by municipalities, such as the City of Phoenix, that separate the locations of the mmj cultivation and the mmj dispensary. Perhaps there should be two different licenses - one for specifically cultivating and harvesting mmj and one for actually dispensing it to patients.
Please consider allowing a Nurse Practitioner to fulfill the same roles granted to M.D. or D.O. with regard to medicinal cannabis.
Remove the Patient/Physician timeline requirements.
There are a few ways. The process by which patients get to know their doctor is too difficult. I have one of those serious conditions, if my primary care physician will not recommend marijuana then I will have to look to a medical marijuana physician, two visits, not 4 are a reasonable relationship. The fee for the patient's card - $150 - Is too extreme. Most of these patients are on a limited income. Third, the 24 hour cameras in the dispensaries violate privacy of the patients. How will this video and these records be stored and secured. I fear you are regulating this program beyond what is allowedby prop 203. ADHS will cause patients not to particpate in the program and the dispensaries will fail without sensible regulation. Don't forget, dispensaries, patients, and caregivers already have to deal with local zoning, ADHS should facilitate this program and use minimal regulations as required by Prop 203.
Leave the definition of ENCLOSED, LOCKED FACILITY" MEANS A CLOSET, ROOM, GREENHOUSE OR OTHER ENCLOSED AREA EQUIPPED WITH LOCKS OR OTHER SECURITY DEVICES THAT PERMIT

ACCESS ONLY BY A CARDHOLDER alone Allow people to build their own grow area, don't worry, they'll be secure, until you remove the profit from medical marijuana, it's just worth too much not to.
The draft rules mention that the fee for a qualifying patient is $150. And this registry ID card expires at some point. I didn't see where it mentions how long the card is good for until it expires. Also, it costs $150 to renew once it expires. A more clear explanation of this would be helpful. Many of these individuals will be on SSDI and therefore probably not have an extra $150 lying around. Have you thought of offering a sliding scale fee based on income levels? Or allowing paying $50 a month for 3 months?
How can you change definitions the people voted on? Like ENCLOSED, LOCKED FACILITY" MEANS A CLOSET, ROOM, GREENHOUSE OR OTHER ENCLOSED AREA EQUIPPED WITH LOCKS OR OTHER SECURITY DEVICES THAT PERMIT ACCESS ONLY BY A CARDHOLDER.
Why do you want to require 12' walls, 1" metal gates, and 1/2" metal bars around medical marijuana grown outdoors, if people can grow in a glass greenhouse? Don't make bad guys break into people homes and kill them in a home invasion robbery. Remember, marijuana has never killed anyone, you're requiring more security on marijuana than spray paint, that kills young people all the time.
1) a process for waiver of fees for a qualified patient or caregiver with low or no income. (the Department makes a provision for no address for the homeless, but makes no provision for fee waiver for this type of applicant) 2) Although draft rules require licensed dispensaries in Arizona will be to grow 70% of the marijuana sold, there seems to be no rules on where it is cultivated or who exactly does the cultivation.
Why require a two year AZ residency? Wouldn't one year be sufficient to keep out people who will want to move to AZ just for this? In addition, what's with the 70% growing rule for dispensaries? This is going to discourage many from trying as it significantly ups the start up and maintenance costs from a dispensary alone to a dispensary/grow center. Why not allow dispensaries to contract with AZ growers for the product?
I am VERY CONCERNED/ OPPOSED TO live-time surveilance piped directly to the Department; this is a GROSS VIOLATION of basic rights to privacy for proprietors/employees. THIS WON'T FLY!! Who's to say some PERVE in the Department isn't getting his/her jollies via a candid shot of someone doing his/her job; NOT APPROPRIATE, IN FACT, IT'S INDECENT!! Where are Big Brother's cameras in nudey joints, smoke shops, liquor stores, pharmacies? Why must you DEMONIZE this natural remedy/ herb when this whole program is intended to serve ligitimate patients? SET UP ADEQUATE QUALIFICATIONS FOR PATIENTS AND LET THE WELL-INTENDING, INDUSTRIOUS PROPRIETORS SERVE THEM AND MANAGE THEIR OWN ENTERPRISES!!! The restrictions and requirements on the facilities and business operations are INVASIVE and OFFENSIVE. Here's the deal: I, a prospective proprietor, wouldn't sell a crumpled leaf out the back door because I intend to run a COMPLIANT, SUCCESSFUL business. All we are sayin' is "give compliance a chance!" Why shouldn't qualified caregivers be allowed to grow for patients, NO MATTER WHERE THEY LIVE?? For that matter, WHY SHOULD QUALIFIED PATIENTS BE ALLOWED TO GROW, NO MATTER WHERE THEY LIVE?? Doesn't it weaken the premise that the patient is actually qualified when you take away his right to grow his own medicine? DON'T FIND YOURSELVES ON BOTH SIDES OF THE FENCE; DON'T PUT QUALIFIED PERSONS IN DOUBLE JEOPARDY, scrutenizing their ligitimacy, then prohibiting their liberties. SO MUCH OF THIS IS LUDICROUS! TAKE A BIG STEP BACK, AND RESOLVE THAT LESS IS MORE; DON'T SHOOT YOURSELVES IN THE FOOT!! FYI, the 10 or 12 foot walls around a pot patch will telegraph it as a grow op; it only informs assailants that they need a rotohammer &/or a metal blade in a grinder or recip saw or a torch (plasma cutter?) and a generator to fire-up in the bed of the truck when they knock-off a grow op. Do you really think prescribing construction is going to help? It will certainly postpone any

crops or local supply. BTW, where will initial inventory come from if the AGENTS are bogged down not only with managing to heads of the monster (retail and grow op), but also subcontracting construction in two locations, one of which has to be complete before the first seed can be planted, BOTH OF WHICH HAVE TO BE LEASED BEFORE THE APPLICATION CAN BE PROCESSED!!! GET THE F**K REAL, PEOPLE!!! The Valley has MANY, MANY VIABLE VENUES FOR BOTH RETAIL AND GROW-UP FACILITIES-- YOU JUST HAVE TO ALLOW THEM TO HAPPEN; GET OUT OF YOUR OWN WAY! The weak/seedy ones will fall by the wayside and you'll have your black sheep to make examples of, and the GOOD PROPRIETORS WILL RISE TO THE TOP, MAKING YOU PROUD OF YOUR PROGRAM AND SHARING IN A HEALTHY, FUNCTIONAL PROGRAM. What about this 'no compensation' thing for caregivers? Are we leaving this role to SAINTS? What is wrong with anyone profiting from what you are establishing as a ligitimate patient condition? Are we ensuring the Pharmaceutical companies aren't profiting too much? What if your kid triples his money on a lemonade stand? Would the Department be heartbroken to find a fiscal surplus? DON'T SQUASH FREE ENTERPRISE; DON'T PUNISH THIS INDUSTRY BEFORE IT CAN EVEN PROVE ITSELF. If you've learned from CA & CO, etc., learn also what has worked, not that I'm a fan of those models; see their grow ops: they are specialized, skilled cultivation entities with little to do with retail, just like the cotton farmers who know nothing of what fashions are comin' out of Fashion Square Mall, GET IT?? Why must Dispensary and Grow Op be remote? How remote? Why fragment security measures/staff and create transportation issues? Hey, if you're going to make them conjoined, how about letting them take prudent measures to separate the space responsibly and thereby ENHANCE SECURITY BY LOCALIZING RESOURCES!!! Heck, the Department could inspect both at the same time, everytime! ...that's all I have for now, but tomorrow's another day; I hope this is constructive, albeit reactive-- I just think some of this is SO OBVIOUS! Please don't get too far ahead of yourselves; pride yourselves with early recognition of gross oversights and awareness of well-intended, but erroneous presuppositions, and GO MAKE SOME MAJOR CHANGES. WE WILL ALL APPRECIATE IT WHEN WE ARRIVE AT A WORKABLE PROGRAM!!! MANY THANKS FOR YOUR CONSIDERATION.

Arizona Association of Dispensary Professionals 10640 N 28th Ave Suite C-205-2 Phoenix, AZ 85029
This is the formal response from the Arizona Association of Dispensary Professionals , (AZADP), to the Arizona Department of Health Services, (AZDHS) concerning the implementation of the Arizona Medical Marijuana Act. The AZADP is an organization comprised of over 4600 members. AZADP membership includes concerned dispensary candidates, individuals who believe they are qualifying patients, Physicians and other individuals and entities involved in the Marijuana industry. While we want to believe Mr. Humble when he states that, (EXHIBIT A), “Fairness and Transparency are the keys to effectively implementing the AZ Medical marijuana Act”, the evidence contained herein suggest otherwise. We believe that the AZDHS has been influenced by and is conspiring with other organizations, namely the Marijuana Policy Project, (MPP) and their recently established association, the Arizona Medical Marijuana Association, (AzMMA), to create an elitist and monopolistic program where only the wealthy influential, informed sponsors of MPP will qualify for one of the 125 licenses. We believe that the following evidence will show that the AZDHS in collusion with MPP are intentionally developing program rules that are so complicated and costly so as to preclude otherwise qualified applicants merely on the basis of wealth and influence. We believe it is the intention of MPP to control the marketplace. Accordingly, we submit the following: Citations: 1. Arizona Medical Marijuana Act, hereinafter referred to as “TITLE 36” 2. Arizona Department of Health Services, hereinafter referred to as “AZDHS” 3. Marijuana Policy Project hereinafter referred to as “MPP”, a national political action committee who sponsored Proposition 203 in Arizona. MPP has a local chapter in Arizona. 4. Arizona Medical Marijuana Association hereinafter referred to as “AMMA”. An association recently established by MPP. 5. Arizona Association of Dispensary Professionals hereinafter referred to as “AZADP”. An independent association comprised of concerned citizens. 6. Arizona Voter’s protection Act hereinafter referred to as “AVPC”. A 1998 voter approved initiative petition amending the Arizona Constitution, to revoke the government’s power to amend an initiative measure approved by a majority

of the votes cast thereon, unless the amending legislation furthers the purposes of such measure. (AZ Cons. Article 4 Section 1(6)(c). 7. Regulatory Bill of Rights, (A.R.S 41-1001.01) hereinafter referred to as "TITLE 41". An Arizona law to ensure fair and open regulation by state agencies, limiting a state agencies rule making ability to subject matter listed in the specific statute and provides for citizens right to file a complaint with the States Administrative Rules Oversight Committee. 8. Affirmative Defense, (A.R.S. 36-2802), hereinafter referred to as "ARS36-2802". Qualifying Patients and Caregivers mat assert medical purpose as a defense to any prosecution of an offense involving marijuana. 9. Sherman Antitrust Act: To establish a violation of The Sherman Act, Monopoly Power may be defined as the power to fix prices to exclude competitors, or to control the market in the relevant geographical area in question. Prefatory Statement: AZADP was established as a direct concern of so many individuals who are alarmed at the direction the AZDHS is taking in their rule making progress. Prior to the election some of our members where involved with MPP and provided us with internal documents generated in the course of MPP's campaign operations. These documents will be produced herein and used as evidence to support our arguments. In September, 2010 MPP established an advisory committee. According to the local Campaign Manager for MPP, [redacted], this Advisory Committee was established at the request of AZDHS. Presumably, AZDHS was concerned that should the voters approve Prop 203, their understaffing and budget cuts would curtain their ability to complete the rule making process in the time allowed under the law. (120 days). According to [redacted], AZDHS asked MPP if they could assist AZDHS by preparing some proposed rules for consideration by AZDHS. "A blueprint to help AZDHS start the process". MPP agreed to assist AZDHS and established the Advisory Committee, also known as the "Roundtable". MPP invited 12-14 of its members to join the Roundtable and create proposed rules for consideration by AZDHS. Presumably most of the members on the Roundtable were either dispensary candidates or have other business interest in the medical marijuana industry. The members of the roundtable were divided into "task forces" each given a specific assignment. (EX: Cultivation rules, testing /quality control, security, applications, qualifications, etc) The roundtable participants also worked together to develop and establish the MMP Association, "AzMMA". It is no coincidence that the acronym for MPP's Association and Title 36 are the identical; "AzMMA". MPP took ownership of Title 36, and intended to impose its own agenda on the people of Arizona. MPP's stated agenda was to limit the competition and to assure that as many of their own members as possible received dispensary licenses. During the weeks leading up to the election, the Round table became fractured. Some of the members realized the true agenda of MPP and resigned from the group. Let us first understand that MPP is funded and sponsored by very wealthy individuals and organizations. The following evidence will show that MPP invested over half a million dollars of its money to secure an elitist program designed to solely promote the interest of their sponsors. The agenda of MPP is to make the dispensary application process as difficult and expensive as possible to preclude all applicants except the well informed wealthy members of MPP. As evidenced by the attached internal memorandum (EXHIBIT "B"), MPP, in the process of establishing it's Association , recommended that, "AZDHS implement dispensary applications and licensing standards that are rigorous enough to deter trivial applications, but that do not unduly impair the ability of serious applicants to operate successfully". It would be a serious conflict of interest to allow a Association comprised of wealthy future dispensary owners to determine what a "trivial application" is, but that is exactly what they moved on to do. Contained within the same documents MPP makes the following recommendations to AZDHS; A. Would require applicants to provide proof that they have obtained dispensary and /or cultivation facilities that meet the requirements of the ACT and local zoning. B. Requiring that the applicant provide a business plan demonstrating that the licensee will be operational within a specific time frame. C. Requiring the applicant provide proof of financial competency through a BOND or other means. D. Requiring that the applicant demonstrate medical expertise by having physicians or pharmacists on staff or engaged as consultants. Contrary to the assertions of Mr. Humble, (EXHIBIT A), clearly these MPP proposals have had significant influence on AZDHS, since all of them are incorporated into the AZDHS proposed rules. Additionally, these proposed rules, should they be adopted, will further the agenda of MPP by adding momentous increases to the cost of obtaining a dispensary license for the following reasons: A. Section 36-2804, of Title 36, among other requirements, necessitates an applicant to provide AZDHS

with a “Physical address of both the Dispensary and Cultivation center, and a sworn statement that the applicant is in compliance with local zoning requirements. This in and of itself creates a significant expense to an applicant, since they will have to secure a physical location without ever knowing if they will qualify for the license. However AZDHS has added a significant additional expense to the cost of the applicant by requiring a Certificate of Occupancy. This adversely changes the intent of Title 36. Under proposed rule R9-17-302, B-5 AZDHS is requiring an applicant, as part of the initial application process, to produce a Certificate of Occupancy. This would require a applicant to not only secure a location for his/her dispensary and Cultivation center, but build-it-out as well at a cost of hundreds of thousands of dollars, all at risk, since all is done without any assurances that they will obtain a license. This rule alone will serve to eliminate all but the wealthiest of applicants. B. At the request of MPP, (See EXHIBIT C), AZDHS’s proposed rules regarding business operations are outrageously over-regulated. We recognize the need to maintain strict business operations, but the proposed rules are simply overkill, intended to play into the hands of MPP’s agenda. (More on this below). C. There are no provisions in Title 36 that requires an applicant to produce a Bond. According to statements made by MPP all applicants with less than a million dollars of cash liquidity are considered “Trivial” and should be required to post a two hundred thousand dollar bond.(See Exhibit D). While there is no clarity or designation as to the purpose, type , amount or third party beneficiary of said bond, AZDHS has nevertheless, under proposed rule R9-17-302,15-D, and as part of the initial application , asks the question, “Whether the dispensary has a surety bond and , if so, how much?”. While we have sought clarification from AZDHS on this point, none has been provided. Attention must also be given to the availability of said bond. Because of the unique nature of the medical marijuana business model, obtaining such a bond might be impossible or extremely costly. Under federal law Medical Marijuana Dispensaries are considered a criminal enterprise; consequently, most if not all insurance companies would consider a request for a bond a very high risk. Therefore, potential applicants may be denied a license merely because he/she is not a millionaire. D. The prompting by MMP to have a medical director on the staff of each dispensary is not necessarily a bad idea. Unfortunately, AZDHS, at the urging of MPP has taken the Medical Directors position to place where no Doctor will go thereby making it impossible to comply with this rule, unless you are wealthy enough to afford a full time Doctor on your staff. A medical director retained to provide assistance in developing the medical aspects of the program for a Dispensary is a welcomed idea; however, to have the Medical Director interact with patients or develop any materials for use by patients could be considered interference in a patient-physician relationship. All qualified patients of a dispensary must have a recommending, primary doctor to obtain their registration card. Any log books, rating scales, or guidelines for patient’s self-assessment, as set forth in AZDHS proposed rule R9-17-310-2, may create a conflict of interest for the medical Director. This again plays into the main scheme of MPP. E. We are deeply concerned about the AZDHS’s plans concerning the selection process. As you will note AZDHS’s proposed rules are silent on this matter. On October 29th 2010, Director Humble wrote on his blog, (Copy Attached EXHIBIT E), that he had three choices before him, He asserted that method 3, (Evaluate the complete application using some kind of objective criteria), is probably the best because we’d be able to select the best qualified applicants. Humble went on to say, “ An Interesting twist on method 3 would be to send the completed (And blindfolded) applications to a 3rd party (e.g. a consulting law firm) and ask them to score the applications for us. It is perhaps more than coincidence that just prior to that Blog entry, MPP sent AZDHS a proposal to use their new Association (AMMA) as an Application Review Board. (SEE EXHIBIT F). This is the most outrageous conflict of interest we have ever heard of. A group of weathly potential dispensary owners, reviewing their own applications! We demand that AZDHS immediately disclose their selection process. We further suggest, in fairness, and in compliance with AZDHS proposed rule R9-17-319, a, 2, g, that any member of the MPP roundtable be excluded from consideration of a dispensary license. We would further ask that Director Humble make a full public disclosure as to whether or not any member of AZDHS has had any contact with MPP, AMMA or any representative or agent of said organizations. As most people know, MPP staff actually wrote Prop 203, now the Arizona Medical marijuana Act. Title 36. What most were not aware of is the fact that under section 6 of Title 36, AZDHS compliance under A.R.S 41-1001 is waived. Title 41, The Regulatory Bill of Rights, is an Arizona law to ensure fair and

open regulation by state agencies, limiting a state agencies rule making ability to subject matter listed in the specific statute and provides for citizens right to file a complaint with the States Administrative Rules Oversight Committee. Any reasonable person would have to cast a sinister eye on MPPS reasoning in exempting AZDHS from compliance with these provisions. This exemption eliminates the public's ability to object to the abusive behavior of the AZDHS. Point by Point Objection to AZDHS Proposed Rules: 1. Medical Director Definition: Should change to include any Doctor who is permitted under Title 36 to recommend Medical Marijuana. 2. Ongoing Definition: this is merely an attempt on the part of AZDHS to create an artificial bottle neck, choking off a potential revenue stream for struggling new dispensary owners. This is an unfair, abuse of authority on the part of AZDHS, intending to further the agenda of MPP. This rule is intended to dissuade marginal ("Trivia"l) applicants from submitting applications. AZDHS should rely on the recommendation of a Arizona licensed Physician, regardless of the relationship period, so long as the recommending physician complies with the provisions of Title 36, or until such time as there is evidence of fraud. 3. ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rule making be implemented "without imposing an undue burden on nonprofit medical marijuana dispensaries...." 4. ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. 5. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. 6. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. 7. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not (or cannot afford) to seek other medical care at all (whether prior or subsequent to application). 8. R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. 9. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. 10. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not

allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. 11. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. 12. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. 13. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information 14. R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. 15. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. 16. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. 17. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. 18. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. 19. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. 20. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. 21. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. 22. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse. ADDITIONAL RECOMMEDATIONS: 23. SURETY BOND: Clarify the purpose, the type, the amount and the third party beneficiary, of the surety bond, or eliminate its reference from the rules. 24. NON-PROFIT ENTITY: Clarify the need to establish a non-profit entity. Title 36 only requires an applicant to operate the dispensary under a non-profit "basis". Can an applicant establish a LLC or other entity so long as his/her bylaws comply with Title 36? 25. 70% COOPERATIVE GROW: Clarify if a group of dispensaries can form a cooperative to grow their medical marijuana under one roof, so long as the facility is in compliance with Title 36 and the AZDHS rules. 26. SEEDS: Please clarify where a dispensary owner can purchase his initial seeds. 27. LANDLORD

RIGHTS: Please clarify landlord rights with respect to entry and inspection of a dispensary/ cultivation facility. (Assuming the landlord is not a registered agent of the Dispensary). Additionally, please clarify access by a repair service to enter upon the restricted areas of a dispensary/cultivation to make necessary repairs. 28. TWO STAGE APPLICATION PROCESS: R9-17-302 Applying for Dispensary Registration Certification; we believe the proposed rules regarding the application process are inherently unfair and favor the wealthy. The average person who may otherwise qualify would be reluctant to invest hundreds of thousands of dollars in a dispensary application without knowing if they will get a license. In order to equalize the application process we believe AZDHS should adopt a two stage application process as follows: 1. Review the principals and legal entity first. Perform whatever background checks AZDHS desires, including FBI and all the other requirements as set forth in the proposed rules relevant to the principals and legal entities. 2. Issue a conditional License to the 125 most qualified individuals subject to approval of the facilities. (dispensary and cultivation sites) 3. The conditional license would require that the applicant to complete the build-out and/or construction of the facilities within 90-120 days. 4. Thereafter, the conditionally approved applicant would submit the second half of his application (Facilities) for inspection and approval. 5. The second half of the application must meet all the requirements of the proposed rules relevant to the facilities. 6. Provided the applicant meets all the facility requirements he/she would then be issued a Dispensary Registration Certificate 7. This system allows for fairness across all demographic and financial groups. It would not preclude individuals simply because they are not millionaires, and would allow those that are chosen to obtain the financing they need to complete the project. Fairness and transparency requires AZDHS to adopt this application process or similar one. IN CONCLUSION: Taken in totality, it appears that AZDHS is working in collusion with MMP to make this application process as difficult as possible, beyond what is fair and reasonable. What was alleged to be “fair and transparent”, has now become biased and opaque, demanding a comprehensive review and explanation. The sole agenda of AZADPs is to assure the success of the Arizona Medical Marijuana Act. To bring the dispensaries out of the dark corner of society into the main stream of America. We understand that to accomplish that we need to change the image, we need to exceed the highest standards, and we need to conduct ourselves and our businesses with the utmost professionalism, always in full compliance with the law. While you allege that “nobody outside the department is involved in the development of your informal draft rules”, it appears that is not correct. The fact remains you may not know if MPP is communicating with your underlings. The answer to your problem is to embrace ALL these organizations rather than create the illusion that you are NOT being influenced by some. You may want to establish a round table of your own, invite all the organizations, associations and industry leaders in Arizona including MPP, to offer and exchange ideas. That way nobody feels left out, and you perhaps may even learn a few things. We would welcome the opportunity to assist you in organizing a round table of industry, leaders. In the alternative we hope you will make a full disclosure of your involvement with MPP. [redacted]

I do not like the rule in the draft that deals with patient doctor relationship being one yar long before being able to issue recommendation for medical marijuana.

THE PROPOSED DRAFT PROPOSED "RULES" SO EVEN YOU KNOW THAT THERES MORE THAN ONE RULE ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed

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Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require

security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic

Would be Referring Doctor Not happy with First Draft December 31, 2010 By admin [redacted] The Green Leaf recently asked Dr. Ed Suter, a board certified physician and medical marijuana activist, to share his thoughts on the first draft of medical marijuana regulations released on Dec. 17 by the Arizona Department of Health Services. Here's his reaction: "The good news: As best I can tell, the Arizona Department of Health Services (ADHS) does not have the authority to enact the cruel and unreasonable package of regulations they proposed on December 17, 2010. Obviously, I am not an attorney, so I do solicit the input of interested attorneys. Because I am a physician, I am restricting my comments here to the matter of patient-physician relationships. I invite others with expertise in dispensary and caregiver matters to share your similar analysis and commentary concerning the draft regulations for dispensaries and caregivers. Please familiarize yourself with the Arizona Medical Marijuana Act (AzMMA): Notice that the AzMMA does not give authority to the ADHS to define or redefine the patient-physician relationship and does not give the authority to amend the AzMMA language, e.g., adding "ongoing" to "patient-physician relationship." The Arizona Voter Protection Act specifically denies authority for such usurpations. Please note that even the Director of ADHS questioned his own authority to do what he proposes. Next please familiarize yourself with the draft regulations. Then please participate in the public comments online and in person. Please plan to testify. Please also mobilize suffering patients to comment online, in writing, and to testify at the Public Meetings: Phoenix, February 15, 2011, 1PM, 250 N. 17th Avenue Tucson, February 16, 2011, 1PM, 400 W. Congress, Room 222 Phoenix, February 17, 2011, 1PM, 250 N. 17th Avenue Some specifics. The AzMMA requires this: 18. "WRITTEN CERTIFICATION" MEANS A DOCUMENT DATED AND SIGNED BY A PHYSICIAN, STATING THAT IN THE PHYSICIAN'S PROFESSIONAL OPINION THE PATIENT IS LIKELY TO RECEIVE THERAPEUTIC OR PALLIATIVE BENEFIT FROM THE MEDICAL USE OF MARIJUANA TO TREAT OR ALLEVIATE THE PATIENT'S DEBILITATING MEDICAL CONDITION OR SYMPTOMS ASSOCIATED WITH THE DEBILITATING MEDICAL CONDITION. THE PHYSICIAN MUST: (a) SPECIFY THE QUALIFYING PATIENT'S DEBILITATING MEDICAL CONDITION IN THE WRITTEN CERTIFICATION. (b) SIGN AND DATE THE WRITTEN CERTIFICATION ONLY IN THE COURSE OF A PHYSICIAN-PATIENT RELATIONSHIP AFTER THE PHYSICIAN HAS COMPLETED A FULL ASSESSMENT [NOTE: "assessment," singular, not plural; i.e. one, not four] OF THE QUALIFYING PATIENT'S MEDICAL HISTORY. So, one

full assessment, specify the qualifying condition, sign and date – done! Without the authority to do so, ADHS proposes: R9-17-202 5e. A statement, initialed by the physician, that the physician: i. Has a professional relationship with the qualifying patient that has existed for at least one year and the physician has seen or assessed the qualifying patient on at least four visits for the patient's debilitating medical condition during the course of the professional relationship; or ii. Has assumed primary responsibility for providing management and routine care of the patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the patient's medical record maintained by other treating physicians, that may include the patient's reaction and response to conventional medical therapies; Talking points: • Any Arizona physician may, in a single visit, prescribe "speed" (e.g., Adderall) to a kindergartener. Without four visits spread out over one year, any Arizona physician may prescribe to a kindergartener a drug that can kill that child by heart attack, stroke, seizures, or other "side effects." • Cancer, HIV, and ALS patients often do not have one year to live. • The patients that do live are cruelly being told to change doctors or suffer for one year. • Deadly and addictive drugs, such as opiates, are prescribed in a single visit by Arizona physicians and, despite the best efforts of physicians, some of those deadly and addictive drugs are illegally diverted, but that does not cause the ADHS to demand four visits, a year-long patient-physician relationship, or that the pain specialist assume primary care of the patient. • Marijuana is 100 percent safe, gives patients good relief, and cures some conditions. Marijuana is neither deadly nor addictive. • The alternative offered by the ADHS to avoid one year of suffering – the cannabis specialist takes over the primary care of the patient's qualifying condition – is unprecedented. Nowhere else in medicine does a specialist take over a patient's primary care. • The ADHS does not have the authority to define or redefine the patient-physician relationship or the number of doctor visits, or the length of time for those visits. That infringes on the patient's choice. • The draft regulations are cruel and unreasonable." - Dr. Ed Suter note: though i don't agree with this dr. suter, whoever he is, about addiction, thc is highly addictive and your prudence to educate and have the caregiver and owner be aware of patient problems should be commended. that said, i agree with everything else he mentions. terminally ill patients and near terminally ill should not have to switch drs. to receive treatment.

1) The proposal by the department that each dispensary have an educational component is valid, however, the requirement to have that function supervised by a Medical Director (M.D. or D.O.) is redundant. The department has ameliorated medical liability by requiring that a Patient have an existing relationship with his or her doctor. A Physician who recommends Medical cannabis to his or her patient will be required to discuss other options, review possible side effects and potential reactions with other drugs just as they would when recommending any other form of treatment. It would be practical for the ADHS to develop a standardized pamphlet discussing any potential hazards of this new treatment. The pamphlets could include a website and/or hotline to call with questions. 2) The dispensary application process is in direct opposition to the mission of the Governor's Council on Small Business (GCSB); the entity assigned to "provide effective outreach of programs and services targeted for small, minority and women-owned businesses." Costs associated with security, specialized computer based record keeping, staffing a Medical director, signing a lease prior to start up, and set up of a commercial growing facility for production of 70% of product, will have the effect of eliminating small business and minority or women - owned business participation in this industry. 3) Requiring dispensaries to grow seventy percent (70%) of their own product will limit opportunities for small business development in our state and may delay the implementation deadlines as set forth by ADHS. Delays can result in a mandamus action in the Arizona Superior Court to compel ADHS to perform the actions mandated by the Act. If the crop is reduced due to unforeseen circumstance (i.e. mold, mites, equipment failure, etc.) will a dispensary be able to supplement the product, above 30%, from another source? 4) The rules, as written in R9-17-107 and R9-17-302, are unclear and out of sequence. We suggest clarification regarding the acquisition of a "preliminary approval" versus the complete application packet. Placing the time frames after each article rather than in a separate section would be helpful.

Here's a detailed list of suggestions to the rules as written so far. Medical Marijuana Program

12/17/10 Draft Rule Comments 1.3.11 R9-17-101. Definitions 16. Ongoing… a. The physician-patient relationship has existed for at least one year and the physician has seen or assessed the patient (add--IN PERSON) on at least four visits… 18. Public Places b. Includes airports, … Should include adult and child care facilities as well as adult & child foster care homes licensed by the state. c. Does not include: vii. Private Residences. – Needs to address prohibition of marijuana in federally funded housing & other federal programs where marijuana is prohibited. Multi-unit housing provider (owner, manager, etc.) should have right to prohibit smoking of marijuana inside units or on property to protect tenants and property. R9-17-108. Notifications & Void Registry Identification Cards Add: Patient's doctor should be required to report to ADHS if they believe the patient no longer needs medical marijuana or believes that medical marijuana is detrimental to patient's health or public safety. R9-17-202. Applying for a Registry Identification Card for a Qualifying Patient or a Designated Caregiver. F. 3. All current photos required should meet size standards of AZ driver's licenses including date and facial dimensions (i.e., not a distance photo). 5. g. Information explaining potential risks & benefits needs to be in written form approved or provided by ADHS and provided to patient. R9-17-202. continued F. continued 5. h. Physician needs to indicate how many future visits are required for continual follow-up. Visits should be in person. Follow-up visits should be required or risk medical marijuana card revocation. Doctor should be required to report to ADHS if patient not meeting requirements for follow-up visits. G. 13. a. Add Physician should be licensed to practice in Arizona and not have any financial or other affiliation with any medical marijuana dispensary (cannot be an employee, subcontractor, patient card holder providing medical marijuana, etc.). Would also help if doctor were limited to 30 medical marijuana patients. R9-17-204. Renewing a Qualifying Patient's or Designated Caregiver's Registry Identification Card A. 4. g. need in writing given to patient by doctor. h. patient should be assessed in person by doctor B. 4. a. physician should be licensed to practice in Arizona R9-17-302. Applying for a Dispensary Registration Certificate B. g. Medical Director should be licensed in Arizona with no financial or other affiliation to any medical marijuana dispensary (not an employee, subcontractor, patient card holder providing medical marijuana, etc.). R9-17-306. Inspection Date & time do not have to be specific. Original Initiative language states in 36-2806, H that "registered nonprofit medical marijuana dispensaries are subject o reasonable inspection by the Department. The Department shall give reasonable notice of an inspection under this notice." It does not say that dispensaries have to be forewarned with the exact date and time. Could be within 30, 60, 90 days etc. with no exact time specified to protect the integrity of the inspection. R9-17-306. Inspection continued. C. Department should allow allegations from anonymous sources for dispensaries non-compliance to protect the safety of the source. R9-17-307. Administration A. 1. e. Patient education approved or provided by ADHS needed in written form provided to the patient. 5. d. Food or other establishments providing marijuana infused baked or other goods to dispensaries should be regulated and licensed as dispensaries to avoid proliferation of marijuana industries with no regulations. Medical marijuana food & other marijuana infused goods manufacturing should be located within licensed dispensaries. R9-17-310. Medical Director Should be licensed to practice medicine in the state of Arizona. C. 1. All educational materials should be approved or provided by ADHS and given in written form. All marijuana products should have warning labels and side effects listed. b. Include long term effects of marijuana use. R9-17-311. Dispensing Medical Marijuana 2. Provide (not offer) information approved or provided by AHDS to patients. R9-17-313. Inventory Control System B. 3. c. Disposal of medical marijuana needs more definition and regulation to avoid potential abuse. 5. ALL medical marijuana infused food or non-food products should be manufactured within a licensed dispensary. R9-17-314. Product Labeling and Analysis A. 3. Dispensing needs to label medical marijuana with tracking ID to identify source of marijuana (dispensary, patient or caregiver's tracking ID). R9-17-315. Security B. 4. Food establishments and other facilities that infused medical marijuana into other products should be licensed and regulated as dispensaries. C. 1. c. vi. should be at least 90 days vii. should be at least 2 hours with back up batteries R9-17-316. Edible Food Products Edible food and other marijuana-infused products should be manufactured and dispensed at a licensed dispensary only. R9-17-320. Denial or Revocation of a Dispensary Agent's Registry Identification Card A. (Add) The Department may deny a dispensary agent's application if 4.

If a dispensary agent is a physician who recommends medical marijuana to patients. B. 4. If a dispensary agent is a physician who recommends medical marijuana to patients. Other Concerns: How are marijuana seeds regulated? How are dispensaries, caregivers and patients who grow getting the seeds? Can marijuana only be dispensed in a form that does not contain carcinogenic smoke by-products? Can doctors be limited in number of medical marijuana patients? How will these rules affect the development of an M-cigarette similar to the E-cigarette? If they are developed, they should only be available in the dispensaries.
how can DHS regulate the doctor/patient relationship? that is just wrong and seems to be illegal! as a patient you can not tell me what doctor can and cannot manage my chronic illness!
why is there no monitoring of the quality of the medicinal marijuana? if people grow crap it will make sick people sicker
Omit the parts that allow law enforcement to have access to the database. Isn't this a violation of HIPPA or privacy laws? Does law enforcement have access to who is on Vicodin? Or Ocycotin (sp)? Or any other med? Doesn't it open the door for abuse?
*dispencery registration fee is outragous.It should be more like 60$ a year *medical cards should not be 150$ more like$10-20$ *There needs to be a bigger range of patenits who can qualify for medical marijiana.Marijuana helps many many illnesses such as depression,ansomnia,Asthma *Qualified pateints need access to medicine in public places such as parks,businesses *A qualified patient should be allowed to grow within 25 miles of a dispencery,not everyone can afford to purchase medicene from a dispencery,or medical marijuana should be offered at $20-$60 an ounce at dspencerys
As someone who could actually benefit, I believe someone may have missed the point: These 'rules' treat cannabis as a threat and a danger - not a medication. Why should cannabis be subjected to stricter regulation than 'legal' drugs which are far more dangerous to individuals and society. You can improve these rules very simply and I think you know that. Make it affordable at all levels: Production, distribution and consumption. Three hundred and fifty dollars a year just for the equivalent of an ID card is... well, it's outrageous. I don't pay that much for supplemental health insurance. I realize this is a bitter pill for those on the right to swallow but we must take the politics out of this . It is the law. Just as it is legal to carry a concealed weapon into a bar; it is now legal for a severely ill person to consume a harmless medicinal herb in the privacy of their own home. Wait... that doesn't sound quite equal does it? Please don't be the agency charged with killing this initiative through the back door with Creative Accounting Practices (CRAP) and legalese. My wife and I will soon be 71 yrs. young (at heart) and we need your help. My wife suffers from chronic pain as a result of spinal cord and shoulder injuries. She has epileptic seizures and severe head pain as the result of brain surgery. Thanks for your time and your service.
ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be “without imposing an undue burden on nonprofit medical marijuana dispensaries....” ARS 28.1 Section 2 “Findings” of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic

and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. 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The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. 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its cruel and unusual punishment to say what doctor you need to see to recieve a recomendation

It appears that the ADHS is attempting to put a stranglehold on this industry. Unfortunataly for the taxpayers, there will be many years of litigation over these so called "Rules". I hope your department has plenty of money set aside to support them.

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Marijuana should be dispensed like any other prescription by any doctor before any visits

I am a Registered Dietitian and work in Tucson. I would make the following recommendations: 1) Marijuana dispensaries may only dispense marijuana in food, in capsules or as suppositories, but never in its raw form or in any other form that can be smoked. 2) Doctors who recommend medical marijuan can have no more than 30 active medical marijuana patients at a time.

Below is information that echoes my sentiment exactly. The proposed rules that DHS is proposing are unjust and cruel beyond measure. Suffering patients should not be denied treatment that their physician would recommend because an arm of the local government sees fit to impose such strict rules regarding a substance far safer than those in most pharmacies that require far less supervision than Medical Marijuana is proposed to have. I hope that DHS will reconsider redefining what a Dr/ patient relationship is, as well as the many other items listed below. ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the

department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. 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I'm disabled and my doc's clinic says no to medical marijuana.

1) The Public Comments Form should also have a public viewing area to see what ideas others are providing, in order to encourage the best ideas to be developed from that synergy, not to mention freedom of information. 2) Abide by the time-line set forth in the proposition. 3) Abide by HIPPA act. 4) Remove 1 year professional relationship restriction with physician. - many will not live that long. 5) Remove the 4 visit minimum with physician - this is arbitrary. 6) Remove requirement that caregiver must be a non-card holder. 7) Reduce card-holder fee to $100.00 per year. 8) Require testing to verify THC strength, and that it and chemicals,fertilizers and pesticides used in it's creation are displayed on product labeling and packaging. 9) Remove requirement that each dispensary has/employs a Medial Director. 10) Remove 25 mile grow your own limit. Any individual that qualifies for a patient card should be allowed to grow their own, within the 2.5 oz limits, as is provided to anyone living outside of the 25 mile limit. - This is burdensome, and discriminatory.

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arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse. Attorneys are already preparing legal action against these cruel and unreasonable draft regulations. the AzDHS does NOT have the authority to enact the cruel and unreasonable package of regulations they propose. Obviously, I am not an attorney, so we are soliciting the input of qualified attorneys. Because I am a physician, I am restricting my comments here to the matter of patient-physician relationship. Others with expertise in dispensary and caregiver matters will share similar analysis and commentary concerning the draft regulations for dispensaries and caregivers. I have attached the AzDHS Timeline. Please familiarize yourself with the Arizona Medical Marijuana Act (AzMMA): http://stoparrestingpatients.org/home/initiative If you pay special attention to Section 36-2803 "rulemaking," you will notice that the AzMMA does NOT give authority to the Arizona Department of Health Services to define-or redefine-the patient-physician relationship and does NOT give the authority to amend the AzMMA language, e.g., adding "ongoing" to "patient-physician relationship." The Arizona Voter Protection Act specifically DENIES authority for such usurpations.

- Dr's are able to prescribe other medicines outside of a set number of scheduled visits. What is accomplished in four visits that can't be completed in less?

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i think you need to change the 25 mile rule for growing your personal marijuana to 0' not all people can

afford to buy at the price the pharmacy will have to charge, being able to grow is very important for those who can not afford the costs, essentially you would be denying them a right to their medicine and creating an act of punishment for living to close

You should remove the restriction on the ability for dispensaries to source medical marijuana outside the state. The other states that have implemented this have become experts in the cultivation and manufacture of said items. You should allow caregivers and dispensaries to acquire the product from other registered clinic in the surrounding states. The idea is that this will improve the quality and the array of products available and lower the prices for the patients. As it sits, this provision will prove to increase the price due to lack of availability. The time it takes to get product to market is restrictive in the current model. Realistically it will take at least six months from certificate issue for the first patients to begin getting relief. If supply could be acquired from the surrounding states patients could begin getting relieve immediately. In a free market the prices become lower due to widespread availability. We need a regulated supply but if the supply is tracked from seed to patient, no matter the source, we will have a sound system. I hope this can again be looked at and changed.

ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and

unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products.

All employees on site should be fingerprinted and backgrounds checked.

First of all I believe if Doctors like [redacted] can get by with prescribing 1,562 narcotic drugs to one patient who ended up and shot herself in the mouth as reported in the Arizona Republic in

2000 August edition. Patients in the 90s who died as a direct result of [redacted] conduct of overprescribing and requesting sexual favors in return. I am an ex patient of his who he assaulted and withheld seizure medicine from and he propositioned me for sex, and I sued him. I believe these acts are very serious as I am sure you do as well. Other patients were turned into drug addicts by him. I would keep my eye on him if I was The ADHS for sure. He will love prop 203. The reason i am writing is I am an acute patient in need of help that prop 203 will give. Closed Head Injury, TBI, nausea migraines, Seizures, (uncontrollable). I am currently allergic to all medications and am at the end of a long battle. How will I know if my current Doctors who I have will even go for prop 203? I am reluctant to change providers due to previous statement of trust with an Arizona M.D. before prop 203 came into being, Doctors literally get by with murder, simply cause they are rich and Doctors as the Attorney Generals Office said in the [redacted] criminal investigation years ago. (PUBLIC RECORD). Will I have to change to some smut bag Doctor to have prop 203 be beneficial for me? Thanks

The draft must take into account the tremendous need that cancer patients, who are terminally ill, and in a hospital, nursing home, hospice or bedfast in their own home. Compassionate care for these individuals demands consideration for their needs -- and legal right -- to receive medical marijuana. These indivduals cannot go to a dispensary themselves to become members. Nor are they able to go to a site to purchase medical marijuana. Physican prescribed pharmaceutical medications are delivered to hospitals, nursing homes, assisted living facilities, hospice and homes; included in the guidelines must be a provision for delivery to institutions and their patients who have received physician recommendations for medical mairjuana. There must be some manner devised in which a dispensary can provide this important and much needed service. Lastly, it seems that to not provide this service to such individuals could be construed as discriminatory.

All forms must include date of the form or request with an expiration date all requests etc must expire and require recertification annually

1) The rules do not comply with Arizona law. Arizona law does not recognize "non-profit" LLC's or partnerships. Either the rules need to be revised in this regard, or clarification needs to be made as to how a non-profit company can be established under this statute. 2) Requiring that each dispensary grow 70% of its own product does not make sense, and puts an a higher burden on regulators. It seems more appropriate that there should be fewer growing facilities, so that oversight is easier. Many of those who are applying for licenses either want a retail store or to be a growing facility-not both. In reality, there should have been special license issued for each area like the following: 1) patient license; 2) medical director license; 3) caregiver; 4) agent; 5) growing facility 6) retail; and 7) edibles. It seems as if each of these areas have different challanges, and different needs. For example, it is likely that a license holder who also wishes to sell edibles will need to have a commercial kitchen license. I don't think the State has thought this process through entirely.

Like to see impartial physician who does not have primary care responsibility for the patient to examine parent at patient's expense to confirm the presence of a debilitating medical condition.

Need to expand definitions "designated care giver" Physician should only be one licensed to prescribe schedule 1 medications under usual regulations associated with the prescription of such medications
Medical marijuana may be prescribed only by physicians trained in it's use and licensed to prescribe schedule 1 medications . Medical marijuana may not be used in a setting where it may adversely affect the health of others such as schools, shopping centers, work places, hospitals Prescribing habits of physicians and indications will be monitored by the DEA and the board of pharmacy as with all other schedule 1 medications The Arizona Medical Association will be asked directly to render an opinion on the indications for use of medical marijuana? The right of the public to breathe smoke free air and avoid real disease will take priority over the need for the use of medical marijuana to relieve symptoms The legislation must recognize the status of medical marijuana as a schedule 1 medication with no affect on any disease and of questionable use for control of symptoms.
ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be “without imposing an undue burden on nonprofit medical marijuana dispensaries....” ARS 28.1 Section 2 “Findings” of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17- 202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require “ongoing” care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient’s care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department’s regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients’ rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17- 105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients’ parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-

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13. A business plan demonstrating the on-going viability of the dispensary as a non-profit organization; Does the Department of Health Services require a business plan for all non profit corporations in the health care field ?

R9-17-302-13 13. A business plan demonstrating the on-going viability of the dispensary as a non-profit

organization; If the AZDept. of Health Services approves the business plan and the dispensary fails is the azDHS libel in any way?
* The 25-mile "halo" is going to be legally challenged, as it effectively sets up monopolies. Dispensaries typically sell medical marijuana for $300-450 per ounce even though production costs for one ounce of marijuana are on the order of $20-30. The "halo" forces patients to buy at incredibly inflated prices. * The fact that the AZDHS is trying to define the patient-doctor relationship is also going to cost the State a lot of money to fight legal challenges. * Tracking individual plants from seed to harvest is an impossible feat. I have extensive experience in this regard and cannot imagine how you came up with this idea or came to believe it could be effectively implemented. * The type of medium used (soil, soilless, hydroponics... DWC, etc.) need to be tracked. * The watering schedule does not; this piece makes little sense and can be taken as an indication that AZDHS has done very little homework with regard to researching cultivation. * A 12' high wall is not necessary for keeping a private medical marijuana garden secure and will be challenged in court, as most residential areas prohibit walls above 6-8' tall.
Take into effect some folks can't afford the high cost of the RED TAPE, extremely high fees.
These rules need to be broken down in laymen terms so the average person can understand them.
The inventory control does not take into consideration weight shrinkage do to moisture loss. Please remember that this is a plant product that is comprised mostly of water, even dried marijuana has some moisture content. As this material is exposed to air some weight loss will occur due to loss of water over time. But the inventory control rules are on point to avoid abuse, but please be advised that small variations in weight will occur due to environmental conditions. The medical director seems to be an odd request for dispensaries since the state has defined the patient/doctor relationship to the strictest levels. The state is requiring a one year relationship with a doctor before access to medicine can be gained. What if the patient has just been informed of severe cancer, you expect them to wait for a year. The state is so fearful of abuse that the state will inflict undue suffering on its citizens. If the state is concerned with the information that the patients receive from the dispensaries, which I think is a great idea, the state should provide standardized information to dispensaries through a state run Medical Director's Office for Medical Marijuana, which in turn would be bound to a more rigid standard and oversight, than a piece meal approach of numerous Medical Directors whom may not have the patients best interests at heart. The state should at least provide an elective state run Medical Director service that dispensaries could purchase through the department, which I think could provide patients with all information via the internet and printed handouts to address all patients needs and concerns. I feel that this system would provide the patients of Arizona with the best information and care.
My Mother has ALS and is confined to her bed, using a ventilator, catheter, and feeding tube to survive. She has no muscle/motor control, I am her primary caregiver. Her current prescription medications alone cost, us as a family, over $1000 per month out-of-pocket. Add to that the costs of medical supplies, equipment, and supplemental in-home care and we find it difficult to afford the basic costs of living. My Mother is excited to try Medical Marijuana once she is able to qualify for a license to do so, we believe it will help reduce her use of Oxycodone, Hydrocodone, Lorazepam, Methadone and Ambien. However, we believe the portion of the rules which state she will not be able to cultivate a small amount of Medical Marijuana once a dispensary is operating within 25-miles of our residence to be detrimental to both her healthcare and that of a great many other patients. If Medical Marijuana pricing trends in the other states with Medical Marijuana laws in-effect are an indicator, a weekly supply of Medical

Marijuana, purchased from a dispensary, will likely cost well in excess of $150, or $200. This becomes so cost prohibitive, that we must evaluate whether or not we can even afford the medicine. Not allowing patients to continue cultivating according to all other laws, regardless of proximity to a dispensary benefits dispensary owners and their profitability at the cost of patient care, who should be the focus of this initiative. Please, reconsider the restrictions on patient cultivation to remove the 25-mile dispensary clause and help patients who need affordable medicine obtain it by growing it, the profiteers who own dispensaries don't need the help, my Mom does.

We believe that Nurse Practitioners have been overlooked. Our group has a nurse practitioner with over 30 years of experience with patients, specializing in pain management, and we feel very strongly that she should be able to fulfill the position of medical director of our dispensary, should we have the opportunity to open one. She brings an incredible background of compassionate care and under current Arizona Revised Statutes can prescribe powerful narcotics which are much more dangerous than medicinal cannabis.

ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards.

R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse.

I need medical MJ. I can't afford the $150. I can barely travel. I'm pretty much stuck in my home. My caregiver can't afford the $250. My caregiver is kind of afraid of being a caregiver as well as being able

to secure MJ for me. I need to be able to have a dispensary deliver MJ to me. There is only 1 doctor where I live. My doctor says he can't recommend MJ for me because of his clinic's rules. I have AHCCCS and I'm locked into my doctor. I don't have a lot of options.
We have a letter we would like to submit to you but can't figure out how to cut and paste into this format. Can you please send me an email address we can direct these to- thanks [redacted]
I dont understand why you would want the dispensaries to be non-profit. One main reason I voted for it was so that Arizona could receive huge tax dollars. I thought the cities, & state could really use the monies generated. I have heard that thousands of people are expected to apply for a license and that the license will cost $5000.00 plus they will have to actually lease buildings. The high amount of the app fee-$5000.00 is ok but to have say 5000 people go out and rent buildings seems a little crazy to me. You dont want people staking everything on this license and then not get it. I would think to have a place in mind, have business plan, give a financial, have scale model of the place your thinking of would be good. People could have the plans for place in mind, security co lined up, background checks done. But actually leasing some place before knowing you have a license is kind of mean. There will be some people who cannot afford to do this but will beg & borrow to try. It would be sad that people hurting and just trying to better their lives would be let down again and now with even less money & probably owing.
I believe that the wording that drs must have consecutive visits with the patient is totally unjust to the vets. My husband is 100% DAV w/ severe chronic pain under VA care and therefore all his dr visits are to the VA and well documented. He will qualify to use but be unable to get if the VA doesn't recommend. This places him at great risk for not being able to use the Medical Marijuana. Following that - it places ALL veterans at risk for not being able to use it. There has to be some sort of coverage written to include the veterans and any others that Federally may fall through the cracks in being allowed to be legal users. The cost is unjust to the disabled , the seniors, and the vets. There must be some sort of discount or this again denies use to those on welfare, SSI, VA becoming cost prohibitive This must be written in a way to allow those who need it most to be free to get it or the law will still be useless since the legal system still plans to prosecute anyone using without legal recommendation. If it can only be bought from a legal dispensary and it is too expensive - then what good is the law? There should be no difference in cost for patient or caregiver to pick up the marijuana. If it is recommended for the patient it should fall under his recommend to get it. The caregiver is nothing but a vessel to carry it to him or her. If the person is incompacitated to go get it there should not be a penalty for that.
One suggestion: Inspections, R19-17-306, C and E: Unannounced inspections should be permitted without an identified source of complaint of non-compliance. Reason: This keeps the dispensary on its toes. It also allows unannounced inspections based on receipt of a credible anonymous tip. Regular certification inspections should be retained with 5 days' notice.
Make it easier to understand. the way it is now written, makes one believe you don't want anything to do with this new bill
I was not sure what "transaction" meant when referencing a grow supplying another grow with up to 30% of that dispensaries medicine. Is it OK to sell the product on a wholesale level...or is it a donation (ie no money exchanges hands) from one dispensary to another. The wording needs to be clearer.
I just found out I have testicular cancer and could be undergoing chemotherapy this year. Under this

proposal I would not qualify because I have a PPO and chose to just go right to the urologist and have not seen my primary doctor in over a year. WHY SHOULDN'T I QUALIFY if it will help me get through chemo?!? I don't think this was the intent of the proposal. And who goes to their doctor 4 times a year when you are in your 30's before you develop a reason to? All newly diagnosed patients are at risk of not qualifying for something that will help them under these rules. Are there rules for doctors like these when prescribing medicaions.
To who it concerns: As far as section G. 13e. I believe AZ voted that doctors can prescribe marijuana for the stated conditions. They voted that doctors can determine who qualifies. They did not vote that there government stipulations as to a one year relationship and 4 visits in a year before they qualify. What if i just moved to Arizona, qualify for medical marijuana and have only visited him once so far? There are NO other regulations in all of medicine regarding prescribing of medications such as these proposed rules. To suggest and enforce these rules is a form of practicing medicine and I do not want my government acting like they know better than my doctor. This was not the intent of the proposal. An Arizona Physician
I may have missed this in the read, but why not allow caregivers or patients who live outside the 25 mile zone for growing the ability to sell the excess product to the dispensaries or just allow someone to be a cultivator for the industry and sell directly to the dispensaries. I understand maybe not this year, but keep it in mind. Also, how about if a patient lives within 25 miles of a dispensary they can get a provisional license to cultivate only two plants; one in vegetation and one in bloom for personal use only. The savings to the patient is tremendous and in times like these I believe it's the proper thing to do. The people who would appreciate a provision such as this would never jeopardize the right to cultivate in a scenario like this by selling for profit or growing more than allowed and some people find comfort and relaxation in cultivation and care of plants. It's all good.
The 70% homegrown requirement for dispensaries dramatically increases the capital needed to run a dispensary. Since funding cannot be secured by banks due to the federal illegality of marijuana, it leaves funding up to private investors. We are thinking of running a pharmacy style dispensary in our town and would rather have someone else in Arizona grow it for us. We don't need millions of dollars to do this. But if we have to grow our own as well, then it puts the ante too high. The kind of people who have those deep pockets in this economy are not the ones who are traditional nonprofit souls. They are corporation folks. If you want nonprofit people to run it, the 70% requirement needs to be eliminated and replaced with something else that gets at the spirit of what you're trying to accomplish. The 70% needlessly eliminates the possibility of scaling.
R9-17-202 Under section F-5-e --- "(i)Has a professional relationship with the qualifying patient that has existed for at least one year and the physician has seen or assessed the qualifying patient on at least four visits for the patient's debilitating medical condition during the course of the professional relationship" This section seems to miss the point. If a patient is having problems with severe pain then it does not make sense that the patient would have to come in four or more times. That means the patient could be going through major pain for possibly months before being eligible for proper treatment. Same could be said for sever nausea, if it is a current problem then the patient would need effective medication as soon as possible. Seems to me like this section is creating headaches for pottential users. (Not something a cancer patient needs)
Medical director for a dispensary is unnecessary. In addition, it will make the process of using medical marijuana more complicated if the medical director for a dispensary is providing information that is different from what the primary physician of a patient is stating. The duties of the medical director could partially be put on the dispensary itself. The dispensary should provide accurate and complete information about marijuana.

for one thing have some public meetings in some other counties and cities besides Phoenix and Tucson, they are not the ruling cities of the State! There are voters in all the Counties and all the Cities in Arizona, not just Phoenix and Tucson, we feel excluded like our opinions and votes don't count, you know that is not Democracy... Arizona is NOT the State of Phoenix and Tucson!! You must participate in all 15 Counties to show fairness...
To provide for the above.
Legalize it.
Cannabis cultivation restrictions based on distance to a dispensary is unenforceable, and cannot be easily determined given the wording... Do both care giver and patient need to be with in the same 25 miles of the same dispensary, any dispensary? The wording assumes that the care giver live within the same locality of the patient.
medical directors in each dispensary? bad idea. medical doctors are better served doing what they do. helping people get better. but in a dispensary conducting education, passing out information about addiction and the side effects of cannabis? look get real mr humble, a dispensary can do this just fine. they may have more information about the effects of marijuana that the average doctor. i'm willing to bet large sums of money on it. so if you call this a control measure ask yourself a control measure for what? this is OVERKILL meddeling and unnecessary burden on the industry in general. sit back and watch how concern dispensary owners can be in addressing the needs of their members. they know how to care for people to. but your going to have to let them do what they do. sell medicine. give us the control measure, which is clearly written into prop 203. the dr must do an assesment period before writting a recommendation period. don't get involved with this idea of how many times a patient has to have visited a doctor before the doctor can write the recommendation. i can walk into any doctors office be assesed for my chronic pain and walkout an hour later with a script for pain killers, that are allot more toxic and dangerous than pot and thats a fact. just let it be and stop meddeling.and being an unreasonable burden to the dispensary. look it up its in prop 203. ADHS cannot make rules that are a burden to the dispensary operation period. stop with all your concerns with what? what the FED thinks. we all know how they feel about marijuana. one minute you don't want the FED meddeling in states affairs unless it suits your disinterest by calling attention to how the FED frowns on medical marijuana. it's a ploy by the ADHS, cities, politicians who want prop 203 rendered ineffective to do what it was intended to do. ADHS needs to help increase commerce for this state and control aspect of this law in making sure that no one diverts marijuana period.
mr to humble should be less apprehensive and really read to understand the quality of prop 203, when compared to prop 215 and SB420 and amendment 20 of colorado. you will see there are already built-in control measure within prop 203. it really doesn't need much outside tweaking from the ADHS.
The part of the rule that states that the patient must have seen the physician for at least one year seems unfair. Perhaps their are patients who are currently using medical marijuana without a physicians supervision because it is currently illegal. Should those patients be forced to wait an additional year before they are protected by this law? AZDHS is overstepping it's authority by adding that the "severe or chronic pain" be caused by a debilitating disease. The proposition that the public passed did not restrict use to people with certain diseases, and for AZDHS to try to add that after the fact is a fear abuse of your power to develop these rules. There are many medical conditions that cause severe or chronic pain that are not necessarily "diseases". Please respect the fact that the citizens of Arizona passed a law allowing those wi severe or chronic pain to use marijuana under the direction of a physician regardless of the cause of their pain.

The current draft is extremely confusing in terms of how a dispensary gets licensed. Under R9-17-107 B. "A registration packet for a dispensary is not complete until the applicant provides the Department with written notice that the dispensary is ready for inspection by the Department." Then R9-17-107 F. "If the Department determines that an initial application for a dispensary registration is in compliance...." and in subsection 1. After the applicant receives written notice of preliminary approval, the applicant shall submit to the Department..." The language is extremely unclear as to the application process and does not define what an initial application consists of and how to fulfill those requirements. The way it is currently written it reads as if a person seeking to open a dispensary has to invest large quantities of money to build a building prior to receiving a license. Also there is a complete failure to clarify how dispensary licenses will be awarded by the Department of Health. On what basis are the 124, which is an incredibly limited number, to be awarded? What rights do the public have to scrutinize this process? How is this process going to be transparent? Is the business plan that is required as part of the application an electronic form? Who determines what needs to be included in the business plan? Explicit language as to the meaning of business plan needs to be included. There are a number of individuals from Colorado and other states that are currently offering medical marijuana franchises, i.e. turnkey operations in Arizona. What is being done to regulate these people and keep them from fleecing individuals for thousands of dollars? Sales Tax on edible food products and medical marijuana - maybe I missed it but can't tell if its included in the bill.

When a patient has a qualifying medical history, when a physician can't recommend medical marijuana because of administrative rules, a qualifying patient can annually see a medical marijuana doctor as a secondary physician to get a medical marijuana recommendation.

Pain management should be easily available to patients in pain, there should be lesser guidelines on the pain that is being accepted. Dispensary's should be open longer and be fully stocked during open hours.

The having to see a doctor for a year before being able to apply for an ID card is cruel to those who do not have regular doctors. If I get sick and go to the doctor who tells me I have cancer and I should start chemo. Am I supposed to wait a year before starting the chemo? so I''ll be able to stop throwing up and be able to eat. Sickness does not give us a years warning, it happens when it happens. REMOVE THE DOCTOR REQUIREMENTS YOU'RE JUST TRYING TO LOWER THE NUMBER OF PEOPLE WITH ID CARDS. THINK ABOUT THE PATIENTS BE COMPASSIONATE. CANNABIS DOES WORK, IT DOES HELP PATIENTS GIVE US ACCESS TO THE MEDICINE WE NEED

How about treating 21 year olds through the end of life US citizens who think there may be value to medical marijuana like adults. This 47 page draft is 30 pages of the government treating adults like 16 year old juvenile delinquents. Are there not rules in place already for pharmacies? Why do I not need to buy an additional license when a get a prescription for 1 of the 20 or so pharmaceutical narcotics? Are people on pharmaceutical drugs much more responsible? Is the AZ Dept. of Health Services position to punish Arizona for passing the proposition and protect the pharmaceutical industry? The heavy handed bureaucracy you have in this draft is insulting to physicians and patients. 1) You need to remove the requirement of the “additional doctor” at the dispensaries. That is an insult to every physician recommending medical marijuana and every adult with a valid concern. 2) I can see where you would need to charge to obtain a registry card but $130! You should apply the fees related to driver licenses. 3) You need to respect the doctor-patient relationship. If a recommendation is written then the state should respect that. Not make that the beginning of an obstacle course. I’m not up on

the legality of the state requiring citizens to tell them what their medical conditions are but it would seem to be in violation of all kinds of privacy laws. Thus setting you up for law suits. The state should respect the privacy of the doctor patient relationship, be extremely considerate of every American citizen's privacy rights and use the guidelines set already set up for other government monitored areas (e.g. existing pharmacies and drivers licensing). Following these two guidelines will reduce the time to implement and the cost to the taxpayers of AZ.

What will be the policy for low income/low population countys that have been slated 2 permits (per our Health Dept). If an IN COUNTY person is wanting to apply for that permit but does NOT on the exact day that permit registration opens will the slot for that dispensary be kept open? Or will it be given to a permit applicant that agrees to go "anywhere"? I strongly feel that dispensarys should be allowed to contract with "growers" as many dispensary owners are not capable of growing the correct kind of product. Those of us in Southern Az will have a very difficult time due to our extreme heat. I am a professional with a medical background, but no clue as to the growing of medical marijuana. Keeping the "professional" and the "medical" in the dispensarys is very important. I believe AZ can be a leader with this. But, GROWERS are another group and are very proud of what they do and how well they so it. Please consider this.

Prop 203 can be rewritten , so it does not directly benifit the rich only. Second your dept can level out the playing field by making it fair and accesable to all.

lower the cost of the identification cards and ease up on dispensaries. doctors also must be given less strict "rules" about what they can and cannot do to help their patients, if a doctor thinks that their patient needs medical marijuana to make their (the patient) lives easier and more pain free etc then that should be enough. the government has no right to tell people what they can take if it makes their lives more live-able, a doctor knows the pros and cons of marijuana and that makes it easier for them to make informed, intelligent, researched, and helpful decisions on how to help their patients; not the government. so why is the government controlling something that causes little to no damage to a persons body while helping them? that's more then oxycotin etc can say yet they are fine with them. i say make everything more tangible to all, not just those who can afford it because it does more good than harm. If the government only taxed it and controlled it so that it didn't become a problem then everything would be fine, but the government is greedy so they want more. i understand the controlling the amount, but they also need to think about those on SSI and our veterans and those who need it but cannot afford it. just because politicians and government officials are rich doesn't mean that they, and their families, will never suffer from the grip of arthritis or cancer or injury etc. the low men on the totem poll are just as equal as the men at the top of it.

Regarding section G, number 13, the regulations as to how a physician can prescribe medical marijuana, the rules are a bit ambiguous and unfair. For a physician to be required to have had a one year "relationship" with the patient is medically very arbitrary. Is there some better knowledge regarding a patient obtained at day 365 that was not there at day 364. Similarly, four physician visits in that year time seems just as arbitrary. Why not 3? I understand wanting to have some sort of regulations to make sure that only patients that need marijuana, receive it but these rules are unacceptable for several reasons. As an emergency physician, I regularly must prescribe narcotic pain medicine and many other medicines to people after only a 5 minute or less interaction. There is no way for me to tell if the patient is lying about their pain or need. Why should marijuana be any different? Secondly, this discriminates against those who do not have medical insurance and cannot afford to go to a doctor 4 times in a year. They may still have a chronic disease that qualifies. Thirdly, what about patients who have just moved to Arizona? Can a physician not make a medical recommendation about the care of their patients because they have not lived in Arizona long enough. Fourthly, what about patients who

change their doctor because of insurance issues, a physician retiring or moving, personal preference or any other reason. They now do not qualify for a year? And what about the healthy patient who has insurance but chooses to not go to a physician every year, then notices (i.e.) a lump in her breast, and before she knows it, finds herself undergoing chemotherapy for breast cancer. This doesn't wait a year. These time frames really have no place in the approval of using marijuana as a medicine as they also have no place in the practice of medicine. As for the physician assuming "primary responsibility for providing management and routine care of the qualifying patient's debilitating medical condition...". What does this really mean? Would I have to be the primary doctor treating a patient's cancer? This is not really how the profession of medicine is practiced. Any disease can be treated by a group of different primary doctors, specialists and sub-specialists. Who has "primary responsibility" is often vague. This language apparently excludes the development of marijuana specialists. As medicine develops, there are more and more specialties. Many physicians may not be able to adequately discuss marijuana with a patient. There are pain specialty clinics prescribing methadone and other huge amounts of narcotic pain medications that do not have similar regulations for physicians as described in the draft. It would seem Arizona is concerned about not being in control of some aspect of physicians prescribing medical marijuana. I understand. However, there are not regulations such as this in any other part of medicine. I may have to prove my training, licensure, board certification. But then I can prescribe anything I feel will help my patients without other similar regulations as you are suggesting in the draft. Marijuana is either a helpful medicine or it is not. A patient either qualifies to use the medicine or they do not. A physician should be entrusted to prescribe or not prescribe without extra regulations. It is what we are trained to do. Thank you for your consideration, [redacted] Arizona licensed physician

each patient must have access to their medication and should have the right to grow their own medication regardless of distance to a dispensary, there are too many strains of Medical Cannabis to expect any certain dispensary to have them all. For this reason dispensaries should be allowed open trade to keep stock and patients and care givers should be able to grow (at a much lessor cost to the patient) the strain that works best for them, regardless of geographic location to a dispensary! Any Medication that can be grown for free is better than having to buy beyond ones means. All Arizonans should have the right to access not just those who can afford the exorbitant $150 fee. what about those on SSI, SSDI, state aid or Medicaid. And what about those who go to the V.A. and not an outside doctor who will make the required recommendation? And what about those who haven't been bugging their doctors for drugs they can't take and haven't been there twice in the last year because they didn't help anyways. These people don't qualify because they won't do Opiates? What about those who use chiropractic's to help relieve chronic joint related skeletal pain? All of these people will benefit if you show compassion. Isn't this supposed to be a Compassion Law? Please show some

In the section regarding the rules regarding the doctor/patient relationship in order to acquire the medication should be taken out. This will allow anyone who believes they have a medical need for the medication to acquire it without rules regarding the doctor/patient relationship.

I beleive we need to include methods/procedures to ensure the same grading and testing are maintained throughout the state. In paragraph R9-17-314 - Product Labeling and Analysis the strain is required to be tracked and also subparagraph 5 directs that chemical additives must be annotated. I don't beleive indiviudal providers should be or can be trusted with this capabiltiy. The areas that should be controlled are: Potency Analysis - Microbiological contaminants (molds and bacteria) Harmful pesticides

The definition of "certain conditions" will need to be defined or left of to the physicians discretion. I favor leaving the required health conditions to be assessed by the specialist. Also, the dispensary license requirements and renewal time frame will need to be defined.

Article 3 Dispensaries (R9-17-107 B.) A definition for "ready for inspection" regarding the dispensary. Specific criteria required in order to “pass” inspection? Clarification between R9-17-107 B. Which states “A registration packet for a dispensary is not complete until the applicant provides the Department with written notice that the dispensary is ready for inspection by the Department.” And R9-17-302 B. 1. j.-k. which states, “Whether the dispensary and if applicable, the dispensary’s cultivation site are ready for an inspection by the department;” If are not ready for an inspection by the department, the date they will be ready. One requirement seems to imply the locations must be ready for inspection at the time the application is submitted while the other leads one to believe a reasonable date would suffice. Will preliminary certificates be issued to dispensaries that are not ready for "physical inspection" but provide all the required information such as, physical address, site plans and otherwise meet or exceed all other criteria? I think it is unjust to expect a dispensary to be fully operational (minus the medical marijuana) in order to submit an application. Allowing for submission with the physical address and plans to make such address a fully functional dispensary, then issuing preliminary approval with final approval based on completion and final inspection is more reasonable. Given the requirement that, the medical marijuana is grown in Arizona and 70% be grown by the licensed dispensary. There will be lag time between licensing and dispensing. This time will allow for a dispensary given preliminary approval to prepare their site for the Departments final inspection and approval prior to any dispensing. If greater than 125 applicants meet all requirements for licensing, how will the final 125 applications for dispensaries be selected? Medical Director Is a medical director really appropriate? If a patient is under the direct supervision of the physician who made the recommendation, any concerns should be addressed with that physician (just as done with prescription concerns in pharmacies). A director will not be familiar with a patient’s condition or history and should not be expected to make medical decisions regarding their care without it. In case of any emergency or concerns a patient should contact their PCP or go to the ER. Medication oversight should be provided by a governing authority such as, a state board of pharmacy, the FDA or in this case the Health Department. As the educational materials, log book, rating scale, and self-assessment may vary widely from one dispensary to another. Especially, given the lack of knowledge about the use of medical marijuana due to its unique use in medicine. Thus, creating possible confusion among patients. The information a patient receives should be standardized no matter which dispensary is utilized. R9-17-302 B. f. iii. Has not provided a surety bond or filed any tax return with taxing agency; this statement is unclear. What is the reasoning for a surety bond?

By eliminating the one year doctor-patient relationship requirement. There are dozens of reasons why that would block access by deserving patients -- the VA doesn't play this game, e.g., or your doctor died six months ago, or wouldn't participate for religious or other reasons and you had to find a new provider, etc., etc .You broke your back three months ago.

I believe that R9-17-102, 5-(a)(b) 6-(a)(b) – Fees, should address a sliding scale or lower fees, for qualifying patient, and designated caregiver, as this may make it impossible for qualifying individuals to obtain their ADHS identification card. Maybe follow other states identifying SSI, SSDI, and Medicaid will fall under the low-income individuals. R9-17-104, does not state how a change on a registry Identification card shall be submitted, will this be electronic as well? R9-17-105, does not state how requesting a replacement registry identification card shall be submitted, will this be electronic as well? R9-17-106, 90 calendar days after receiving the request, notify the requester is much too long, I feel 45 working days should be significant to inform the requestor that they meet or do not meet the requirements. Also, 150 calendar days to hold a public hearing is too long, I feel that 30 days should be sufficient. R9-17-202, F, 1(h) Should read “The qualifying patient’s e-mail address if applicable” R9-17-202, F, 1(I) Should read “ The signature of the qualifying patient and date the qualifying patient signed, or if the patient can’t sign and date, signed and dated by the Patients Health Care Power of Attorney” R9-17-202 F5(e)(i), while it is important that a patient/physician have a professional relationship, there are many physicians cannot or will not provide their patient with a recommendation, this will force their patients to seek a NEW physician. This will disqualify legitimate individuals as well as veterans from

qualifying. This must be eliminated or changed to protect this type of patient. R9-17-204 (A) I think that 30 calendar days before the expiration date is very lenient, but will that give the State enough time, I would consider 60 calendar days. R9-17-302 (A) While I believe, that Dispensaries should only be licensed to an individual/agent that is a Arizona Resident, I do not believe that a board member of a dispensary must be a Arizona Resident; this prevents the potential dispensary from benefiting from the expertise of persons with experience running successful, law-abiding dispensaries in other states.
By being more clear as to how a caregiver, patient or other dispensary can supply a dispensary with up to 30% of their inventory and receive no compensation for the marijuana. Will they gift the dispensary their stock and then the dispensary will donate the worth of the mmj to the caregiver or patient or other dispensary?
Remove the 4 visits requirement. One should be enough. You don't need more than 1 visit to receive Opiates! !50 dollars to be able to have a card? One doesn't need a special card to pick up legal opiate medications from a drug store! May preclude the indigent from getting a card. No doubt on purpose by the proposed rules.
I have no interest in selling medical marijuana to the general public. I think that dispensaries should be required to buy 100% of their product from outside sources. Dispensaries and the Farmers should be separated. The way this is written, a dispensary is like a bar that sells it's own beer 70% of the time and is required to sell outsourced beer 30% of the time. What I am interested in is growing medical marijuana legally and selling only to dispensaries. I would be open to inspections and help to stay with in the laws.
Don't add things that you have no right adding as restrictions.
I can't afford the $150 fee. I can't afford to go to another doctor regularly in addition to my medical doctor. My medical doctor can't prescribe MJ because some kind of rules that the hospital made. I hope you won't make it too hard on me. I want to get off the pain pills and use MJ.
Well I have a dilema. I have been seeing the same doctor for chronic pain on my back for the past 6 years. Our work insurance is changing and my doctor is not in the network. I have spoken with him about this as I have had 1 surgery and they want to do another. He also believes that I could benefit from Medical Marijuana. But if I read this right when it goes into effect I have to see my doctor for 1 year. So does that mean I have to wait another year? Could you send me a reply. Thanks
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Who can recommend medical marijuana to a qualifying patient? Include Nurse Practitioners.
the rules are wrtiiten in such a way that the state is overregulating many aspects. for example you ask for a business plan. i think all businesses should have a business plan. but to require one to be submitted is over regulation and really is no business of the state. you do not require one of other businesses.
The draft rules require residency for 2 years from the date of application. I do not feel these requirements should be met. I believe any resident whom was a resident at the time of the election should qualify. I personally have voted in this election. My vote was to disallow the law. However since the law has been passed I believe with my business and management background, along with my desire to keep this industry a non-red light district type of business, and have them blend into our community, I would be an ideal candidate for a dispensary. I do not believe the state should regulate legitimate

candidates out of this opportunity. Simply put if a resident was allowed to vote in the election they should have the right to apply for a dispensary, just as they would be allowed to apply for a card for use of medical marijuana.
Exceptions for those of us that have no medical care and haven't been able to afford a doctor in years. I am already losing all my benefits in January. Possibly an unbiased medical clinic that maybe patients make a co-op payment so the Prop 203 budget isn't affected. I need this type of service. There are still a lot of doctors that do not believe Marijuana helps people like me. I think that you should try the draft out and then re-evaluate it in 3--6 months to see what needs to be tweaked. A suggestion box from clients or patients would give you feed back as well as a survey sheet when you sign in to gage how the clinics and shops are doing. I have been seeing doctors since 2006 at Magellin/ southwest Network but I have no idea if they can write a MJ script.
you are trying to raise revenue for this program to pay for itself and to create revenue for Arizona. but in the rules you define a consultant and that person has to be a regstered agent. what if you found an expert outsde the state of arizona and you want to get their expertise. the rules are written as such that that person has to be a resident for two years prior to the application of a license. how will you be able to find this expert inside the state of Arizona? for example a grow expert. what if you want to hire an bookkeeper that is not part of the company? do all the staff at the bookkeeper company have to be a designated agent? I would rather pay a tax on sales than be restricted from getting the help i would need to run the business effectively.
R9-17-101 - 4. Calendar Day - the verbiage is confusing. Are you stating just Monday - Friday except for holiday's? Can a dispensary be open on Saturdays? R9-17-101 - 14. As long as you have a legal guardian and have obtained a doctor recommendation, is this portion stating there is no age limit? I am not aware of the youngest medical marijuana patients however I would think this may be something to further consider as the THC levels may need to be lowered for a child. R9-17-101 - 15. Medical Director. I recommend adding NMD's as a doctor able to provide medical oversight at a dispensary. My medical doctor is currently an NMD and the knowledge they have regarding herbs and herbal treatments along with the effects of all vitamins and natural care I feel is best suited for directing a marijuana dispensary. My prior MD was not familiar with herbal remedies or associated treatments which would concern me if I were a medical marijuana patient. R9-17-107 - B. If you are unaware if your registration packet has been accepted and approved, how would you have anything set up for an inspection by the Department? Are you saying that if your application is pre-approved, and after the department has completed their inspection, your application will be complete? Does this go along with F? R9-17-310 C. 2. If a patient does not want to maintain a log book, is this required? Is it just required for the physician to provide them one? R9-17-313 B. 2. In reference to the amount of 30% being grown by others, is there a certain amount that will be designated as 30% and 70%? It would be helpful to be more specific as to the amount of yield along with if there is a maximum amount of patients you can have as a dispensary? If a dispensary has to grow 70% of their own product, is this monthly, quarterly, weekly? It is allowed to have 2.5 oz every 14 days for each patient so can you grow, buy or sell depending on how many patients you have? It would be difficult to determine the amount of yield per plant and if you have more patients through the month, how do you regulate this? R9-17-314 B.1. Will the total weight or estimated amount of marijuana in the edibles be tracked to be included in the 2.5 oz per 14 days per patient? Can you be more specific in this area?
you do not have someone that can answer specific questions. when you call to ask a question, you get a vague answer. you should have an email so that people can submit questions and get real answers. in terms of investing alot of money and time up front, this has to be done before a license is granted. it is unfair if you cant get questions answered with specific answers and maybe this prevents you from getting a license.

i understand the residency requirement but you have left no room for when things evolve and change. for example in R9-17-319. you say that principal offiicer or board member has to be a resident for two years preceeding the application. but later down the road things change with the board and there is a new board memer coming on. this person will have to meet the residency requirement but you have it written that the residncy requirement in such a way that they have to be a resident two years prior.to the application. what if in five yers there is a board member change. you have it written that the person would have to effectively be a resident of arizona 7 years. 2 years prior to the application plus five years of time that has gone by. this is too restictive. this languge is prevelant through out. this leave no room for

In the section titled "R9-17-101 Definitions" Line item 15 in reference to "Medical Director" outlined in "R9-17-310 Medical Director", I would suggest that a Naturopathic Medical Doctor otherwise designated as Doctor of Naturopathic Medicine be added to the list of possible medical directors for dispensaries. A doctor of naturopathic medicine who holds a valid and existing license to practice medicine pursuant to A.R.S. Title 32, Chapter 14 or its successor and who has been designated by a dispensary to provide medical oversight at the dispensary. As primary care physicians in Arizona, Naturopathic Physicians are the only physicians specifically trained in Botanical Medicine required to take 120 hours focusing on the scientific research, actions, interactions, and safety of thousands of plant medicines and their chemical constituents. Along with Botanical Medicine, Naturopathic Physicians take 96 hours of Pharmacology and are required to pass rigorous board exams to obtain licensure and must comply with state requirements for continuing medical education specifically related to Pharmacology. Because of the education, Naturopathic Physicians are uniquely positioned to provide safe direction of medical marijuana dispensaries paying particular attention to possible medication and herbal interactions and offering the best possible medicine to patients specific to their condition keeping in mind actions of specific chemical compounds found in different strains of Cannabis. Also, Naturopathic physicians are ideal candidates as medical directors for medical marijuana dispensaries as they have extensive education and an ability to offer alternative treatments to the patients including diet and lifestyle modification, nutrient supplementation, and have an extensive knowledge of conventional and alternative treatments designed to offer comprehensive integrated medical care to address each patient individually. Please consider adding Naturopathic Medical Doctors to the list of possible medical directors. Thank you for your time. [redacted]

The rules must consider marijuana just like _any other_ prescription medicine. Taking as an example another prescription medicine, say any antibiotic, then consider this point: . How would an "antibiotic dispensary" be treated? (and treat marijuana the same) How would we regulate doctors on prescribing antibiotics? (and treat marijuana the same) . Any different treatment to this medicine would be over the top, overreaching, and acting on fear and ignorance after decades of negative propaganda over a simple and utilitarian plant used to make army uniforms in World War II. Therefore, I beg the board to act with wisdom and discretion instead: treat marijuana like any other prescription medicine. Thank you. [redacted]

I think the "one year doctor/patient relationship" is unrealistic. People who are very sick visit many doctors trying to get relief from their conditon. What if a patient who is very sick and in pain just started seeing a doctor for his/her symptoms? Would they have to wait a whole year to be able to benefit from medical marijuana? It's not right. There has to be a way to change that so that anyone who is sick (regardless of when they got sick) doesn't have to wait a year to get help from this medicine. Not

everyone can handle prescription pain killers. The pills make some people even more sick then they already are. I am asking you to please change this so that people who need it can benefit from it. Make the people who want it provide documentation (xrays, mri, lab results, medical records) proof of their illness. I think this should be sufficient enough. Don't make people jump through hoops. If you are sick, you will have some kind of documentation of it.
I don’t see any area for improvement.
The need for a full-time director is questionable. Appropriate safety and other materials on virtually every aspect of medical marijuana can be printed and provided to patients without the need for an on-site physician. The statute may have been developed to ensure proper labeling and education, but it makes more sense to set specific standards, guidelines and education requirements through the AZDHS. Another solution would be to allow physicians who want to specialize in this area help all dispensaries without limit.
Section R9-17-203 2/ i a-e can be improved by adding "permanent residents" of at least 10-20 years to your definitions. I've been a permanent resident for over 20 years and have paid my federal, state, and local taxes. I've also paid my fair share of Medicare and Social Security. so it kind of seems "unfair" to not include "permanent law abiding residents" who qualify as "patients" or "designated caregivers." I have a qualifying debilitating condition that I've been getting treatment for years, through conventional methods of pills and therapy.
There should be more than one dispensary per 10 pharmacies!!
To include more permanent diseases such as Autisum and Bipolar. Because that is something that could help kids who struggle with thier emotions and logic day by day. Also maybe the language if people on ACHES or Teros who recieve fully paid benefits for such diseases will be approved, or might be on the verge of being approved.
The 25 mile rule is so unfair to patients, I simply cannot believe the state would put something like that into law. No other state has any law like this, and anyone can tell this law was started, and written by folks who are getting ready to become multi millionaires opening dispenarys. A oz of medicine should never cost more than 50 dollars, if being sold at "non-profit" prices, but as seen in every other state, a oz of medicine is being sold at 500 and more. Please please please get rid of this 25 mile rule for patients and care givers. Don't force suck paitents like myself to pay thosands per month. Only you can help us at this point. Don't let them take advantage of us!!!!!
the V.A holds a lot of medical records that adhere to all the rules but they work for the fed goverment and can not leglly write recommendation, most of us vet can only see them and the time frame for doc and pat in the out side world is to long and costly for us that live on a disibility check. vets with disibilty that are with in your rules should be given only a one time charge with no renewable fee. the card should be at least 5 yr good.
I have a problem with the 1 year relationship with the physician rule. I, for instance, have just lost my primary care physician. I do have my medical records from her and have been to specialists. My doctor quit practice. It was my primary physician that knew me for 5 years and prescribed my medications for pain and muscle spasms. I am currently looking for another Dr. What would someone in my situation do? Would there be an acception to the rule for someone like me?
QUIT TREATING AN HERB WITH MORE CONTEMPT AND SUSPICION THAN THOSE SYNTHETIC

PHARMACEUTICALS EVERYONE 'SWALLOWS' SO READILY!!! THE CRIMINALITY IS SOURCED ONLY IN PROHIBITION, NOT THE SUBSTANCE-AT-HAND; I AM NOT A FREQUENT USER, BTW, AND I KNOW YOU CAN'T O.D. ON CANNABIS, AT LEAST NOT NEARLY AS EASILY AS ALCOHOL, PHARMACEUTICALS, OR PROBABLY TOBACCO OR TOMATOES WHEN THE CARCINOGENIC HERBICIDES/PESTICIDES ARE TAKEN INTO ACCOUNT. WHY CAN I GROW MY OWN VEGETABLES FOR MY HEALTH (superior to choices in the market) but not my own medicine? Can I grow basil, St. John's Wort, ginseng? Is the T-shirt vendor required to spin the fabric his shirts are made from? Is he required to grow the cotton and own a cotton farm? THIS IS RIDICULOUS!! YOU, THE DEPARTMENT ARE FORCING A MARRIAGE OF RETAIL AND HORTICULTURE IN REMOTE LOCATIONS!! GET A FREAKIN' CLUE-- THESE ARE DIFFERENT ANIMALS; THE VILLAGE REQUIRES A BUTCHER, BAKER, AND A CANDLESTICK MAKER! This is already a VERY challenging climate and business model to operate, by nature; you have the proprietor not only concerning himself with overly vigilant regulators, security, personnel, clientele, protocol, quality control, inventory control, education requirements, medical directors, zoning ordinances, et.al, but you want to square the equation by HANDCUFFING THE DISPENSARY TO THE GROW OP!!! IT IS LUDICROUS THAT A SUCCESSFUL STOREFRONT CORRELATES TO A SUCCESSFUL GROW OP, in intention, skill, nature, knowledge, etc. HOW COULD YOU BE SO DAFT?? You are showing your ignorance (ass) in a huge way and are asking for RIDICULE! GET OVER YOURSELVES and your SELF-IMPORTANCE and ASSIST with implementing a REASONABLE, WORKABLE, BENEVOLENT, BENEFICIAL PROGRAM and QUIT DEMONIZING THIS INDUSTRY, ESPECIALLY IF YOU INTEND TO HAVE IT BAIL-OUT YOUR BROKE DEPARTMENT AND THIS "STATE OF SAD AFFAIRS." This entire valley is laid-out for STRIP-MALLS: HOW DO YOU PROPOSE THESE BUSINESSES FIND LOCATIONS?? Will you force patients, young, and old, crippled, in pain, to travel to the industrial areas of towns to procure their treatments? How about those operating hours?? Oh sure, your hundreds of thousands (more?) of daytime workers could hire a runner, or employ a caregiver, even if they don't need one, to retrieve their medicine while they work, but why should they have to? They can go get bombed in a bar and put more citizens at risk (even if they DON'T drive) or load up on synthetic concoctions from the PHARMACIES, but don't let 'em buy MEDICAL MARIJUANA at 7 a.m. or 6:30 p.m. before or after work, respectively! ARE YOU FOR REAL???!!! YOU ARE PRESCRIBING THE PHYSICAL BUILD-OUTS OF THESE FACILITIES; HOW ABOUT LEAVING THAT TO THOSE WHO WISH TO PROTECT THEIR BUSINESSES, INVESTMENTS, EMPLOYEES, ETC.? There are SOOO MANY VACANCIES IN COMMERCIAL REAL ESTATE AT PRESENT; MANY FACILITIES COULD MEET AND EXCEED REASONABLE AND RESPONSIBLE CONSIDERATIONS FOR SAFETY AND SECURITY, BUT LEAVE THAT TO THOSE OF US WHO WISH TO DO THE BEST BUSINESS! Cream rises to the top; your model dispensaries and grow ops will be there without your naive, meddling, impositions. Patrons will support the up-and-ups, and REASONABLE REGULATIONS will flush-out the shady ops. LET FREE ENTERPRISE HAVE A SHOT! Will the DEPARTMENT start paying attention to the safety and quality (or toxicity) of the produce we purchase/consume? Wait that is the FDA, who turns a blind eye and flat denies the effects of poisons, hormones, antibiotics, and such IN OUR FOOD!!! PULL YOUR HEADS OUT AND LOOK IN THE MIRROR; WHO DO YOU WISH TO BE IN THIS?? WHO ARE YOU REALLY?? REMEMBER THAT YOU ARE PART OF A HUMAN FAMILY FIRST, THEN, SOMEWHERE DOWN THE LINE, A DEPARTMENT AGENT. THIS IS ABOUT PATIENT CARE, HUMAN RIGHTS, FREE ENTERPRISE, AND GOODWILL AMONG MEN, NOT CRIMINALIZING NATURAL MEDICINE, WHICH SHOULD HAVE NEVER BEEN TAKEN FROM PEOPLE IN THE FIRST PLACE!!! PURGE AND CLEANSE; TRY AGAIN!

1) "A dispensary may provide only 30% of its cultivated marijuana to other registered dispensaries and may acquire only 30% of its own marijuana supply from other registered dispensaries." I'm not sure what the reasoning behind this is. I think the system will evolve better if we just let free market and standard supply and demand principles run their course. 2) "A patient's Arizona physician must either 1) have been treating that patient for the debilitating medical condition for at least a year that included at least four visits, or 2) have taken primary responsibility for the care of the debilitating medical

condition after compiling a medical history, conducting a comprehensive exam, and reviewing medical records." I have been diagnosed with Fibromylagia and Central Sensitivity Syndrome. There are numerous symptoms that I am being treated for and I have chosen to remain under the care of SEVERAL doctors including a neurologist, rheumatologist, chiropractor, naturopath, and my family physician. People that suffer from chronic pain, among other illnesses, often seek medical care from several physicians and there isn't any reason why a particular doctor, simply because he or she recommends the use of marijuana, should have to assume the primary responsibility for the care of the debilitating medical condition for a given patient. It's important to note that physicians do not always agree with one another regarding treatment plans. My primary physician has a great philosophy in that he believes that maintaining wellness is 20% doctor and 80% patient. I do a lot of research on my own and then consult with my doctors for their opinions and recommendations. Marijuana is simply one more treatment option for many people. Whether or not the doctor recommending marijuana is the patient's primary care doctor or not seems irrelevant.

The person in at a dispensary called a "Medical Director" It seems that a pharmacist would be qualified to provide interactions and safe practices as well. That detail should be specified whether or not a pharmacist is capable of providing the same necessary insight as the previously mentioned qualifications of a "Medical Director"

The issues of location vs. approval. Are we expected to find a (2) locations now, outfit both the dispensary and grow facility w/ equipment and sign a lease for 8 months to a year while we wait for approval?.....then hope adhs has not already approved another dispensary 1000 feet away? This could be a $100,000+ investment "gamble" and is really going to scare away legit dispensary owners who cannot afford to spend this kind of money on the hopes of being approved. I really believe that applicants should be applying for certain cities or areas then approved based on their application and qualifications, not the willingness to risk $100k on the small chance of being approved. Once approved for a specific city or area, I would have no issues w/ finding, leasing and outfitting this facility. As a nurse, I have money to spend but cannot be leasing 2 facilities for a year while I wait on approval. This is going to deter reputable qualified applicants to dispense this medicine and allow applicants w/ deep pockets and possible corrupt connections to fund these facilities.

The intent of this law is to medicate those who need the product not to over-regulate the process. I think that restricting the free flow of the product would make hardships and restrict free enterprise. R9-17-307 C-1 through 5 limits acquisition to 30% and burdens dispensaries with mandatory production of 70%. The limitations imposed by any percentages will likely cause shortages and /or price increases. This would be an attempt at price-fixing. Prices should be regulated by free enterprise.

Using some actual COMMON SENSE when the subject comes to sick, in pain, mentally unsettled PATIENTS! STOP NIT-PICKING AND MAKING STUPID, "HARD" RULES! A lot of people can not afford to "PURCHASE" the "RIGHT", which I thought the State of Arizona voted into LAW. Why force an ill patient to PAY $350 total to just access their pharmacy???

The thing that I am haveing the biggest conflict with is this. If your NOT demanding that liquor stores, convienent stores, bars & distilleries give 24 hour remote video access options, why would you force that on dispenceries and cultivation sites? I'm not even applying for either liscense but I can say this, EVERYONE i've ever met who smokes marijuana is 1000% more responsible than ANYONE consuming, making, or selling the deadly "DRUG" known as alcohol. Yet we still don't make these people agree to remote surveillance by authorities? I think this is prejudice, no offense intended. Come in, do your inspections, pass the place or don't, but don't treat us like criminals when there are plenty of other laws passed allowing WAY more deadly things to be accessible to the general public wich are NOT under remote surveillance. The only other thing I can say I disagree with is this states aparent discrimination against people with felonies in their past who may wan't to obtain a liscense to open a

dispencery or cultivation site. These people have done their time and payed their debts to society, and it's just plane cruel to allow them to kill themselves working a heavy labor job day in and out to go out as a consumer, but things, pay taxes like EVERYONE else to support this economy, and then be told "Yes, your allowed to keep our economy afloat by killing yourself, but NO we can't allow you to open a buisness in your name because of a history that has had it's debt paid in full.

The rules stress the importance of having a long term relationship with he client. And then the rules say the dispensary with have a Medical Doc on hand to handle clients. That seems contradictory. from my experience a Medical Doctors (spinal-thoracic) either operate or send a client of to one of their Medical Pain Doctors who inject a variety of chemical to numb the pain, the symptom. This works for days, or weeks,months but don't really know. Again they are just treating symtoms. D.O.'s and NMD's treat the problem either looking for a cure, or pain relief. In the medical model and when the pain is numbed, I can't feel what the problem is or where it is. In the holistic model I have been able to treat the problem so I have come from a place of probably not being able to move or walk, to a place where I am almost completely mobile. So with the use of moderate pain relievers I have been able to identify where and what the problem is. With the medical models I have been offered I would probably still be bedridden convinced That was my only choice. I feel this Medical Marijuana measure will serve people in a way that the medical model hasn't, and probably won't. My personal team of providers includes MD's, D.O.'s, 2 NMD's, plus a variety of physical therapist. I resist any form of narcotic since I believe they impair recovery.

A qualifying patient should be able to obtain Cannabis from any designated caregiver to insure that the sick are not held hostage to the dispensary system and their high prices. A qualifying patient should be able to obtain a recommendation from any physician willing to review their medical history, without the unnecessary obstacle of having to wait a year. Designated caregivers should be licensed separately from individual qualifying patients outside the 25 mile dispensary buffer, and a licensed "designated caregiver" should be allowed to cultivate for up to 5 qualifying patients for a total of sixty plants. Cannabis produced for but not used by a qualifying patient could be donated to the purpose of creating REAL clinical trails. This puts Cannabis production in isolated areas of the countryside, and outside the city limits. It also promotes diversity and quality. A proposal to conduct real clinical trials should absolutely be a part of this process. This is particularly true of the Chronic Pain category. Should also be done in the process of adding PTSD as a qualifying condition

Make it easy and inexpensive for the ill.

Fees should be lowered by a factor of 10: Patients card - $15 Caregiver's card - $20 Dispensary application fee - $500 Remember, the goal is to make marijuana legally available to those who need it, even it it means erring on the side of being too easy. The rules shouldn't make it so difficult or expensive to obtain marijuana legally that people continue to support the illegal drug trade and Mexican cartels who use the money to kill our citizens. Requiring a 1" thick metal gate at the cultivation area is excessive, so are 12 foot high concrete walls. The only areas that will meet those requirements are prisons.

Relocations fees should not be incurred until sites are up and running. until then relocation should be subject to approval. The reason being is that there are too many unknowns with each city having different zoning and codes, it might be difficult to get all necessary approvals at time of application. I think it would be appropriate that all hospice patients automatically qualify as a patient, no matter what their diagnosis, no matter what their symptoms. As former hospice nurse, I believe they might benefit from marijuana as much as any other patient. Of course every patient is different, but for many it might allow for decreased dosage of the common symptom management pharmaceuticals which all have side

effects. Additional medications are often necessary just to control side effects. If nothing else, marijuana might simply reduce the anxiety of knowing one's life is coming to an end. There are not many valid studies or objective data evaluating medical marijuana. I would like to see Arizona become proactive on this front by instituting requirements that would assist in compiling objective data which would then serve to validate (or if the case may be, invalidate) the efficacy of marijuana use in each of the different diseases, or more accurately symptoms, that people are seeking relief from. Among the various states with existing medical marijuana laws there is sufficient population for objective evaluation, yet I don't see it being done. I think that Arizona should somehow make it mandatory that patients participate in a study to evaluate the effect of marijuana on their symptoms. Patients should be interviewed at the time of the first dispensing. This interview should address the symptom or symptoms which they are seeking relief from, how long they have had these symptoms, what they have tried in the past which has helped or didn't help, how severe the symptom is on a scale of 1-10, what level they would find acceptable, what medications they are currently taking or any other therapies to relieve the symptom. In addition some simple vital signs such as BP, heart rate and weight would be appropriate. Patients should be required to fill out a re-evaluation and get their vital signs checked once a month. AZ DOHS should collect and analyze this data.
The section allowing a person experiencing "severe nausea" to apply for medical marijuana use is uncomfortably vague. Specific diseases which create chronic nausea would be better, if listed. Otherwise, such events as episodes of binge drinking of alcoholic beverages could be passed off as "severe nausea", as could episodes of food poisoning or abuse of barbiturates.
Allow a patient to keep their regular doctor and still see another doctor if their regular doctor can't recommend medical marijuana.
see above
R9-17-108 should include if the physician is no longer licensed by the state osteopathic or medical board. R9-17-201 - Cancer - should not include any cancer in remission and should require that the specific cancer have the same required evidence as new medical indications or leave cancer out, as the indications for use of MJ in cancer is during treatment, which is covered in items 8-10. Glaucoma - only if current medical therapies are failing. Hepatitis C - meaning active disease process, not just positive for hepatitis C virus/antibodies. Caregiver permits should be voided if they test positive for marijuana. Patient permits should be voided if it is shown that their supply has been made available to others (patient's should have appropriate storage, similar to requirements for physicians and narcotic storage - double locked secured container with log book. Patients convicted of felony offense should be excluded, similar to custodial parents and caregivers. Custodians, caregivers, and physicians should not also be patients. Physicians testing positive for marijuana should not be allowed to sign off on treatment. Treating physicians should not be associated with (owner, board member, potential financial gain - i.e. related) or be permitted as a dispensary. The dispensary's medical director should not also be a treating physician for patient's purchasing from other dispensaries. The physicians who will be signing off, should also have a separate registration (similar to the dispensing of prescription medications in office). Physician's license type should be identified and not include license types such as chiropractic, homeopathic, optometry, etc.
Hello - I am recievieng SSDI and am on Medicare. I do not think my Dr. will give me a recommendation. I have extentsive back problems, 3 bulging dics pressing directly on nerves. And also have crushed right leg giving me serious pain. Because of my situation a Medicare Dr. will not go for it.
I have had one of the conditions on the approved list for over 20 years. My doctor privately recommends marijuana to me and other patients of his, but he will not write on paper a recommendation. So now you say I have to find a new doctor and wait a year to apply for a card. So,

you leave me with the choice to take prescription drugs with horrible side effects to stop my seizures and muscle spasms or for a year I should buy the one medicine that works without bad side effects from criminals? Why would you do that?
please provide a section on how the approval process will work for dispensary certificates. will it be 1st come 1st serve?, lottery?, or the most logical way, which is to look at business plan and model, and make an informed decision. the 70/30 grow rate for each dispensary seems a bit lopsided. some dispensaries that qualify may not have the capacity to grow 70% and would need to purchase wholesale from other dispensaries who have the capacity.
The rules reguarding the relationship between Dr. and patient are way too strict. Specifically the one year rule isnt always practical. I live in a rural type community and the two Dr.'s I have had for three years and two years, respectively; both recently moved away. Now the next specialist is scheduled to come here in Feb. 2 more months before I can even start the one year relationship. I feel that any Dr. should be able to write the recomendation, they are professionals in their field and this is what the people voted for. Why dont we use another states successful policy as a guideline. Montana has been successful, and that state offers as much diversity as our own and this might save time and money.
* A patient must pay $150 each year for an identification card, and a designated caregiver, $200. There does not appear to be a sliding scale or lower cost card available for low-income patients, as most other states have. We suggest reducing the fee for patients receiving SSI, SSDI, or Medicaid benefits. * A dispensary may provide only 30% of its cultivated marijuana to other registered dispensaries and may acquire only 30% of its own marijuana supply from other registered dispensaries. This is very problematic and not in the best interests of patients, as it will likely create acute shortages in rural areas and drive costs up. Those patients within 25 miles of a rural dispensary unable to meet demand will have no secondary option for safe access to their medicine. Please create an open wholesale relationship between dispensaries. This will assure consistent supply to rural Arizona, easy access for all qualifying patients, and lower costs due to increased competition of organizations trying to meet demand. * A patient's Arizona physician must either 1) have been treating that patient for the debilitating medical condition for at least a year that included at least four visits, or 2) have taken primary responsibility for the care of the debilitating medical condition after compiling a medical history, conducting a comprehensive exam, and reviewing medical records. This provision is stricter than in most of the medical marijuana states, but does not appear designed to prevent a seriously ill patient with a demonstrable debilitating medical condition from getting a written certification. It may make it impossible for some veterans to qualify, because Veterans Administration Hospital doctors do not issue recommendations.
It can improved for most veterans that suffer from illnesses that cannot be cured no matter the type of pills percribed to an patient. these conditions are considered debilitating medical condition and the mixture of prescibed pills from a provider can bring serious problems due to the mixing of the pills that are given to cure multiple problems such as PTSD, depession and axiety. these medical conditions should be considered a debilitating medical condition and should be considered as a factor for medical marijuana
I personally feel that section R9-17-201 Line 10 regarding medical conditions causing nausea is way to general and have no way to be validated and can easily be exploited. If nausea is truly an on going condition then a doctor needs to find the underlying cause of nausea and base the qualification on that diagnosis. I can see a high school kid walking into a doctor and claim he is nausea to get a id card. It is what happens in California and I would rather not have medical marijuana which i need really bad just to protect the youth in the state.

i feel the amount that you have stated to be charged is too much for sick patients , and 4 appointments for a referal is unneeded burden on already suffereing patients and 5000 non refundable charge for the pharmacys is crazy, this proposition was passed to help people so do that please
1) (R9--17--102) There does not appear to be a sliding scale or lower cost card available for low income patients, as most other states have done, which should be remedied. 2) (R9--17--202(F)(5)) While it is reasonable and important to ensure that a physician has a bonafide relationship with a patient, this language may be overly restrictive and may prevent veterans from qualifying for the program. 3) (R9--17--307) This restriction is unnecessary and not in the best interests of patients. Please reject this rule in favor of an open wholesale relationship between dispensaries that does not limit how much of a dispensary's supply must be self-produced and how much may be acquired from other registered dispensaries. 4) (R9--17--101(15), 310) allowing nurse-practitioners/advance practice nurses, public health PhDs, and Arizona doctors and osteopaths with nonactive (but not invalid) licenses to serve in that capacity as well.
This section of the Draft needs to be adjusted as the part i of this section is biased and totally irresponsible on the part of the AZDHS to require: "A statement, initialed by the physician, that the physician: i. Has a professional relationship with the qualifying patient that has existed for at least one year and the physician has seen or assessed the qualifying patient on at least four visits for the patient's debilitating medical condition during the course of the professional relationship; or ii. Has assumed primary responsibility for providing management and routine care of the patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the patient's medical record maintained by other treating physicians, that may include the patient's reaction and response to conventional medical therapies"
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Many people that may benefit from medical marijuana can not afford multiple visits to acquire doctors approval. A visit, a history equals control.
I am afraid that people who are low-income will find the costs prohibitive. I would like to see a sliding scale for those on SSI, or other forms of fixed income or low-income. Through information provided to me about other states, I think it would be overly restrictive to disallow dispensaries freely provide wholesale products to each other. Hopefully, then, rural areas will always have enough product

available for patients. If good records are kept, there should be no problems. Also, I wonder about veterans who receive care from VA docs who are not allowed to recommend-what recourse do they have? Some of the rules about owners of dispensaries are too restrictive. We need experienced owners from other states to be able to mentor and help those from AZ.
I think it would be beneficial to be a more clear with regards to the rules involved in becoming a caregiver. To be more specific, does the Qualifying patient HAVE to live 25 miles from a dispensary or can any Patient apply to grow? If a Qualifying Patient designates a Caregiver, does this possible distance requirement then go off of the Caregivers address?
R-9-17-202 is extremely misleading as how to it is interpreted by AZDHS as to how to get a qualified patient card. It clearly states in the Draft that the Doctor has control of the diagnostic aspect, and does not require four visits over the course of a year. It clearly states that a recommendation for medicinal marijuana can in fact come from a Dr. that has reviewed other physicans' diagnosis of a patient. For example, a Nerologist can diagnose someone with a type of trauma from an injury/disease. Then they eventually get care from their PCP, who is primarily responsible. Why should the patient have to then wait a year and see a Dr. 4 times when they have already been diagnosed? This may also prove benficial to patients who have moved here from another State and are in pain (which is the whole purpose of the law).
First of all the ADHS should define marijuana and their honest intentions for medical marijuana. And the ADHS should issue some statements acknowledging the history, medical benefits, safety and potential for safe access and affordability of marijuana for the poorest citizens.
Qualifying Patient Records This is the most dangerous aspect of the rules. Arizona would have all of the states patients self incriminate by recording every single element of a federal crime be required in exquisite detail with the exact amount of schedule 1 drug signed for and documented as dispenced by a state licensed facility DEA will will will raid one of these dispensaries one day. The DEA has been active in the medical marijuana industry in all 14 prior states to allow medical marijuana. The state of Arizona would be putting the DEA in an akward position at time of such raids. Never befor has the DEA raided a dispensary that had been required to keep such detailed records of federal drug violations. What should the DEA do when suddenly provided with the names addresses and exact details of each and every illigal drug transaction. The DEA will not be able to politically refuse arresting patients who may have purchased dozons of ounces. The DEA has only one word for this in any state or teritory, (Distribution) ie dealer At a minimum the DEA will end up breaking into homes of regestered patients who may have been the latest to visit the dispencary knowing that they have a home with drugs in it.
People on social security should not have to pay for the card or have a sliding scale to help lower income people have access.
Fees: It looks as though we are pricing this medicine out of reach for most patients. I am a SSI recipient and I am recognized as a service connected 100% disabled Army Vet. I am 42 years old and even though my medical condition will most likely shorten my life substantially I will require aggressive therapy both physical and medicinal for the rest of my life. I was a registered patient in Michigan's program, and was able under the supervision of my Dr to manage my medical condition for around $90-$110 a month and that would have come down once my equipment was paid off. Even if I did decide to purchase at a dispensary in MI as I did a few times in-between growing plant cycles .The cost was kept down because patients had a choice to grow. The extreme requirements of such large sums of money be involved for registry cards, Doctors needing to be on call or present, and all of the regulation involved along with the fact that Az. will also be forcing prices up artificially because of the bottleneck

created by the size limitation on dispensaries yet mandating that they grow 70% of what they sell. I see $600 and up an ounce here in Arizona. $600 an ounce I believe is on the low side and that would equate to $39,000. a year of medical marijuana. Much more then my tiny SSI. I use Marijuana to replace two other meds that I would need to continue living Just one of them Lyrica (not covered by VA) is over $300 a month add my morphine to that and you can see why I chose marijuana. Just to apply it will cost me $350 in application fees for myself and my wife who would need to pick up and help administer the meds. Add to that thousands of dollars a month, the decision will not be weather to apply for a registry card or not. Instead the only decision I will have is weather to break the law and use Black Market or home grown marijuana, or shift back to a perpetual Morphine sleepless zombie.

The draft states that the dispensary must be completely built out for approval. The draft also states that no two dispensaries can be within one mile of each other. With the way the draft is written currently applicants can spend 100's of thousands of dollars meeting the regulatory requirements and may impede within the one mile rule of another applicant. This is an unfair rule as it currently stands unless a two part approval was enacted. First phase to qualify the applicant on personal qualifications and location and second part on build out and facility requirements.

Medical Directors for dispensaries: This requirement will make the AZ. medical marijuana program a fiscal and legal disaster. The increased cost of employing a Dr. would keep this medicine under ground and fule the black market in Marijuana. Lets not do everything possible to make this medicine as expensive as we can with hobbling cost additives simply to discourage those who would not meet the requirements of the program anyway. Legal nightmear as well, with the requirement that a Medical Director not establich a Dr. Patient relationship, along with the lengthy detailed Patient records you would have him in charge of spells forced testimony and no Patient privelege as well. Under AZ. law there would be no way possible to protection against any federal inquery or audit

I would suggest that the ADHC avoid any involvement in any patients' records or history requirement which incidentally, automatically restricts legal access for any VA patients. Though the VA has approved acceptance of medical marijuana patients as of July 2010, they have currently restricted themselves from prescribing. Further restriction of medicinal marijuana patients in medical diagnosis would have resulted in no one coming to any Arizona VA Hospital for treatment under fear they would be turned in to law enforcement though having acquired another State's approved medicinal card. I believe any requirement based on a patient's personal medical records and history would constitute discrimination against Veterans and ultimately low income patients and those concurrently in rehab facilities, and discriminate against all the people who voted for 203. There arises questions such as, if determination of a debilitating medical condition is required to obtain an Arizona State card, will that affect "disability" benefits and/or requirements? I would suggest you trust in the referral of any licensed doctor, naturopath, chiroprator, dentist, etc. I believe that's why licenses are required. I am compelled to remind you all that marijuana is a weed, an herb, intended for mankinds' benefit. I also believe other State's cards must be accepted and honored at any dispensary and recognized by law enforcement.
I speak as a 63 year old woman who has resided in Arizona for 40 years. We want free access to our own discretion to choose a doctor, what kind of doctor, and how many times we want to see that doctor in order to incur the varied expense thereof, with or without benefit of insurance. May I mention those of us who have spent our lives avoiding doctors now to find ourselves ordered to see a doctor several times in order to obtain permission to use a weed. We want an open wholesale relationship between dispensaries to assure consistent and healthy supply and easy access thereto to qualifying patients, and would result in lower costs due to increased quality competition as well as stimulate urban farming growth throughout the State. Some may be stimulated to grow a few vegetables as well for healthy living. I read a statement that Director Humble believes the draft rules will reduce the estimated qualifying patients from 100,000 to 20,000 people. Is that the primary intention of the ADHC? How does that promote the health, welfare, and individual freedom of the 80,000 potential qualifiers and the well being of this State's population? I only see these draft rules benefiting the law enforcement,

doctors, lawyers and outdated juris prudence of Arizona, not the people or "patients". Perhaps the ADHC must take a tax and revenue approach to their regulations. A dollars and cents approach would benefit from NOT restricting growth or designated growth areas on any privately owned land designated and taxed as agricultural.
Defining a patient-doctor relationship: Under AZ. rules, US Military vets under the care of the VA would be excluded. I am a 100% disabled veteran receiving all of my medical care from the VA. Under your rules I would have to refuse treatment at my current VA health facility and hire a private physican at my own expense for a year before even thinking about applying for a registry card. VA Doctors are now able to treat patients that are using medical marijuana in states that allow it however those same VA Doctors are not authorized to fill out a recommendation. Arizona already has a legal understanding of what a Doctor Patient relationship is, it is tried and tested in tort laws and case study. I suggest we simply use what we have known all along. A common sense approach would be to use the medical industry standard as to what a Dr. Patient relationship is instead of redefining it for only one medication. Fact: Not one drug in this nation requires you to enter into any kind of exclusive contract with a Doctor for a predetermined period of time.
The ADHS does not have the authority to define or redefine the patient-physician relationship or the number of doctor visits, or the length of time for those visits. That infringes on the patient's choice.
I qualify medically. But, unless you allow me to see my primary doctor who isn't allowed to make a medical marijuana recommendation....and make it easy for me to see a second doctor for a recommendation...and if the yearly fees aren't ridiculous....I'll continue buying it illegally on the streets.
We must improve the doctor to patient relationship. I feel that we do in deed need to set some grown rules, but to see the same doctor for up to a year I feel is a bad idea. I feel that with the way people are getting laid off from jobs they are losing their insurance thus having to see a different doctor. Put your self in that situation. You need medical marijuana for HIV or chronic pain, but just before the act goes into play you change your doctor so this means you must find a need doctor and wait for a year before you can get a medical card to help your medical needs? I feel that a year is to long. Maybe if the patient have medical records of having the issue(s) for up to a year would sound a lot better.
I believe Mr. Humble is purposely developing Dr. / Patient rules and fees to exclude a large population of patients because he was against Prop 203. Mr. Humble just does not realize the medical benefit of marijuana; his focus is on making the Act fail.
A dispensary may provide only 30% of its cultivated marijuana to other registered dispensaries and may acquire only 30% of its own marijuana supply from other registered dispensaries. This is very problematic and not in the best interests of patients, as it will likely create acute shortages in rural areas and drive costs up. Those patients within 25 miles of a rural dispensary unable to meet demand will have no secondary option for safe access to their medicine. Why not create an open wholesale relationship between dispensaries. This will assure consistent supply to rural Arizona, easy access for all qualifying patients, and lower costs due to increased competition of organizations trying to meet demand.
a sliding scale or lowercost for SSDI patients, I can't afford $150 for my card.
* A patient must pay $150 each year for an identification card, and a designated caregiver, $200. There does not appear to be a sliding scale or lower cost card available for low-income patients, as most other states have. We suggest reducing the fee for patients receiving SSI, SSDI, or Medicaid benefits. * A

dispensary may provide only 30% of its cultivated marijuana to other registered dispensaries and may acquire only 30% of its own marijuana supply from other registered dispensaries. This is very problematic and not in the best interests of patients, as it will likely create acute shortages in rural areas and drive costs up. Those patients within 25 miles of a rural dispensary unable to meet demand will have no secondary option for safe access to their medicine. Please submit comments asking DHS to create an open wholesale relationship between dispensaries. This will assure consistent supply to rural Arizona, easy access for all qualifying patients, and lower costs due to increased competition of organizations trying to meet demand. * A patient's Arizona physician must either 1) have been treating that patient for the debilitating medical condition for at least a year that included at least four visits, or 2) have taken primary responsibility for the care of the debilitating medical condition after compiling a medical history, conducting a comprehensive exam, and reviewing medical records. This provision is stricter than in most of the medical marijuana states, but does not appear designed to prevent a seriously ill patient with a demonstrable debilitating medical condition from getting a written certification. It may make it impossible for some veterans to qualify, because Veterans Administration Hospital doctors do not issue recommendations, likely due to Federal laws and regulations under which the VA must comply.

The idea of having a medical director will cause more problems than they will solve.They will be challenged and more than likely will be ruled it is an evasion of the Client /Doctor relationship. Who is going to pay for them? You already have the right to inspections and have 24/7 monitoring, don't understand reasoning, need for them.

The only hope we have to keep Mexican cartels and other criminals out of the medical marijuana business in Arizona, is to use the not-for-profit parts of Prop 203 to remove the profit, and there for the incentive for cartels to be involved. Remember, the cartels grow in Mexico, pay people to transport, and smuggle marijuana into the US, the also literately loose tons at the border. Still they make enough money to challenge the Mexican Government.

It seems to me that Article 3. "Dispensaries" requires that an applicant for a Dispensary Registration Certificate undertake all of the very significant organizational work and expense of getting a dispensary all ready to open its doors before being granted a Certificate. This could easily require an investment of a quarter million dollars; signing real estate leases and making significant property improvements as well as contractual commitments that may not be easily unwound in the event that a Certificate is not granted to that entity. This substantial risk will likely discourage many responsible business entities from making application, thus reducing the pool of qualified and financially stable applicants for the DHS to review and choose from. I would suggest that the DHS consider the implementation of Dispensary guidelines that list such things as minimum standards for facilities, distances from public or private schools, zoning requirements, on-site education facilities, required security, etc. Perhaps then an applicant for a Dispensary Registration Certificate could make application for a "conditional" approval, that would then allow time for that applicant to then proceed with purchasing or leasing and outfitting a suitable space, and fulfilling all of the DHS rules, requirements and inspections before being granted the final approval. I understand the substantial responsibility and hugely increased work load that proposition 203 has dumped on the DHS. I hope this input will assist the Department in coming up with the best possible program for all citizens of Arizona.

the one rule that i see needs the most improvement is the rule that a patient must have seen a dr. for at least a year about there issue and at least 4 times in the last year. the problem with this rule is that you are leaving out about 50% of peaple in this state who have no medical insurance. People who live below the poverty line are more likley not to have insurance and tend not to follow up on expensive treatments. so this rule total discluded them as potential canidates for a card. these people will continue to self medicate putting them selves in danger on many levels. the second rule that i think can be improved on is the rule of where a dispencery can get there medican from needs to be changed. by

limiting where the product can come from you put the state in situation where there can be a shortage. if that happens prices would go threw the roof. once again living the people with less out in the cold and forced to deal with street dealers. the dispenceries WILL NOT BE ABLE TO PRODUCE ENOUGH MEDS! The law has passed. the people have spoken. please keep it profesional and under control but open up. the people want it, the fed has turned there back to it and the state of AZ needs the tax dollars and the jobs. AZ has a chance to be and industry leader in a billion dollar buisness and you will control this industry. don't miss out and let california make all the money! be easy be open for growth. every one stands to benefit>
A patient must pay $150 each year for an identification card, and a designated caregiver, $200. There does not appear to be a sliding scale or lower cost card available for low-income patients, as most other states have. I suggest, compassionately, reducing the fee for patients receiving SSI, SSDI, or Medicaid benefits. A dispensary may provide only 30% of its cultivated marijuana to other registered dispensaries and may acquire only 30% of its own marijuana supply from other registered dispensaries. This is very problematic and not in the best interests of patients, as it will likely create acute shortages in rural areas and drive costs up. Those patients within 25 miles of a rural dispensary unable to meet demand will have no secondary option for safe access to their medicine.I recommend, to keep costs down, to the creation of an open wholesale relationship between dispensaries. This will assure consistent supply to rural Arizona, easy access for all qualifying patients, and lower costs due to increased competition of organizations trying to meet demand.
The $150 annual fee for patients is excessive and will discriminate against qualified patients with low incomes. The 30% rule between dispensaries should be changed to create an open wholesale relationship between dispensaries to ensure a consistent supply. The restrictions regarding the Arizona physician's relationship with the patient are too restrictive because many qualified physicians may be predisposed against the use of medical marijuana or afraid to issue recommendations to their patients. This is a new field in medicine that is controversial and subject to political discourse, which may influence doctors views. Patients should be allowed to change doctors and not have to wait a year to qualify. As a patient who takes compounded medicines I am all too aware of the big drug manufactures influence on doctors and how that affects patients abilities to obtain alternative medicine such as compounded prescriptions.
Would like to see under R9-17-102 5B, a place for a spouse or significant other as a designated caregiver for only the one patient to have fees of $100.00. Being on disability, money can get a little tight. I would need help from my spouse on occasion to pick up my meds or help take care of plants if I were unable to. I want to be in compliance, but the extra $100.00 dollars a year could cause a burden.
Limiting those who can write for a certificate of use to M.D. sorts only is too restrictive. I am a PhD Psychologist and many of my patients suffer from Chronic Pain Symdrome, Others from Post Traumatic Stress Disorder, still others from Acute Anxiety, Panic Attacks, Depressive Disorders, Etc. I highly recommed that Psychologists at the PhD level with State or national certification be allowed to write a certificate of use for the many patients we see who would benefit from medical marijuana. There is no need for them to have to see me and a Doctor for this type of treatment.
NDs (Naturopathic Physicians) should be included with DOs and MDs to be medical directors of dispensaries. This makes sense because Naturopathic Physicians learn about the efficacy and

responsible use of all herbs and herbal supplements as part of their medical education.
i don't see much correlation to the prroposed TA2010017 rules proposed by Maricopa County P & Z. how do they mesh? are they supposed to?
by allowing more people access to the herb, thank you
I think the rules should follow closer to what Ca. and Oregon have.
Dispensaries should be the only place where marijuana is allowed to be grown and sold, if others outside the dispensaries are allowed to grow then the State will not have oversight of those individuals. This is critical.Dispensaries should be required to report quarterly revenues to the State.
No Medical director, or referring Physician, or Physician providing prescription for Medical Marijuana shall have a finanical interest in dispensary directly or indirectly. No Medical Director shall be paid based on sales revenue or any other compensation where increased volume of sales of Medical Marijuana would provided incentive for increase of sales. All dipensaries shall be of a non-profit entity. If the true nature of the law is to provided Medical Marijuana to individual with medical need no profit should be needed. The same benefactor the the call for this law should be willing to set up non-profit dispensaries.
Drop the fee requirement to the same level as that of any other drug prescribed by a doctor. That level is zero in case you were not aware. Drop the number of doctor visits to the same level as any other drug prescribed by a doctor. That would also be zero in case you are not aware.
I believe that the cost of a patients card should not be set at $150. After all, if patients had to pay this fee to register to use other legalized drugs like Codeine and Percocet, I believe many patients that actually needed these drugs would not be receiving them. I say this as an unemployed Veteran of this country, who also suffers from Post traumatic stress syndrome. This brings me to my next point. I believe that PTSD is the the most obviously left out debilitating medical condition in the draft, and hope that it is included in section 36-2801.01. I am sure you have received thousands of these requests, so I will not go into any further detail.
Please consider a reduction in fees or provide a sliding scale for the identification card and designated caregiver based on low-income/SSI/SSDI/Medicare recipients.
The 25-mile rule should to be removed or modified. This rule was included to insure the success of dispensary's and not for the benefit of the patient. Please review this link and listen to the statement made. http://stash.norml.org/mpps-andrew-myers-discusses-medical-marijuana-in-arizona The rules intentions fall under the definition of extortion. The cost in a dispensary is $200. To $400. an ounce. The cost for a patient to grow is a few dollars an ounce. Growing is a needed option for many patients. A growing marijuana plant is not dangerous or toxic to any plant, animal or human. If this rule cannot be removed I would expect many conditions be added to it. Example: A patient may grow if they prove a financial hardship to afford dispensary prices. A patient may grow if desired strain is unavailable. Let's remember the mission is to the patient.
I beieve you are too harsh on the draft rules for seeing a doctor 4 times in one year to get medication.

That is not what the voters spoke for, thank you . Tom Jones

As a glaucoma specialist in Tucson, I would strongly recommend that "glaucoma" be removed as an indication for medical marijuana on the draft rules. All other conditions on the list are characterized by chronic pain, nausea, weight loss etc - all fairly well accepted reasons for the palliative use of marijuana. Glaucoma is completely different. It is not typically painful, does not produce weight loss or nausea. It is well treated by proven and safe topical medications. There has been no study to date that has shown a role for marijuana in the chronic treatment of glaucoma. It has been shown to produce a very transient reduction in the intraocular pressure, which immediately elevates once again after cessation of smoking. It is thought by many experts that a patient would have to smoke marijuana for 24 hours a day to produce a sustained response similar to even the weakest of available topical medications. This would obviously be deleterious to the health of the patient and impractical as a treatment option. Again, glaucoma is completely different from all other proposed conditions on the list. It is the only disease listed that marijuana is being proposed as a therapeutic, rather than palliative option. There is no science that shows that this is a viable option at this time - in fact all science today shows the opposite - that marijuana only produces a transient beneficial effect. Should such data surface in the future, the rules can always be amended at that point to include glaucoma. I have no issue prescribing any treatment to my patients that has a proven beneficial effect. I would certainly have no problem prescribing marijuana for chronic pain, cancer, and wasting conditions. However, I strongly urge the committee to rethink the glaucoma indication, as this is (in my opinion) an incorrect indication for therapeutic considerations. The inclusion of glaucoma on the list will only complicate and confuse patients and physicians alike in the treatment of this blinding disease.
http://www.aao.org/eyecare/treatment/alternative-therapies/marijuana-glaucoma.cfm
http://www.glaucoma.org/treating/medical_marijua.php I challenge the committee to produce a single glaucoma specialist in california or arizona that thinks marijuana is a viable option for glaucoma given the current state of knowledge! Please feel free to contact me at any point, [redacted]

i think that $150 fee each year will make it harder for people with low income to get the medicine they need, perhaps a reduced fee for those people. There needs to be an open wholesale relationship between dispensaries. This will assure consistent supply to rural Arizona, easy access for all qualifying patients,and lower costs due to increased competition of organizations trying to meet demand. A patient’s Arizona physician must either 1) have been treating that patient for the debilitating medical condition for at least a year that included at least four visits, or 2) have taken primary responsibility for the care of the debilitating medical condition after compiling a medical history, conducting a comprehensive exam, and reviewing medical records. This provision is stricter than in most of the medical marijuana states, but does not appear designed to prevent a seriously ill patient with a demonstrable debilitating medical condition from getting a written certification. It may make it impossible for some veterans to qualify, because Veterans Administration Hospital doctors do not issue recommendations

The following appears to be a violation of the HIPPA privacy rules. A statement by the doctor that the patient qualifies for medical cannabis should be sufficient as it is with a prescribed medication. This would also apply to any renewal. d. An identification of one or more of the debilitating medical conditions in R9-17- 201 as the qualifying patient's specific debilitating medical condition The

following should be changed as it creates an impossible situation for people who may visit hospital ER's, clinics, VA's or medical centers for healthcare. Establishing a doctor patient relationship can be made with one visit. Some people see different doctors at every visit or move within the state or have other conditions that apply. If this is a specialist they cannot and should not assume primary responsibility. This should read that the licensed physician has examined the patient and their condition and medical records and has made the recommendation. There are no other conditions or medications that have this stipulation and this particular rule may prevent qualifying patients from receiving relief for their condition. Renewing the application can be made by the recommending doctor or any licensed physician within the state. e. A statement, initialed by the physician, that the physician: i. Has a professional relationship with the qualifying patient that has existed for at least one year and the physician has seen or assessed the qualifying patient on at least four visits for the patient's debilitating medical condition during the course of the professional relationship; or ii. Has assumed primary responsibility for providing management and routine care of the patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the patient's medical record maintained by other treating physicians, that may include the This particular rule forces a patient to create a log and a state record that self incriminates them on possible federal charges which would be a violation of the patients 5th amendment rights. 6. Enter the following information into the medical marijuana electronic verification system for the qualifying patient or designated caregiver: a. The amount of medical marijuana dispensed, b. Whether the medical marijuana was dispensed to the qualifying patient or to the qualifying patient's designated caregiver, c. The date and time the medical marijuana was dispensed, d. The dispensary agent's registry identification number

I have read over the document and am overall impressed with its thorough and real approach to making access to safe and effective cannabis-based medicines. The following are a list of suggestions on minor changes I would make to help the program work better: • The program needs to more clearly define the application process it would seem. It is imperative that the process be based on the best provider for the job, meaning a competitive application process would be the most desirable. A first come-first serve process, or a lottery process can leave the operation of a limited number of facilities to chance. Patients deserve to have competent and compassionate operator, therefore it may be best to assign districts to the different areas of the State and allow for a certain amount of dispensaries in each district. Then operators could apply for specific districts with facilities in those districts. This would help ensure the largest numbers of geographic areas are reached with patient access. This could also be based on the pharmacy population for the area to remain consistent. • In section R9-17-101 under Definitions I see a couple of potential issues. o Number 6: “Cultivation site” says “...marijuana will be cultivated...” Does the phrase “will be” mean that cultivation must be done at a different location? Should it be “can be?” o Under 10(b) is there a reason wood is not included in the approved building materials? o Number 15: “Medical director” is defined as a doctor of medicine. Just wondering if this includes a Doctor of Pharmacy (PharmD)? There is a reference later in the document asking if a pharmacist would be on duty or on call, but it is unclear if that is the same as the “Medical director” or if a Doctor of Pharmacy is allowed for that position. • R9-17-102- Fees: The patient fees seem very high. A patient who has a caregiver will pay $350 a year just for the privilege to be able to possess and use a safe and effective medicine. Cannabis can be expensive, and while some patients may have no problem paying these fees, many will. When a person is choosing between their medicine and the fees to be able to use that medicine, this will encourage them to continue using the black market and in turn having a less safe and more illicit experience. To put it in perspective- a patient with a caregiver is paying 7% of what a dispensary is paying for their license. I think the fees are about twice as large as they should be and that having a caregiver should not cost more, but about half of what it costs to be a patient, if anything at all. It is unclear why a person who needs a caregiver should be so heavily penalized beyond the actual cost of a card and minor processing to accompany the patient process. ALSO- Is there a place for low income exception programs? People on fixed incomes will most likely need assistance with these fees. Being poor should not inhibit your ability to be well. • R9-17-106: Adding a Debilitating Condition

o Under number 5 is unnecessary. Because there may or may not be conventional therapies on the market has no relevance of the effectiveness of cannabis therapies as a safe and effective alternative. o It is unclear who does the decision making n the adding process. Is there a decided constituency within the Department that makes this decision? a panel of people? One person? An appointed committee? Further definition may be needed. • R9-17-202: Applying for a Registry Identification card.... o It is unclear why a separate statement for each patient from the physician stating the same thing for every patient and caregiver is necessary, as it would seem more effective to require the physician meet all of the requirements listed for each patients they write a recommendation for. It would seem that a lot of unnecessary paperwork required to ensure the doctor realizes his liabilities and responsibilities to the patient. Is there a more effective way to accomplish this? o For patients under 18-years-old that need their parents to be their caregiver to access these therapies, is it necessary to be concerned with the parent's being convicted of a felony. While I see the overall spirit for this requirement, it would seem that this could limit a needy child patient's right to their medicine because of their parents past bad behaviors. Is there another way to accomplish this without penalizing the child, such as working with child services to ensure no abuse is taking place? • The renewal process is the same as simply applying from scratch. It would seem that making the renewal simpler would encourage people to not allow it to lapse because it is just as easy to apply again when it is more convenient. • The Department should devise a voluntary email registry that notifies a patient when their renewal is 60 days out if you require it be renewed at least 30 days before expiration. A simple notification calendar will help patients stay legal and help the department see the revenues on time. • R9-17-302: Applying for a Dispensary Registration Certificate o Does being a resident for two years coincide with the State requirement for residency, and if not why are medical cannabis providers being treated differently from other citizens? o In Section (B.) number (1.) subsection (j.) and (k.) should be combined and changed to read "When the dispensary, and if applicable the dispensary's cultivation site will be ready for inspection." By separating the two points it seems to make having the dispensary ready immediately is somehow preferable. If a person has it ready immediately they would just say so. o Number (3.) subsection (d.)- How do the proof of residency requirements establish the required two-year term if the most recent incarnations of these documents are required for the most part? o Number (4.) While staffing is mentioned in policy requirements after the application and quality control is briefly alluded to in the inventory section, it would seem these would be important parts of the puzzle for the application process. Also, Cultivation Standards and Methods are important things to help decide if an applicant if prepared. Including "Staffing, Quality Control, and Cultivation" to Inventory Control, ...Record Keeping, Security, and Patient Education...will produce more well-rounded and informed applicants. o Number (5.) Clarify what forms of certificate of occupancy are acceptable: Lease, lease option/letter of intent, or ownership docs. • R9-17-304 (2) Location Change- Do "local jurisdictions" have to allow for dispensaries in any given zones or does this give them the power to ban or de facto ban dispensaries in certain areas? • R9-17-306 Inspections: Subsection (E.) should be clarified to avoid abuse from disgruntled people, people who oppose marijuana in general, or even competitors who would file false "allegations" against a dispensary without warrant. Is there a way to ensure the allegations are credible or does anytime a person complains trigger an inspection? • R9-17-307 Administration: o Section (C.) requires a dispensary cultivate 70% of its own medicine and not distribute more than 30% of their inventory. It would seem a 60-40% split would be more appropriate and ensure patients have access to medicine. It is unclear what this is meant to accomplish. It would seem the spirit is to avoid a dispensary growing a lot of marijuana and then distributing it. As I mentioned previously, some organizations will produce better cannabis and patients should have access to a good supply, so just because their local group may not produce great medicine, getting medicine from other sources will enable them to hopefully have a high quality product regardless. This ratio policy may cause confusion. Organizations naturally will want to cultivate their own product, but some will need to find better resources for a larger percentage due to ineffectiveness or higher demand than space allowance in populated areas. • R9-17-311- Dispensing Medical Marijuana: Number (5.) requires control of the 2.5 ounce limit in a 14-day period. While this s adequate for 99% of the community, does a patient with a verifiable greater need have a method of filing for an exemption to this limit. For example, a patient that solely eats their medicine may use up to 3-tmes the amount of

one that does not. If a doctor verifies a greater need due to various valid reasons, can a patent apply to have their limit adjusted? • R9-17-313- Inventory Control System: o Number (3.) For cultivation: Would it serve the Department to define more clearly what the usable and unusable parts of the required measurements are? Does the person need to weigh all stems and root balls of the plant, as well? Does unusable include that or is it meant to mean flowers and leaf materials that are unusable for one reason or another because of quality. Are the weights done wet or dry? o Number (6.) subsection (a.): "The amount of marijuana received" should specify an increment and subsection (b.): the amount of marijuana used is not as important as the quality of marijuana used to make the product. It may be wise to establish a qualification of high, medium, and low grade to accompany the amount and give the patient greater perspective. • R9-17-314: Product Labeling and Analysis o Would encourage requiring lot numbers to track medicine. o Section (A.) number (5.): Listing all chemicals, fertilizers, etc. is not great for labeling aesthetics. Much like fast food restaurants do for caloric and nutritional facts, having them "available for the patient upon request" is a better idea. o Section (B) number (2.): Requiring the product say it was made with "no regulatory oversight" is inaccurate, as the entire system is oversight and providers should also have regulatory practice in place. Maybe the term "limited oversight" is more accurate. • R9-17-316- Edible Food Products: Section (1.) mentions the "local health department." Are local health departments required to participate in the program? Could the refuse and therefore these types of medicines be limited or banned as a result? • R9-17-319- Denial and Revocation of Dispensary Registration Certificate: o Section (A.) number (1.): Is there any variance allocations for a location that may have an adequate barrier bit does not meet the sensitive use proximity standards? o Section (C): number (1.) subsection (b.): How rigid is the standard for the implementation of the application/plans for the organization. Is there a common sense factor regarding some things that may have to be adjusted due to unseen circumstance?

Section R9-17-102 FEES - I would suggest increasing the fee for changing or replacing an ID card to provide incentive for people to protect these cards and provide accurate information and not change them frivolously. I would suggest a fee of $25 to $50 - consider at least $25 for changing a card and $50 for replacing a lost card. Section R9-17-104 - In changing a card I would also require that they submit their current registry ID card when they submit a request for change and fee.

Providing guidelines and language for patients who live in rural areas where dispensaries may not exist to grow their own medical marijana.

I am a caregiver for a severely disabled elderly woman who wants to get medical marijuana. I probably don't mind the fingerprints, but the fees are outrageous. Plus I have to worry that I'll be arrested even though I will only be delivering it to my patient. If I don't get the card she'll have to have it delivered by some dispensary. Also her doctor is also staff of one of those clinics that has outlawed recommendations by their doctors. So I see a lot of problems with what you've drafted. Allow my patient to keep her doctor and allow her to see a marijuana doctor maybe annually for a recommendation.

The number one rule of the draft that needs to be changed is the cost of the ID card for a patient. I am a disabled person with chronic pain in my side, legs, feet and arms; I have tried marijuana and it does help with tolerating my pain. However, there is no way I could afford to purchase the ID card at that price being on SSD; since most of my money goes towards rent, utilities, food and medical and prescription co-pays. I think there should be a decrease in the ID costs for low income persons as well as the cost of the prescription. DHS needs to create an open wholesale agreement between dispensaries; the way it is now there will always be a shortage of marijuana especially to the rural areas where patients need it. By having an open wholesale agreement with dispensaries would assure that shortages would not occur as often. I am sure even with the wholesale agreement shortages will occur

but the way it is now most definitely a lot of them. The cost the dispensaries pay seems a little high and wonder if there would be enough of them that would pay that amount to keep up with the demand.
I think that the wording that Medical Director be a M.D. or D.O. is limiting. Nurse Practitoner practices medicine under their own license and due to their consulting training and patient education culture maybe a better fit as medical director of a dispensary that either a M.D. or D.O.
first a sliding scale needs to be implemented.2nd has any body calculated the cost of gas within the next 2 years? they're talking about five a gallon, if I have to pay that rediculous amount for gas I won't have any money to go see a doctor. then there are those of us that cannot go see a doctor due to making 1$ to much to get acchs, like me. there are those of us in society that just don't go to doctors for any number of reasons, now I have to wait a year to get meds? and spend money I don't have, oh wait a second I'll take the food money and use it for this, sorry kids it's just bread and water tonight.
The Az Medical Marijuana Act requires this: 18. "WRITTEN CERTIFICATION" MEANS A DOCUMENT DATED AND SIGNED BY A PHYSICIAN, STATING THAT IN THE PHYSICIAN'S PROFESSIONAL OPINION THE PATIENT IS LIKELY TO RECEIVE THERAPEUTIC OR PALLIATIVE BENEFIT FROM THE MEDICAL USE OF MARIJUANA TO TREAT OR ALLEVIATE THE PATIENT'S DEBILITATING MEDICAL CONDITION OR SYMPTOMS ASSOCIATED WITH THE DEBILITATING MEDICAL CONDITION. THE PHYSICIAN MUST: (a) SPECIFY THE QUALIFYING PATIENT'S DEBILITATING MEDICAL CONDITION IN THE WRITTEN CERTIFICATION. (b) SIGN AND DATE THE WRITTEN CERTIFICATION ONLY IN THE COURSE OF A PHYSICIAN-PATIENT RELATIONSHIP AFTER THE PHYSICIAN HAS COMPLETED A FULL ASSESSMENT [NOTE: "assessment," singular, not plural; 1, not 4] OF THE QUALIFYING PATIENT'S MEDICAL HISTORY. So, it should be sufficient that one full assessment & medical history review, specifying the qualifying condition, sign, and date a ecommendation & the Patient is done! Remember folks are living in pain & dying, they may not have another year to wait, or live to see another 4 appoinments. The need is now & is Urgent!! Without any authority to do so, Az DHS proposed: R9-17-202 5e. A statement, initialed by the physician, that the physician: i. Has a professional relationship with the qualifying patient that has existed for at least one year and the physician has seen or assessed the qualifying patient on at least four visits for the patient's debilitating medical condition during the course of the professional relationship; or ii. Has assumed primary responsibility for providing management and routine care of the patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the patient's medical record maintained by other treating physicians, that may include the patient's reaction and response to conventional medical therapies; Key points: • Any Arizona physician may in a single visit prescribe "speed," e.g., Adderall, to a kindergartener-without 4 visits spread out over 1 year any Arizona physician may prescribe to a kindergartener a drug that can kill that child by heart attack, stroke, seizures, or other "side effects." • Cancer, HIV, Hepatitis C, and ALS patients often do not have 1 year to live. • The patients that do live are cruelly being told to change doctors or suffer for 1 year. • Deadly and addictive drugs such as the opiates are prescribed in a single visit by Arizona physicians and, despite the best efforts of physicians, some of those deadly and addictive drugs are illegally diverted, but that does not cause the AzDHS to demand 4 visits, 1 year of visits, or that the pain specialist assume primary care of the patient. • Marijuana is 100% safe, gives patients good relief, and cures some conditions-Marijuana is not deadly and is not addictive. • The alternative offered by the AzDHS to avoid 1 year of suffering, the cannabis specialist takes over the primary care of the pt's qualifying condition, is done nowhere else in medicine-Nowhere else in medicine does a specialist take over a patient's primary care. • The AzDHS does not have the authority to define or re-define the patient-physician relationship or the number of doctors visits, or the length of time for those visits-that infringes on the patient's choice • The draft regulations are cruel and unreasonable. If you pay special attention to Section 36-2803 "rulemaking," you will notice that the AzMMA does NOT give authority to the Arizona Department of Health Services to define-or redefine-the patient-physician relationship and does NOT give the authority to amend the AzMMA language, e.g., adding "ongoing" to "patient-physician relationship." The Arizona Voter

Protection Act specifically DENIES authority for such usurpations. Please note that even the Director of AzDHS questioned his own authority to do what he proposes: http://directorsblog.health.azdhs.gov/?p=810 See also: http://blogs.phoenixnewtimes.com/valleyfever/2010/11/prop_203_legal_weed_will_be_av.php
There have been times when I've gone to the MVD and they've failed to return the old ID or DL. What about those people who don't have an ID or DL from before: "f. If the qualifying patient is designated an individual not previously designated as the qualifying patient's caregiver the identification number on and a copy of the designated caregiver's: i. Arizona driver's license issued after October 1, 1996; ii. Arizona identification card issued after October 1, 1996; iii. Arizona registry identification card; iv. Photograph page in the designated caregiver's U. S. passport; or v. An Arizona driver's license or identification card issued before October 1, 1996 and one of the following:" - - - It mentions "before October 1, 1996 several times throughout the draft. Is this accurate?...I couldn't find the importance of the date October 1, 1996.
The dispensery's should be able to buy and sell product between one another to insure that product is available in all areas of the state. The 30 % rule would severly limit this. Rather have large growers who can sell to all dispensery's from a secure and controlled location. Having 124 growing areas would also encourage more crime from robberies or theft and would make it more difficult to controll amounts produced and dispensed. Their should be exemptions or low cost fees for people who are low income, on SSI, SSD or just can't afford the medications. I have not heard or seen any cost figures for buying medical marijuana only that it is a not for profit enterprise. A cost guideline would be helpful.
This question seems like it will be better answered by the next question, so I'll put my focus there, but in general our country was founded on principals of life, liberty, and the pursuit of happiness in the sense that the founders fled overbearing countries in Europe to start a new one in the states where the government would meddle with the citizen's affairs as little as possible. I'd remove the 1yr clause and replace it with a good faith clause.
I did not see how you are going to figure out who and where dispenseries are going to be implemented. For instance I know there is going to be 120 disp. But is this going to be a random pick and not by county and how many to a particular county. I think you need to explain this. Also if that is going to be the case in the application do you request a specific County. The start up of a dispensery nobody in AZ has Medical Marijuana it takes time to grow and where do you get seeds to start this in AZ. I think a lot more verbage on dispenseries needs to go into thought and explaination. Also the initial yes or no to an applicant for a dispensery they have to form a non-profit and spend a lot of money before they yes or no on the application I think because this is new you need to have applicants submit an intial business plan with general locations and rents and fees and if approved then move forward with the rest.
DEA and other federal agencies have threatened doctors who write Rx for Medicinal Marijuana. I am not sure how this will affect physician's willingness to prescribe despite patient's best interest. The scheduled fee is agreeable but there should be a sliding fee for patients who are low income. If they have qualified for AHCCCS, SSI, Medicare, there should be a reduced fee. Patients in rural areas may face discriminatory sales due to lack of access. Establishing an open market for dispensaries to sell/transfer inventory should be established.
I believe Medical Marijuana is a last resort. Other therapies should be used first to manage pain. Other medications should be tried first. Good job. I LOVE THIS PART. Chronic pain doesn't pop up overnight. The above section makes sure the doctor knows about and has been trearting that pain and documenting it.

PUT THE PATIENT FIRST, NOT MONEY ! ! ! PATIENTS SHOULD SEE A DOCTOR ONE TIME, AND THEN ONCE A YEAR AFTER THAT. WHAT IF A PATIENT HAS BEEN SEEING A DOCTOR FOR 10 YEAR'S, ARE YOU GOING TO SAAY THAT DOCTOR DOESN'T KNOW HIS PATIENT ? THE APPLICATION SHOULD ONLY BE $10.00, A LOT OF US ARE ON DISABILITY, PLEASE KEEP THE PRICE LOW,THIS IS A PRESCRIPTION AND CAN SAVE LIVE'S ! ! !

No or sliding costs for any ID cards..that's an unnecessary expense that could be prohibitive in case of low income patients. An open wholesale relationship between the dispensaries; permitting them to share the marijuana as they see need. The ability for Vets to obtain medical marijuana via the V.A. docs..(don't know if this is even possible but it should be being tested especially with all the horrendous incidences of PTSD and comorbid suicide that is showing up in returning vets). Less stringent requirements to qualify. People use marijuana for less than death-related reasons, much like they drink alcohol or smoke cigarettes. This is treating people in an unequal fashion. The worst thing about this bill is it doesn't go far enough.

I,would prefer to see dispensaries located at least 5 mi, away from schools and church locations.I did vote for 203 and I,hope matters will be handled in a responsible mater.I would like there to be a sliding scale patents,lowincome,disabled ssi .

ADHS employees should read the Constitution of the United States, the Arizona Revised Statutes, the Arizona Constitution, the Uniform Building Code, some metal fabrication manuals, how to farm instructions, your own web-site rules and then re-educate yourselves on the principals of the free market. The ADHS and all government has demonstrated their hatred of marijuana users with almost 100 years of prosecution and imprisonment. The Rules as presented must be scrapped and a new rule making process started in an environment devoid of anti marijuana zealots and progressive/communists. Your current work will be tossed aside at the next election and never be implemented.

In Article 2. Qualifying Patients and Designated Caregivers, a newly released draft proposes to include the following; “A statement, initialed by the physician, that the physician: i. Has a professional relationship with the qualifying patient that has existed for at least one year and the physician has seen or assessed the qualifying patient on at least four visits for the patient's debilitating medical condition during the course of the professional relationship; or ii. Has assumed primary responsibility for providing management and routine care of the patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the patient's medical record maintained by other treating physicians, that may include the patient's reaction and response to conventional medical therapies” This language imposing such an onerous restriction does not appear in the proposition voted on and passed by the people of Arizona. The propostion language reads as follows; The language on section 36-2801. 18 (a) (b) clearly stipulate “THAT IN THE PHYSICIAN'S PROFESSIONAL OPINION THE PATIENT IS LIKELY TO RECEIVE THERAPEUTIC OR PALLIATIVE BENEFIT FROM THE MEDICAL USE OF MARIJUANA TO TREAT OR ALLEVIATE THE PATIENT'S DEBILITATING MEDICAL CONDITION OR SYMPTOMS ASSOCIATED WITH THE DEBILITATING MEDICAL CONDITION. THE PHYSICIAN MUST: (a) SPECIFY THE QUALIFYING PATIENT'S DEBILITATING MEDICAL CONDITION IN THE WRITTEN CERTIFICATION. (b) SIGN AND DATE THE WRITTEN CERTIFICATION ONLY IN THE COURSE OF A PHYSICIAN-PATIENT RELATIONSHIP AFTER THE PHYSICIAN HAS COMPLETED A FULL ASSESSMENT OF THE QUALIFYING PATIENT'S MEDICAL HISTORY”. This decision is to be made between the patient and his or her physician whatout any interference whatsoever by the state. What if a patient developes cancer, should a the one year restriction apply before treatment is rendered, of course not, that would be foolish, as it is in this case as well. I strongly urge that this language be removed from the final draft. It is simply another case of government overstepping its authority and would not stand up in court anyway.

The fees for patients and caregivers should be lowered for lower income people; like other states that

have implemented MMJ laws. We should reduce the fee for patients receiving SSI, SSDI, or Medicaid benefits. The regulation about the relationship a patient must have with their doctor is overly restrictive; much more so than ANY other states with MMJ laws, and may make it impossible for some veterans to qualify, because Veterans Administration Hospital doctors do not issue recommendations. The regulation requiring anyone on the board of a dispensary to have been an Arizona resident for two years is also anti-business. Persons from other states with current MMJ laws SHOULD be allowed to open dispensaries here so that Arizonans can benefit from their expertise. This regulation is also problematic: A dispensary may provide only 30% of its cultivated marijuana to other registered dispensaries and may acquire only 30% of its own marijuana supply from other registered dispensaries. This is very problematic and not in the best interests of patients, as it will likely create acute shortages in rural areas and drive costs up. Those patients within 25 miles of a rural dispensary unable to meet demand will have no secondary option for safe access to their medicine. Please create an open wholesale relationship between dispensaries. This will assure consistent supply to rural Arizona, easy access for all qualifying patients, and lower costs due to increased competition of organizations trying to meet demand. Also, the regulations concerning dispensary medical directors are overly restrictive, nurse-practioners and other similarly educated persons should be eligible for these positions. In addition, five years of record keeping seems overly burdensome, and if it included names and addresses, would likely violate the rules of patient confidentiality legistlated in HIPAA.
A dispensary may provide only 30% of its cultivated marijuana to other registered dispensaries and may acquire only 30% of its own marijuana supply from other registered dispensaries. This is very problematic and not in the best interests of patients, as it will likely create acute shortages in rural areas and drive costs up. Those patients within 25 miles of a rural dispensary unable to meet demand will have no secondary option for safe access to their medicine. Please submit comments asking DHS to create an open wholesale relationship between dispensaries. This will assure consistent supply to rural Arizona, easy access for all qualifying patients, and lower costs due to increased competition of organizations trying to meet demand. * A patient's Arizona physician must either 1) have been treating that patient for the debilitating medical condition for at least a year that included at least four visits, or 2) have taken primary responsibility for the care of the debilitating medical condition after compiling a medical history, conducting a comprehensive exam, and reviewing medical records. This provision is stricter than in most of the medical marijuana states, but does not appear designed to prevent a seriously ill patient with a demonstrable debilitating medical condition from getting a written certification. It may make it impossible for some veterans to qualify, because Veterans Administration Hospital doctors do not issue recommendations.
A patient must pay $150 each year for an identification card, and a designated caregiver, $200. There does not appear to be a sliding scale or lower cost card available for low-income patients, as most other states have. I suggest reducing the fee for patients receiving SSI, SSDI, or Medicaid benefits.
I have a few suggestions. There should be unlimited wholesale between dispensaries as to not cause a shortage in rural areas and as a result driving prices up. Also, I think the dr requirements might be just a little bit to strict. I see my dr about twice a year regarding my condition. There is no cure for my condition its something that I have to live to deal with and I have actually been living with it for 16 yrs, with periods of 5 yrs without any doctor care. It cant be cured, it cant be controlled, why should I waste my money on doctor visits? I do go twice a year, physical and 1 follow up per year on my condition. I cant take meds long term beause its an antibiotic which would eventually break my stomach down. Surgery removes the problem but has redevelped in 100% of cases! Last I wouldnt be a candidate for this but I feel like low income clients shouldnt have to pay the $200. There should be a prorated fee.
A patient must pay $150 each year for an identification card, and a designated caregiver, $200. There

does not appear to be a sliding scale or lower cost card available for low-income patients, as most other states have. We suggest reducing the fee for patients receiving SSI, SSDI, or Medicaid benefits. A dispensary may provide only 30% of its cultivated marijuana to other registered dispensaries and may acquire only 30% of its own marijuana supply from other registered dispensaries. This is very problematic and not in the best interests of patients, as it will likely create acute shortages in rural areas and drive costs up. Those patients within 25 miles of a rural dispensary unable to meet demand will have no secondary option for safe access to their medicine. Need to create an open wholesale relationship between dispensaries. This will assure consistent supply to rural Arizona, easy access for all qualifying patients, and lower costs due to increased competition of organizations trying to meet demand. A patient's Arizona physician must either 1) have been treating that patient for the debilitating medical condition for at least a year that included at least four visits, or 2) have taken primary responsibility for the care of the debilitating medical condition after compiling a medical history, conducting a comprehensive exam, and reviewing medical records. This provision is stricter than in most of the medical marijuana states, but does not appear designed to prevent a seriously ill patient with a demonstrable debilitating medical condition from getting a written certification. It may make it impossible for some veterans to qualify, because Veterans Administration Hospital doctors do not issue recommendations.This should be changed!
The rule that 70% of all dispensory product has to be grown by the dispensory is good except that for the first year while the dispensory begins the growing of the medical marijauna it will not be able to supply enough marijauna for all of its patients. A first year rule needs to let the dispensories obtain marijuana from other sources to be able to supply as needed until in house production can keep up with demand. After that first year the 70/30 rule will not be a problem unless a dispensory looses a crop due to unforseen events. Some flexability needs to be built in to let the department adjust to the unknown events that may plague dispensories due to lack of experience in this system of medical marijuana dispensing. The voters want medical marijuana to be available to properly approved patients and this system of rules needs to be flexable enough to address the needs of all properly approved patients.
- It will be VERY hard, if not impossible, for Veterans to get approved, because VA hospitals won't give them the record. The treatment requirement (a year or more, etc.) is prohibitive, especially for those who have put their lives on the line serving our country - The cost of the card is VERY prohibitive for those who are, let's face it, poor. I think that those on Medicaid or Medicare, and those with limited income, should be able to get a discount on the card at the very least if they can't have one for free. Look, I'm a student. I can't even afford $80 for a new pair of glasses, let alone a $150 card to get a prescription for glaucoma (which I thankfully don't have, but if I did, I'd be screwed). I'm not using my own example to be self-serving, I'm just trying to make a point that $150 is more than most people even get for their weekly unemployment benefit, and we still have a lot of folks unemployed. Basically, I think it needs to be easier for the poor and, especially, for Veterans to get the card.
I am a combat veteran of Operation Iraqi Freedom who suffers greatly from PTSD along with other physical disabilities. As a veteran I am under the healthcare of the VA, unfortunately for me and thousands of other veterans our doctors cannot legally recommend marijuana for any of our medical problems. I have discussed with my doctor numerous times about how much more effective marijuana is, compared to the multiple medications they've put me on. They understand this and support my decision to smoke in order to live some sort of normal life. The doctors who work for the VA are some of the best medical staff I have ever dealt with, but I know they have their hands tied with this law. Please find some kind of exception to the law for veterans...PLEASE!! Or at least help myself and fellow veterans in our fight to allow VA doctors to recommend/prescribe medical marijuana. Thank you for your time and consideration. God Bless America!
I,M A VIETNAM VETERAN, AND I USE THE VA FOR MY MEDICAL, THEY WILL NOT GIVE ME A PRESCRIPTION, FOR MEDICAL MARIAJUNA, SO WHAT DO I DO

I am unemployed and even with my Social Security payments I can't pay 150 dollars for a permit. Please look and make a cost around what it costs you to maintain the system. This will be costly initially but should fix itself over time. If you are trying to make this out as a drug for those who need it,then treat it so, don't put expensive costs on the user who may only be getting part of their medicinal needs taken care of and Medical Marijuana is not even available with the costs you intend to put on them and I'm sure the costs of the medication. Also, please don't tax Medical Marijuana, unless you tax regular medication, don't furthur push Medical Marijuana as an outcast drug. I would think the state would have the sheriffs and police who confiscate large quantities at great cost to taxpayers should turn this over to caregivers, not burn it as a terrible drug. This throws away a great amount of useful medicine.Note these is no know deaths associated with the use of Marijuana, less than that of aspirin and completely out of line with Alcohol and tobacco.
There does not appear to be a sliding scale or lower cost card available for low-income patients, as most other states have. We suggest reducing the fee for patients receiving SSI, SSDI, or Medicaid benefits. Those patients within 25 miles of a rural dispensary unable to meet demand will have no secondary option for safe access to their medicine. Please create an open wholesale relationship between dispensaries. This will assure consistent supply to rural Arizona, easy access for all qualifying patients, and lower costs due to increased competition of organizations trying to meet demand. Any physicians recommendation should suffice. It may make it impossible for some veterans to qualify, because Veterans Administration Hospital doctors do not issue
Imposing guidelines for all growers, making them care about the safety of their products. Filing of documents that prove they are using good guidelines in anything they produce. Showing a history of their business and how they are protecting the industry from bad feedback. Using labs like CW Analytical is the best and only safe way to better your business's.
The main area that really needs attention to is one; the area where it defines who is eligable for the prescription, there should be more situations and illnesses in there. Two; the time frame the patient doctor relationship which is in there seems a bit harsh when already many pain clinic doctors are already putting signs up stating they will not be prescribing for it, which is their choice, but then that leaves patients that feel that medical marijuana would be more benifitial to them and their health to have to try to find a new doctor that not only writes the prescriptions but that their insurance covers the doctors. Not to mention the patient then trying to get established with the new doctor under the time frame. Three; the time frame for patients to get thier approval and registration card should not be more then two weeks not up to 45 day. That really makes it hard for a lot of patients especially when they have exausted all other means of medical relief.
Why is there an annual fee of $150.00 to issue approval to fill a prescription? This is not required for any other script. Are we not encouraging a large portion of the qualifying patients who can't afford this Taxation to look elsewhere? This seems counter to our goal of eliminating the criminal element in the process.
Tighter regulations on growers, setting conditions that will create a cleaner more healthy grown product. Making all growers aware that production of a clean product is what the American business person is held accountable for in the food industry and so should it be imposed on them.
I think that 90 days can be a long time if a disponsory had any urgent reason to relocate. This would cause suffering patients an inconvenience that they sometimes can't afford, healthwise. In addition, the dispensories are generating no revenue and are unable to replenish their stock or maintain their crops.
Anyone with a medical marijuana card can grow 2 plants, anywhere.

1 ask for identification to many times. drivers license should be enough! way too long! 2 no finger prints. we are not criminals. 3 doctors should only state patent meets critera establish. should not comment as to benifit to condition. it will be hard enought to find a doctor willing to jepordise their position by recognmendation. 4 home growt should be the responsibility of patent a should be no more requlated then growing tomatoes, corn, ect. should not have to provide a lab condition for home growth! 5 sales at offices a commercial growth shall be reglated to quanites and purity. no insane relations to hold prices up. one of the best ideas for use is getting away from extragent costs of pain pills like oxycontin. 6 physcians should not be able to refuse treatment becuase they are against ligallization! should only determine wheather patent is a canadate.
R9-17-310 Medical Director. I do not feel that dispensaries need a so call "Medical Director" to oversee patients. The patients in question have a doctor and have the doctors approval to use M.M. The patient should see his doctor regularly and inform him of his condition and effects of the M.M. If the ADHS feels the need to distribute educational materials at every dispensary, that is fine, I do not think a "Medical Director" is needed for that. The Manager and agents should know the effects of M.M. and the different ways to use the product. I do not even know if there are qualified "Medical Directors" that know that much about M.M. and the different ways to use it. It looks to me like this is just another avenue someone thought up to "Pay" a so called "Medical Director" This is a waste of potential hard earned money. Again, the patient already should have a doctor...
the cost of the card and yearly fee, would cripple the effect for people on ssi and low income,i have been disabled for 9 years and recieve ssi ,to get away from the meds i take now and the damage it does to the human body,the mpp program would have great healthy results for me,but the cost alone would not allow me to be involved,low income living people r there not by choice, thanks for reading my statement [redacted]
I cant afford the fees as I am disabled with MS but have no job.....its a lot of money to me - a whole weeks groceries and I cant afford that. All that will happen is the black market will grow among the poor! Also I don't have any medical insurance so I cannot see this doctor you want times a year (and wait now another year until the dispensary is allowed to supply me) - neither do I have the funds to attend a doctor and have a $500 medical exam!.....welcome back to the black market hooray! So far I could have bought several months supply with the money I will save - incentive to address this problem properly?....or is the State of Arizona just in it for the money? A large amount of "foot-shooting" appears to be on the menu for AZ..... hmmmmmm.....
Fees for ID card are too high. Please consider a sliding scale for low-income patients. Allow dispensaries to obtain marijuana from other dispensaries as needed to meet demand, thus keeping prices low. Rules for medical qualification are too strict, for example Veterans cannot obtain recommendations for ongoing medical conditions from the VA. Either shorten the waiting period or eliminate it.
The price for the card should be on a sliding scale of some sort. Most people with conditions severe enough to need medical marijuana usually are unable to work full time, or at all. This provision is clearly in favor of those patients that have money and those who are poor are left to rot (as is usual in our country). This needs to be fixed so that those who are suffering are able to afford their medicine.
* A patient must pay $150 each year for an identification card, and a designated caregiver, $200. There does not appear to be a sliding scale or lower cost card available for low-income patients, as most other states have. We suggest reducing the fee for patients receiving SSI, SSDI, or Medicaid benefits. * A dispensary may provide only 30% of its cultivated marijuana to other registered dispensaries and may acquire only 30% of its own marijuana supply from other registered dispensaries. This is very problematic and not in the best interests of patients, as it will likely create acute shortages in rural areas

and drive costs up. Those patients within 25 miles of a rural dispensary unable to meet demand will have no secondary option for safe access to their medicine. Please submit comments asking DHS to create an open wholesale relationship between dispensaries. This will assure consistent supply to rural Arizona, easy access for all qualifying patients, and lower costs due to increased competition of organizations trying to meet demand. * A patient's Arizona physician must either 1) have been treating that patient for the debilitating medical condition for at least a year that included at least four visits, or 2) have taken primary responsibility for the care of the debilitating medical condition after compiling a medical history, conducting a comprehensive exam, and reviewing medical records. This provision is stricter than in most of the medical marijuana states, but does not appear designed to prevent a seriously ill patient with a demonstrable debilitating medical condition from getting a written certification. It may make it impossible for some veterans to qualify, because Veterans Administration Hospital doctors do not issue recommendations.
Further Elaboration on on going treatment that may qualify one to participate in the program.
Lower fees the patients Totally remove the weird rules about doctors and patients relationships. Trying to keep as many patients away from their medicine will no doubt end up as court a court case. Some patient group will be suing the AZHS. for denying patients their medicine.
My doctor also says he can't recommend medical marijuana due to his clinic's policies. I can't afford to change doctors due to transportaion costs, due to losing my medical coverage, due to my doctor's expertise. Don't make me see another doctor as my primary physician.
1. Are the fingerprinting cards issued by the Department of Health going to be unique, or will standard FBI fingerprint cards be sufficient? 2. How many copies of the application will need ro be submitted initially? 3. What is the criteria for the issuing of dispensary licences?
I find many aspects of these rules interesting and I'll provide a few thoughts. 1. I just find it interesting that we are speaking of MEDICAL marijuana to treat/alleviate medical symptoms yet we are setting up a whole new way of dispensing these agents. There is already a whole system with associated rules/ regulations / safeguards / licensing etc. for dispensing drugs – but for some reason these will not suffice. Rather we are setting up an alternate method for only this "medication". This alternate method requires an owner / employee of a dispensary to pay $5,000, attest to not being a felon, not owe back taxes or be delinquent to government loans etc. – but no educational requirements, degrees, medical degree of any sort etc. I just find that very interesting. 2. As well when a prescription for a drug is dispensed there are laws that mandate what information is required on the label. As well under these proposed rules there are requirements but the requirements differ greatly from what other drugs must have on a label. They should consider at least having the patient NAME (plus registry number), and some directions as how it is to be smoked, consumed etc.
Having the board actually understand what medical marijuana is & does. It is very clear by their comments they do not understand the benefits and misstate the negatives. It is practically IMPOSSIBLE to overdose on marijuana. You technically CAN do it, but it takes MANY POUNDS to do so. They also need to let law enforcement handle any DWI incidents. Just as with many prescriptions, you should not drive while you take them and will be punished if you do. There are dozens of prescription pain medications that are FAR worse for you than medical marijuana will be.

When new people move to Arizona, they cannot wait a YEAR to get medicine. What are you thinking?
The out door growing thing baffles me, you can grow in a closet with a padlock, or a shed with tin walls and a roof using a light, but need a 12' wall and 1" metal gate to grow with the sun. I guess we should ask the AG's office to see how many employees at the department of health have stock in APS.
As a doctor, I firmly believe that marijuana for medical use should never be dispensed in a form that can be smoked. Marijuana can be made into capsules or suppositories or cooked into food, but marijuana smoke contains dozens of carcinogens. Preliminary research shows that smoking marijuana can increase the risk for respiratory problems and several types of cancer–lung, head and neck, testicular and bladder. This post reviews some of the research. The medical profession and others in public health have made a huge effort for several decades to eliminate the smoking of tobacco because it's such a serious health hazard, and doctors should not recommend any substance to be smoked. Following the adage, "First, do no harm," doctors should always prescribe medications by the least harmful route of administration. And, in fact, we always try to give medications orally. For people whose illness makes it hard to take a pill or to keep one down, we have skin patches and suppositories. The last resort is injecting medicine. But there is no precedent for a medication that is smoked. To my knowledge, there is no medicine prescribed today that is smoked, and for good reason. Smoking any plant material causes cancer and lung damage. And there is no need for a medication that is smoked; there is nothing that smoking accomplishes from a medical point of view that can't be accomplished by safer routes of administration. Arizona should forbid the dispensing of medical marijuana in any form that can be easily smoked. Here's some of the research on problems caused by smoking: Research has shown that marijuana smokers have several respiratory tract changes including lesions that are considered pre-cancerous. So far there is no evidence of emphysema, but smoking marijuana does cause problems with airflow obstruction. There are a small number of studies of cancer in marijuana smokers, some positive, some negative. Negative studies are quite common in research, and all they mean is this particular study did not find this particular result. Negative studies are not proof unless it happens repeatedly and there are no positive studies. However, many pro-marijuana websites and media outlets have taken a single negative study and claimed marijuana does not cause cancer. There are also articles designed to look scientific that make this claim. This is an incorrect reading of the research. Two studies did show no increase in cancer in marijuana users, but both studies have been criticized for bias. One large study (Tashkin 2006) of 1200 people with head, neck and lung cancer showed no increase in cancer in marijuana smokers. Tashkin was the same researcher who had previously found that marijuana caused pre-cancerous changes in the respiratory tract, so he was surprised to find no increased cancer risk. That large study has been criticized for selection bias—marijuana users in the control group were more likely to also smoke cigarette than the marijuana users in the group with cancer. The authors admitted selection bias possibly explained their negative findings. One other study published in the American Journal of Public Health in 1997 (Sidney et al) that found marijuana smokers had no increase in cancer has been criticized for using subjects who were too young, so cancers would not have had time to develop. There are several research studies showing increased cancer rates in marijuana smokers. A New Zealand study published in the European Respiratory Journal in 2008 looked at 79 patients with lung cancer and found the risk of lung cancer increased by 8 percent for every joint-year (averaging one joint daily for one year) and 7 percent for every pack-year (averaging one pack of cigarettes daily for one year), leading them to conclude that smoking marijuana posed the same lung cancer risk as smoking cigarettes. Three North African case studies showed a very strong link between marijuana smoking and lung cancer, but none of these studies controlled for tobacco use, so these results are questionable. A 2009 study done at the Fred Hutchinson Cancer Research Center in Seattle and published in the journal Cancer found that men who smoked marijuana once a week had twice the risk of testicular cancer when compared to men who never used marijuana, and marijuana was most strongly linked to nonseminoma, the most aggressive form of testicular cancer.

Research published in the journal Urology in 2006 showed increased rates of bladder cancer in marijuana smokers. They also found that marijuana-smoking patients were younger at the time of diagnosis than most patients with bladder cancer. Cigarette smoking is a major risk factor for bladder cancer, but the researchers concluded that smoking marijuana may be as bad or worse than cigarette smoking as a risk factor for bladder cancer. In 1999, a study published in the journal Cancer Epidemiology found that squamous cell carcinoma of the head and neck increased with marijuana use and there was a strong dose-response curve, the heavier marijuana users had higher rates of cancer. However, in 2004, another study published in Cancer Research found no association between marijuana use and squamous cell carcinoma. This is not a complete list of studies, and there aren't many. So it is not enough to draw definitive conclusions on marijuana and cancer. However, the evidence that smoking marijuana is linked to cancer is far more substantial than the research supporting marijuana as treatment for many of the disorders listed in Arizona's new medical marijuana law. Also, remember, it took decades of heavy tobacco use by large swaths of the population before we had a definitive link between tobacco smoking and cancer. On several pro-marijuana websites I found the claim that there is no direct evidence linking marijuana smoking to lung cancer in humans. That is exactly what the tobacco industry said for decades after the first studies came out linking cigarette smoking with lung cancer. What they said was technically true; until recently we did not know for certain the exact mechanism by which smoking caused cancer. However, the statistical evidence was overwhelming, so the tobacco industry was being completely disingenuous and so are the pro-marijuana groups who say marijuana doesn't cause cancer. Anyone who claims that marijuana does not cause cancer is ignoring the research. Also, in November 2010 an article printed in the European Journal of Immunology described a possible mechanism by which smoking marijuana causes cancer and the research supporting this possible mechanism. If further studies support these findings, then we will have direct evidence linking marijuana smoking to cancer in humans. Anyone who goes on the internet will find the pro-marijuana groups misrepresenting research. What they almost always do is take one study or one bit of information and run with it as if that were the whole story. That's how Arizona ended up with a law that says marijuana is good for glaucoma even though the Glaucoma Foundation warns patients not to use marijuana because it could make their symptoms worse. The American Cancer Society points out on its website that it's hard to study marijuana and cancer because so many marijuana users also smoke cigarettes and because it's hard to study illegal drugs. British cancer researchers noted the same problem. However, one part of the research is very clear. We know for certain that marijuana smoke contains many of the same carcinogens as tobacco smoke, produces more tar than tobacco, and that the way people smoke marijuana (down to the roach, unfiltered, inhaling deeply, holding it in) delivers more tar to the lungs than the way people smoke tobacco. California's Office of Environmental Health Hazard Assessment ruled in 2009 that marijuana smoke is carcinogenic. They are not calling the marijuana plant a carcinogen, just the smoke. That seems right; the research shows a link between smoking marijuana and several types of cancer also commonly caused by smoking tobacco. There is no evidence that ingesting marijuana by other methods causes cancer. Smoking marijuana is also linked to respiratory problems. Research shows that marijuana smokers have decreased respiratory function, increased airflow obstruction, and fewer of the anti-oxidants that protect against cancer and heart disease. In summary, smoking marijuana has been implicated in several health problems including cancer. Not definitively, but enough evidence to make it likely. So no doctor should be recommending marijuana in a form that can be smoked. And states with medical marijuana laws, including Arizona, should not allow such a potentially dangerous route of administration. Marijuana can be mixed into food, formed into a suppository, or cooked in vegetable oil or butter and put into a capsule. Dispensaries should only be allowed to dispense marijuana in these forms, and they should not be allowed to sell marijuana in a form that can be smoked. Marijuana users have responded to the harm of smoking by developing vaporizers so they can continue to inhale cannabinoids without the dangers of smoking. However, the reason for vaporizing marijuana is still to get a quick high, just like smoking it. It still offers no medical advantage over taking cannabis orally or rectally, and it allows marijuana to be dispensed in the same form that can be smoked, allowing diversion. Besides, the vaporized product has not, to my knowledge, been tested for carcinogens. I also suggest a rule against transporting

marijuana in its raw form. This will help to distinguish recreational from medicinal use. It will also help law enforcement because, in other states with medical marijuana laws, it is a common practice for drug dealers to get marijuana cards so they can claim the marijuana they are carrying around is for medical use. Most of all, though, I ask DHS please do not put doctors in the position where they are recommending a likely carcinogen, a smoked drug, if they decide to recommend marijuana to their patients. The marijuana users who sponsored this law in the hope of surreptitiously legalizing recreational marijuana will come up with all sorts of reasons that marijuana should be dispensed in its raw, easily-smoked form. I know how convincing the stories of some of my substance abusing patients can be, but please do not believe them. And if you do find yourselves believing them, then at least let's try for one year with a rule that marijuana cannot be dispensed in it's raw form or any form that can be easily smoked. And after a year we can assess the situation and see if anyone with genuine medical need was really harmed by such a regulation. I quote a lot of research in my discussion here. You can find links to all the research at my website, [redacted]

However, there should be an exception when an oncologist recommends marijuana for a patient receiving cancer chemotherapy who has already tried at least two anti-nausea or appetite stimulating drugs with no success. The 4 visit rule should still apply to oncologists, since there are several conventional anti-nausea drugs that should be tried first, but the one year rule might be too long for a patient referred to an oncologist when the cancer is already advanced. But that is the only exception I'd suggest. And the oncologist should be required to document that he or she is an oncologist, that the patient has laboratory- or radiolgically-proven cancer, that the patient is receiving chemotherapy, and that two conventional medications for the symptoms were tried and failed. [redacted]

Section 36.2801.01 you need to include a amendment that includes othropedic injuries. I was a Navy Seal many years ago and have two herniated disks in my back L-4 & L-5 from parachute jumps. Also I recently had a motorcycle accident on March 14th, 2010. So conciquently I have lots of titianium in my left shoulder with a multiple fracture of my left humerous and right radial neck. I will have chronic pain for the rest of my llife, just will have to deal with it. I can get all the vicodin and percocet I want, but don't want to go that route, would rather just take a couple of hits when my pain acts up and call it a day. I don't like taking pharmacuticals and the state could make some money instead of giving it to the pharmacutical compainies? My Fiance' also has Lumbar issues with documented MRI studies and would benefit from Medicinal Marajuana instead of doing pain killers, less destructive on your liver. I'm in the medical field my whole life and would like to see the draft ammended to included severe othropedic injuries, which I see MS is included?

No comment.

What do have against medical marijuana patients? These parts of the draft rules are all wrong. You don't want them on the board of directors of dispensaries. These are the very people who should be on the board. In New Mexico dispensaries must have on their boards a patient and a medical professional You don't want them to be principle officers of dispensaries. Why not? They're the ones affected by how a dispensary is run. You charge them an outrageous $150 just to be able to go buy their medicine. Why don't you just charge $150 for people to go to Walgreens? You insist patients have to see the same doctor for a year. And what if he's not educated enough about medical marijuana to be able to recommend it. What if he says you should see a specialist who knows about marijuana. I know my primary doctor says he doesn't know enough about it one way or the other so he won't be recommending it any time soon.

Remove the 25 mile distance from a dispensary and allow true patients that can't afford the high dispensary price the right to grow their own and lower the distance to 10 miles.

The aim of Proposition 203 is to provide marijuana for the medical treatment of debilitating medical conditions. However, in other states with similar laws, most of the marijuana has been recommended and given to people who did not have a genuine medical need, but were pretending to have serious illness in order to obtain legal marijuana for recreational use. This is a well-known problem with other drugs of abuse that also have both medical and recreational uses. So the purpose of my suggested regulations is to provide marijuana to people with a genuine medical need while screening out people who are only interested in using marijuana recreationally. I also want to make sure the regulations are not too burdensome for patients with genuine medical need or for their physicians. In other states, the two biggest loopholes that divert medical marijuana to recreational use are doctors who go into the business of recommending marijuana to anyone who wants it, and diagnoses that are easy to fake, particularly severe and chronic pain. I like the proposed rule that patients must have seen the recommending doctor at least 4 times and known him for at least one year. However, I did not see anyplace that this is enforced. There is another rule DHS could adopt that would eliminate the possibility of doctors setting up practices of just writing marijuana cards. Doctors who are permitted to prescribe buprenorphine to opiate addicts are limited to having 30 active buprenorphine patients at a time. Buprenorphine is a potent opiate similar to methadone, used in the same ways. A 30-patient limit will prevent doctors from earning a living by handing out marijuana recommendations, but should not be a problem for legitimate doctors. I notice that in all of the proposed rules, there is no section or article about what the recommending doctors must do, except the documentation they provide to the patient. As a doctor, I like that; it's a law that does not give us extra paperwork or administrative responsibilities. However, certain ones are necessary to make sure doctors cannot abuse their authority to write medical marijuana recommendations. I am writing to suggest several changes, but the most important one is the limit of 30 active marijuana patients for each doctor. Limiting the number of active marijuana patients will go a long way to preventing drug abuse and abuse of the law by unscrupulous physicians. This should not be a problem for legitimate doctors who are only recommending marijuana to patients who need it. Marijuana is not a first line medication for any problem, so legitimate doctors will not recommend it often. There should also be some system for registering doctors who will recommend medical marijuana. It should be very simple so it won't be a problem for the doctor who only recommends it once a year or less. This would be just like the requirement that doctors get a DEA certificate before prescribing scheduled medications like benzodiazepines, narcotics and stimulants. It's no problem to get a DEA certificate, but doctors have to do it to write prescriptions for scheduled drugs. Also, if doctors abuse their prescription privileges, revoking the DEA certificate gives the DEA some control over the doctor. There should also be a way for DHS to revoke a physician's medical marijuana registration if it is abused. Here are my rationales for each of the number language recommendations made below. 1. This should be a simple process, otherwise it discourages doctors who might only recommend the drug a few times. Doctors should be able to call a number at DHS and then receive a letter or fax saying they are registered. DHS should require the doctor's name, degree, office address, phone and fax numbers, and any specialties or subspecialties, even if they are not board-certified in the specialty. When a doctor receives a registry with DHS as a recommending physician, it should be accompanied by a description of what is required of the doctor, so they know the law. 2. The record requirements are similar to the requirements for buprenorphine. DHS should look at what is required for buprenorphine and devise a simple form for doctors to use and keep as part of their office record. This is not an onerous requirement as all the information is in the patient's chart anyway, and so they just have to keep a list of patients currently using marijuana medically. 3. I previously made suggestions to be included in R9-17-205 as to when a doctor can have a card revoked, so I also included them here. This section is similar to the rule with stimulants which are Schedule II drugs. Prescriptions for stimulants, used for ADHD, are only good for 60 days, so usually the patient must be seen every two

months. Some doctors simply write prescriptions every two months and just let the patients pick them up, but ADHD is not a debilitating medical condition. Anyone with a genuinely debilitating medical condition will be seeing their doctor that often anyway, and it will not pose a hardship to have to see the doctor every 3 months. 4. This is identical to the rule the DEA has for buprenorphine. Thirty should be plenty for all legitimate doctors. The only people this rule will pose a hardship for are doctors who want to earn a living handing out marijuana recommendations, and those are the people we want to stop. This is the most important recommendation in this list. 5. Second opinions are used in medicine to prevent inappropriate prescriptions. They are most commonly used when surgery is prescribed, and the use of second opinions has prevented a lot of unnecessary and inappropriate surgery. However, the state of New Mexico uses second opinions as part of its medical marijuana law for certain diagnoses. Second opinions are useful in medical marijuana laws when the disorder has only subjective symptoms and is easily faked, like pain. It's a good way to make sure the patient really has the diagnosis and really needs medical marijuana. And what they found in the surgical field is that doctors started being much more careful about how and when they suggested surgery because they knew there might be a second opinion. So the second opinions don't actually get used that much and the seconding doctor rarely says no, but the first doctors are more appropriate in their recommendations just knowing there might be a second opinion. If DHS adopts second opinions, you could have a managed care company administer this part of the program. Pain specialists are not usually specialists in the underlying illness. For example, if someone has a musculoskeletal pain, for a second opinion they should see an orthopedist or specialist in osteopathic manipulation, not a pain specialist. 6. Section e will not be necessary if the much stronger requirement already proposed by DHS that patients must be treated by the doctor for one year with at least 4 visits stands.

The requirement for a dispensary to produce seventy percent of its product should be deleted to avoid driving the price to patients too high.

The doctor who writes a medical marijuana recommendation should be able to revoke a patient's card for a number of reasons. This is the case with all other prescriptions and should be the case with medical marijuana as well. Especially with addictive drugs and drugs of abuse, doctors often find it necessary to cancel a prescription, cancel refills or stop giving a patient a medicine they had previously prescribed. Could you imagine if the only way to prescribe Oxycontin or Xanax were to allow someone to use the maximum dose for a year? Doctors should have the same control over medical marijuana recommendations that they have over all other prescriptions. Prescriptions for Schedule II stimulants such as Ritalin (methylphenidate) and Adderall (amphetamine salts) can only be given for 60 days. Patients must get a new prescription every 2 months, and that usually means seeing the doctor every 2 months. We should have a similar rule with medical marijuana. Although it is legal to write a benzodiazepine prescription with a year's worth of refills, no one I know does it. In New York, benzodiazepines can't be refilled without getting another prescription, so the patient must see the doctor often. Many states have had similar laws with narcotic pain medications, requiring frequent visits to the doctor. It's important for doctors to be able to control drugs that are addictive or frequently abused, and we should have similar rules with medical marijuana.

The aim of Proposition 203 is to provide marijuana for the medical treatment of debilitating medical conditions, and DHS should work to fulfill that aim. However, in other states with similar laws, most of the marijuana has been recommended and given to people who did not have a genuine medical need, but were pretending to have serious illness in order to obtain legal marijuana for recreational use. This is a well-known problem with other drugs of abuse that also have both medical and recreational uses. So the purpose of my suggested regulations is to provide marijuana to people with a genuine medical need while screening out people who are only interested in using marijuana recreationally. I also want to make sure the regulations are not too burdensome for patients with genuine medical need or for their physicians. In other states, the two biggest loopholes that divert medical marijuana to recreational use are doctors who go into the business of recommending marijuana to anyone who wants it, and

diagnoses that are easy to fake, particularly severe and chronic pain. The regulations I suggest are already in use with other medications and can easily be applied to medical marijuana. These are regulations used to control scheduled medications that are commonly abused and to make sure standard or conventional treatments are used before controversial or experimental ones. Three such regulations used for other medicines are: 1) Prescriptions for Schedule II stimulants such as Ritalin (methylphenidate) and Adderall (amphetamine salts) can only be given for 60 days. Patients must get a new prescription every 2 months, and that usually means seeing the doctor every 2 months. This should not be a hardship for the seriously ill, who are usually seeing their doctors regularly anyway. New York state has imposed a similar rule for benzodiazepines, and some states have had similar rules for the more powerful narcotic pain medicines. 2) Managed care companies often require that standard medications be tried for a particular illness or symptom first, and medications that are not standard treatment can only be used if the doctor documents that the standard medications did not work. Often the aim is to make patients try less expensive generics first, but some companies are now using this type of regulation to make sure standard treatments are tried first. This includes Cenpatico, a managed care firm that has contracts with the state of Arizona. DHS might want to consider contracting with a managed care firm to administer parts of the medical marijuana program. 3) Second opinions are used in medicine to prevent inappropriate prescriptions. They are most commonly used when surgery is prescribed, and the use of second opinions has prevented a lot of unnecessary and inappropriate surgery. However, the state of New Mexico uses second opinions as part of its medical marijuana law for certain diagnoses. Second opinions are useful in medical marijuana laws when the disorder has only subjective symptoms and is easily faked, like pain. I suggest that Article 2, R9-17-201 be rewritten to include further restrictions. There should be restrictions on when marijuana may be recommended for each medical condition. Marijuana should be prescribed for a specific reason, not just because the person has an allowed illness. Also, marijuana should never be a first line drug, and should only be used when standard medicines have failed. The problem is that medication failures are often simply reported to the physician by the patient. I will often fill out a prior authorization form saying the patient has tried and failed on medicines he received from other doctors. I simply take the patient's word. That will not work with a drug of abuse because patients who want the drug for recreational use have a strong motivation to misinform the doctor. For example, doctors are very suspicious of patients who claim that non-steroidal anti-inflammatory drugs don't work and that they must have narcotics. That is why I include that documentation of medication failures must always be written by the doctor prescribing the failed treatment. The American Glaucoma Society recommends against marijuana for glaucoma as it can make the condition worse, so it should only be used under extreme circumstances. This should only be done by a qualified ophthalmologist. Doctors should be careful about recommending marijuana to HIV positive patients as it is known to suppress the immune system and there is some evidence that marijuana can hasten the development of Kaposi's sarcoma. It should not be a first line drug. Regarding Hepatits C, marijuana has been shown to increase liver fibrosis and decrease immune function, making it a risky drug for patients with liver disease. Also, hepatitis C is commonly associated with substance abuse, and substance abusers will be more likely to ask for marijuana because they are drug abusers and not because they have symptoms. Additionally, substance abusers are more likely to use marijuana heavily, and heavy marijuana use is associated with higher rates of liver fibrosis and faster progression of the illness. So marijuana poses definite risks to patients with liver disease. Marijuana can help with nausea and vomiting, which are side effects of anti-viral treatment with interferon. However, since the only evidence for marijuana helping patients with Hepatitis C is for the side effects of interferon treatment, it should only be used while the patient is receiving interferon. Regarding Amyotrophic lateral sclerosis, very preliminary evidence suggests that marijuana might help with several symptoms and possibly even delay the progression of the disease. However, the diagnosis should be clear before marijuana is recommended. The sort of requirements I am suggesting for each diagnosis are the type of checks often run by managed care firms. A managed care firm would be able to administer this, and if you institute these requirements I suggest using a managed care firm. I have made several suggestions based on research I have looked at. If you need more information, please contact me at [redacted].

The first thing you can do.... Is lower the prices you plan to start charge the MMP's for access to this services. How you going to charge someone to purchase medicine. The only thing you will need is thier current state issued ID, after a paintent Register. This could save 3 billion dollar over the life (10 years) of this program. One data base with muiltples access points to access the database, that will save 3 million dollars in start-up cost. I will be glad to demostrate any and all cost cutting measures to implement this program to the Director. This is what the price should be for this program; R9-17-102. Fees An applicant submitting an application to the Department shall submit the following nonrefundable fees: 1. For registration of a dispensary, $2,000; 2. To renew the registration of a dispensary, $375; 3. To change the location of a dispensary, $50; 4. To change the location of a dispensary's cultivation site, $50; 5. For a registry identification card for a: a. Qualifying patient; $25; b. Designated caregiver, $25; and c. Dispensary agent, $50; 6. For renewing a registry identification card for a a. Qualifying patient, $50; b. Designated caregiver, $50; and c. Dispensary agent, $50; 7. For amending or changing a registry identification card, $5; and 8. For requesting a replacement registry identification card, $5. These are the price we want to see changed for the best!!! We are the paintents and caregiver until the people can move on. We can help them, by trying to care for them as paintents.

Any patient should be able to cultivate marijauna for medical use no matter how far the distance from a despensary. Despensarys are ok for patients who are able to pay for the medcine but some patients may go with out it because of the cost.

When holding hearings on suggested new conditions, I hope you make it possible for anyone to also submit testimony in writing without attending the hearing. I also notice that the law provides no way to rescind a medical condition. This is necessary in case it is found that patients with one of the approved diagnoses are significantly harmed by marijuana. For example, for many years medical marijuana advocates have been claiming that glaucoma patients can be helped by marijuana. However, the Glaucoma Foundation, the American Glaucoma Society and the American Academy of Ophthalmology have recently recommended that patients with glaucoma not use marijuana as it can make their condition worse. It is very possible that as evidence mounts, ophthalmologists will ask that this indication be removed from the medical marijuana law as it is inappropriate to have harmful practices enshrined in state law as if they were good medicine. Also, it is possible that some day the whole process will be abused and a really bad use will be approved, and we would need a way to rescind that.

Simplify the process. We're not selling nuclear weapons we're selling pain relief to patients. The 13 point medical ailments you list as qualified conditions acceptable for medical marijuana is grossly understated. Everyday a new efficacy is being found for this herbal remedy and its lack of toxicity has been demonstrated over and over ad infinitum. Your draft rules ignore the positive advances in a myriad of new medical conditions and make it onerous to ask for a new condition be approved. Further, the cost to the patients for a state card is exorbitant and borderlines profiteering by your State.

Having a physician see a patient for at least a year at least 4 times and having that the only doctor who can recommend marijuana is unfair in so many scenarios. 1.Someone who hasn't seen a doctor in along time, gets cancer, starts chemo but can't use marijuana because he hasn't seen the doctor for a full year yet? 2.Someones primary doctor, who they've gone to for years, refuses to recommend marijuana because he voted against it. Don't understand it, don't want to understand it. 3. Someone, LIKE ME, goes to the same doctor for years and this doctor agrees with and understands medical marijuana. He believes it helps me, says he's seen the difference. He even voted for it but he doesn't understand the laws. He hears its against Federal law but within Arizona law. He says he won't recommend it, because he's afraid it will somehow get him in trouble. So, he says to me, "Here's your

medical records, go find another doctor to recommend it and let me know who that doctor is so I can suggest him to my other patients" These strict restrictions concerning 4 doctor visits over a year will make it hard and even impossible for some patients to get their medical marijuana. We as patients want safe, affordable access to our medicine. Is that to much to ask for? William Humble spoke out against Medical Marijuana during the election. Is he now trying to make this system so complicated as to punish as many marijuana patients as possible?

They need to address, if not reward, sustainability in the cultivation, production, processing and distribution of the plants.

We beleive cost should be be lower for this Pro 203. Cost should start at half of the listed cost in this draft. Some paintents will have to travel long distances to get their medicins, and this will add to cost for the paintents. The government should not be making money, after they have refused to provide these services to AZ paintents. It should not cost more that $25.00 for paintents to register. It should not cost more than $2,000 for a despensry. This should be a help for paintent, and not a piggy bank for the government. Kepp the cost down for people to afford their medicine. R9-17-102. Fees An applicant submitting an application to the Department shall submit the following nonrefundable fees: 1. For registration of a dispensary, $2,000; 2. To renew the registration of a dispensary, $5000; 3. To change the location of a dispensary, $1,000; 4. To change the location of a dispensary's cultivation site, $500; 5. For a registry identification card for a: a. Qualifying patient; $25; b. Designated caregiver, $50; and c. Dispensary agent, $200; 6. For renewing a registry identification card for a a. Qualifying patient, $25; b. Designated caregiver, $25; and c. Dispensary agent, $25; 7. For amending or changing a registry identification card, $5; and 8. For requesting a replacement registry identification card, $5. These fee are more inline with paintents traking to get their medicine... We would like to see these changes in the draft and finial plan of the Pro 203... This is what the people want today!!!!

Change what I said above

We understand and the patients we represent are under the impression that it will take a full year for a patient to receive a recommendation. We have also read the alternative and find that it could be problematic. If the physician assumes primary responsibility for the debilitating medical condition, it is our position that a recommendation will be easier to obtain for a chronic pain condition then it is for a cancer or an ALS condition. In assumption, a physician would be willing to assume the responsibility for chronic pain and not for the more serious conditions such as cancer or ALS. This will put the extremely sick and the "time is of the essence" patients without an outlet for medical marijuana and possibly force them into the black market which this voter approved law was meant to avoid. In fact, many issues that you have proposed will increase the costs of the medicine which will force patients back into the black market and increasing cartel activity. In regards to possible violation of the law and the intended proposition, we are of the belief that surveillance of all dispensaries will violate the Health Insurance Portability and Accountability Act (HIPAA) privacy rules in regards to specifically what information is protected. The law states the following information about what information is protected.
* Information your doctors, nurses, and other health care providers put in your medical record * Conversations your doctor has about your care or treatment with nurses and others * Information about you in your health insurer’s computer system * Billing information about you at your clinic
* Most other health information about you held by those who must follow these laws I would like to hear you expand on why surveillance in your proposal does not violate these laws. Essentially you would have to redact the video of any patient that enters a dispensary since a medical director is necessary. Furthermore proposition 203 states the following. H. REGISTERED NONPROFIT MEDICAL MARIJUANA DISPENSARIES ARE SUBJECT TO REASONABLE INSPECTION BY THE DEPARTMENT. THE DEPARTMENT SHALL GIVE REASONABLE NOTICE OF AN INSPECTION UNDER THIS SUBSECTION. Your accessibility to a live feed of the dispensaries day to day operations would be considered an inspection of the dispensary and the timeliness would hardly be considered reasonable. In regards to

the 70% rule. We feel that the proposition has provided for multiple channels of inventory such as cultivation, patients, and caregivers. Putting a percentage requirement on the inventory circumvents the propositions intent and would require a three quarters majority of the legislature to enact. The organization we represent has had multiple discussions and cannot even fathom a reason why this was put into the draft. Requiring a retail dispensary to cultivate the majority of the medicine helps no one. The only possibility is that it is a political football aimed to torpedo the industry. The industry is designed to help the patient provide safe access to medicine. Forcing a dispensary to sell its products when other dispensaries, patients, and caregivers have superior products will never help the patients receive better and more advanced medicine. Please do some research on the main medicine in marijuana, cannabidiol (CBD). We took this directly from the Wikipedia article on cannabidiol. Medically, Cannabidiol has been shown to relieve convulsion, inflammation, anxiety, and nausea, as well as inhibit cancer cell growth. Recent studies have shown cannabidiol to be as effective as atypical antipsychotics in treating schizophrenia. Studies have also shown that it may relieve symptoms of dystonia. Without the ability to get to that substance which inhibits cancer cell growth, this medicine will never make it through federal approval. We know that Marinol, the synthetic marijuana has does not contain the proper CBD compounds and thus is not viable alternative. Sativex, which is the only pharmaceutical product that is a true derivative of marijuana has been approved in 5 countries. The knowledge gained by cultivation, plant genetics and sales operation will be vital to the research needed to further the medicinal usages of this drug. Please remove any cultivation requirements and allow free trade so that high CBD strains will be readily accessible to patients.
I'm confused by the following in regards to a dispensary agent's application. The draft say one of the following is required: A copy of the dispensary agent's: a Arizona driver's license issued after October 1, 1996; b. Arizona identification card issued after October 1, 1996; c. Arizona registry identification card; d. Photograph page in the dispensary agent's U.S. passport; or Does this mean an agent needs to be a resident of Arizona or a citizen of the U.S.? What if the applicant is a permanent resident alien with a Green Card who is a resident of another state. Could the Green Card with a picture also be used for identification purposes or would the person in this example be rejected?
Currently, the draft states that all Dispensary Agent's must be residents of Arizona. Because all dispensaries starting up in Arizona will be new businesses it would make sense to bring in experienced help from other states who already have established businesses. Growing quality medicinal marijuana takes skill and practice. I like that dispensaries must be owned by established residents of Arizona, but I believe the owner's should be able to hire experienced medical marijuana horticulturists to manage the growing operation and you can only find experienced growers out of state.
Charge patients less for MM card $150/year is too high. Dispensaries should have to provide some % of what they sell but 70% is way to high. Would a contract with people strickly invovled in growing count as a dispensaries own supply? Cameras in the growing areas is very invasive and for 6 of the 9 week growing cycle there will only be 12 of light per day, would that mean we would have to provide infared cameras which seems unnessesary and expnsive. I'm all for security cameras in the dispensary for security but don't see any practical use for them at grow sites which will have thier own security systems.
I would like to see that only ONE GROUP of Dispensary Requestors be granted on One License.
Clarify the selection process for dispensary licenses asap. Chicken or egg question: isn't it better to acquire a license & then get a location versus securing a location in the hope of receiving a license? The

work & expense required to secure a location is significant, especially if no license is subsequently granted.

1. Reg 303 should be revised to clarify whether the certificate can be conveyed when the dispensary itself is sold. It says that the dispensary cannot assign its own certificate. That's fine, but what if the dispensary operator wants to transfer his whole operation (lease, inventory, employees, equipment, and the certificate)? The very hard distinction you need to draw is between "mere changes in directors or other principals" (as when one partner drops out of a six-partner dispensary) and when a change in control equals "assignment or transfer" (as when six of six, or five of six, partners change). The "sale" of a whole dispensary should hit the Department's radar screen before the annual renewal application comes in, specifying a whole new slate of officers/directors. Perhaps there should be a mandatory informational filing upon any change in control. More generally, the regs should specify what happens when a dispensary chooses to go out of business for some voluntary reason. Is it processed as a "renewal"--merely with different principals, or can the dispensary be overtly transferred, or does the certificate go back into the hopper to be issued anew to some qualified applicant? Any ambiguity left open by the regs will be exploited, I guarantee. 2. The renewal application in reg 305 does not require a certifcation of continued compliance with local zoning. This could become an issue because some cities (Phoenix) are requiring annual use permits for dispensaries. Thus, a dispensary that complies with zoning upon initial certification could nonetheless stop complying with local zoning later on. That lack of compliance with local zoning should, at a minimum, be a reason for non renewal. 3. A huge legal issue is going to be the degree to which a certiciate holder has some sort of "vested right" in renewal, so long as the dispenary is free of violations. The statute (36-2804.06C) says that renewals "shall" be issued unless the certificate has been revoked or is suspended. The regs would prevent lawsuits and confusion if they clarified more exactly where things will stand when someone is up for renewal. In particular, why do the regs not use the term "suspension" as the statute envisions? I imagine something like a provisional/probationary license--a certificate holder could be placed on "suspension" status if it's in any degree of trouble, and the regs could clarify that is such cases there is to be no right or expectation of renewal. More technically, do the reasons for "denials" in Reg 319 also govern with respect to renewal applications? 4. I believe the Medical Director is a good idea. But his duties in Reg 310 strike me as one-time, up-front duties with very little ongoing role. What will happen is that the protocols for dissemination of educational materials will become an "off the shelf" item that can be borrowed from one dispensary to another. The MD will charge to set that up, and thereafter monitor it to add or delete materials from time to time. But after the set up the duties are pretty minimal. The regs require the MD to "be available" after that, but to do what? The regs refer to pagers and telephones, but if you really want the MD to personally return phone calls immediately, the regs need to say that. Otherwise you will get a designated email address that the physician's staff monitors, with messagesr returned whenever. 5. A certificate of occupancy comes very late in the business/real estate development cycle--after maybe 95% of the money and time has already been expended. By requiring a C of O with the application, Reg 302 requires something that is extremely different than the way most businessess operate. They will say that you cannot spend 95% of what it takes to open your doors, as a precondition to finding out if you will be allowed to open. As written, this requirement will tilt the applicant pool in favor of the most risk-tolerate, well-funded players. You might think about that. If the requirement went one step back in the business process, it would require the applicant to produce a building permit (which will have required the payment of fees and preparation of plans, but not the actual completion of work). 6. A dispenary officer or board member should not be able to prove Arizona residency with a utility bill or a lease. Accepting such evidence is fine for AHCCCS or food stamp eligibility, but not in this context. Right now, an out-of-state resident could go rent a cheap apartment someplace and therefore set himself up, when he files his upcomign application, both a local lease and several months of bills from APS (or whatever). Any principal of any potential dispensary has the resources to do this, and by listing this stuff as acceptable "proof" of residency the reg only invites gamesmanship. 7. A textual ambiguity with the word "dispensary" lurks through many of the regs. The statute and Reg 101 define "dispensary" as the

intantible business entity itself. But then many regs implicitly use the word "dispensary" to mean "the dispensary's primary business location." For example, sometimes the regs refer to "the dispensary" and "the dispensary's cultivation site" when in fact, both of these mean something different than the intangible business entity. The regs could either use someting like "dispensary business location" when a location is meant, or at least clarify in the definitions that the word must be considered in each context.

Regarding Dispensaries: I read that the dispensaries can "grow" up to 70% of the product grown and 30% MUST come from patients, caregivers, or other dispensaries. This seems impracticable because each dispensary will not know initially what the demand for the product is. So what is 100% of product? How does a dispensary determine what 70% of an unknown demand? Secondly, how does 30% come from a patient? Does that mean that "patients" who live 25 miles or greater from a dispensary can become sellers to a particular dispensary? Same for caregivers. The informal draft rules require dispensaries to have an efficient inventory control program that tracks where all marijuana sold was grown and to whom it was sold. How can a dispensary determine with any sense of accuracy how and where marijuana was grown from a "patient, or caregiver?" To solve these problems and improve the rules I would suggest the following: 1. Dispensaries are just that - a retail outlet where medical marijuana, edibles, paraphernalia, and merchandise can be sold to those who possess a legal medical marijuana card. 2. Dispensaries DO NOT grow on-site. Medical marijuana is grown OFF-SITE at a secure location unknown to anyone but the County and the ADHS. Having product grown at a dispensary will absolutely invite crime and vandalism. Dispensaries should only be required to have a safe where product is stored, but not grown. 3. A person who is applying for a license must be approved for a retail site AND an off-site secure GROW operation where there can be strict inventory and quality controls put in place. This operation can then supply the dispensaries based on a particular demand. If you allow dispensaries to grow, you will not be able to control quality or inventory and then product may get in the wrong hands. OFF SITE GROW areas will be required to have SOP's, record keeping, and inventory. It will have 24 hour video surveillance and tight security and it's location is NOT disclosed to the public, only relevant government agencies will know the exact location. The location should be in an "industrial" location away from retail outlets. 4. In order to produce reliable product that is safe for use as a medicinal, Arizona must allow for initial seeds and/or clones to be obtained from neighboring states such as Colorado or New Mexico where quality control measures have been in place for some time. 5. There should be no minimum square footage required for a Dispensary since a dispensary is a retail facility only. In Pima County, there is an informal requirement to make a dispensary between 2500 and 3000 sq.ft. That's a BIG space for retail. However, they specify that 25% is used for retail (roughly 500 sq. ft) and 2000 used for grow. Again, I believe STRONGLY that a dispensary should not be allowed to grow on site. You're only inviting trouble by allowing this to happen! 6. As far as a patient-doctor relationship, I believe that the requirement to have a patient have been seen by a doctor 4 times minimum in a year is not practical. I understand it's intent to be good to prevent abuse, however, let's consider a patient who was just diagnosed with terminal cancer. My mother went to see a doctor because of severe back pain. She thought she had pulled a muscle. It turned out she had bone cancer of the spine. She was given 3 months to live. She immediately underwent chemotherapy. Most cancer patients don't die from the cancer itself, but from starvation and malnutrition because the effects of chemo interfere with their appetite. She couldn't even choke down a scoop of ice cream without feeling nausea. In this case, medical marijuana would have been very helpful. Many patients won't live long enough to qualify for the proposed "doctor-patient" relationship rules. I think if a licensed doctor recommends a patient need medical marijuana that should suffice unto itself in these kinds of severe cases. Therefore, the language should make an exception for severe cases such as cancer or other very serious condition. I agree that mild conditions require a longer evaluation period to determine need. That's it for now. I appreciate all the hard work and consideration your team is doing. Please consider my recommendations for improvement. Most

importantly the concept that dispensaries and grow operations should be separate facilities. This improves quality control, inventory control, public safety, and security.
Since the Care Giver is not allowed to be compensated, it might explain better the role of a caregiver other than the role of a parent/guardian and child relationship. What advantage is there to being a Caregiver? If you cannot receive compensation, is this a volunteer position?
Since the Care Giver is not allowed to be compensated, it might explain better the role of a caregiver other than the role of a parent/guardian and child relationship. What advantage is there to being a Caregiver? If you cannot receive compensation, is this a volunteer position?
Outdoor cultivation sites would not be any more secure with a fence over the top. To really make it secure what is needed is a superior electronic security system, razor wire atop the walls and a 24/7 live guard. The fence on the top would appear to make it secure but offers no real security.
It will be helpful to provide a graduated dispensary approval process so that all applicants will not sign leases that they will only have a need for if approved. If all applicants are required to have a lease signed at the time they apply and then they back out of the lease due to a refused application, the owners and managers of comerical space will look upon the DHS rules as being responsible for a lot of problems that could have been avoided.
This nonsense of having to see a doctor 4 times before being able to get a prescription for Medical Marijuana is foolish and nonsense. You can go to Urgent Care and get a broken arm looked at and set and the physician does not know a [redacted] thing about you and your have never seen them before! Also, in most medical plans you see the doctor who is on call that day and there is NO continuity between the physicians only a written record. This provision put an undo and expensive burden on the backs of people needing this medication..... Change it.....
Eliminate the requirement that dispensaries grow most of their MJ themselves. They should be treated the same as a local drug store and just have the job of distributing the MJ. Keep the growing operations separate.
R9-17-202 5e, states that you must have a relationship w/ a doctor for at least one year can not work. I myself have had 6-7 doctors in 2 years. two left the area, one will not see medicare anymore,etc,etc,. doctors come and go. so now you are setting things up so it will take another year(if I'm lucky to find a doctor for a year) this does not sound right to me. Myself I have been diagnoised with qualifing patent problem for more than 3 years.but like i said i now have a new doctor beyond my control. I believe this needs to be changed to"if you can prove you have the condition you should quailify.," Immeaditly.
R9-17-101 Definitions: #16: Definition of "ongoing" is to rigid and puts undue stress on the patient-doctor relationship and requires by state definition an unnecessary time limit on the waiting period required before a new physician can prescribe medical marijuana to a new patient. This time period adds A) expense for the patient because of the office visits required to establish the suggested 1 year "patient-doctor relationship". B) Takes the decision making process away from the qualified physician and puts a unjustified "standard" waiting period on all patients no matter what the recommendations of the physician might be. C) Adds undue stress and pain to the patient who could be benefited by the medical marijuana. D) Physicians will want to refer established patents to pain specialist (which is

current practice) for extended use of pain medication (Marijuana included). The referred physician should not have to wait 1 year before recommending marijuana as a viable treatment.
The wording of F 16 (pg 13/47 is unclear and confusing. R 9-17-205 (pg27/47) as determined by what? R 9-17-312 (pg 40/47): include a copy of the log book or rating scale referenced in R 9-17-310. There is no second level review of the application for an identification card, aand no system to validate the diagnoses provided by a physician. This leaves the process vulnerable to the type of misuse of the system seen in California. I would recommend that the dispensorys' medical directors be responsible for providing second level reveiws of a designated percentage of applications (including past medical record reviews) to ensure the diagnoses provided are accurate and confirmend by documentation. I would also add to section R 9-17-31`2 (pg 40/47) that the dispensory shall provide qualifying patient records to the Depatrtment for review upon request, including the medical records provided to the dispensory's medical records for second level review. This will afford the Department another level of oversight/validation to the process essential to ensuring legitimacy to the referal process.
Creating some security measures for food establishments making edibles.
Dispensaries, by definition, are very structured and will be contained in urban environments. If a CVS or a Wal-Mart Pharmacy were to apply for a Dispensary License, they would almost be perfect for the License. These facilities are now faced with creating a grow site. Could the Bill be rewritten to allow these Dispensaries to have a common grower for a supplier? If this grower was located in a rural area, zoned as agricultural , it would be easier to regulate one site than several hundred spread around the state.
I'm immobile and I spoke with my caretaker about having her get me medical marijuana once available. She refuses because she is afraid of federal law. She also says the fees are too high, there is too much invasive paperwork, and it is too hard. What am I to do? Please make sure easy delivery with proper ID will be available. Please make sure marijuana couriers are not restricted or that city zoning won't prohibit me from getting access to medical marijuana. Please make rules easier for true caregivers. Please be aware that many patients already have caregivers, unrelated to this marijuana law. Also allow me to continue seeing my primary physician. He is against recommending medical marijuana to any patient. allow me to get a yearly recommendation from a second doctor.
Please make medical marijuana affordable for patents on limited incomes. I have nerve pan in my legs and feet. I don't know how to explain it other than someone putting 110 volts into my feet all the time. I've tried narcotics and even anti-seizure medications with no luck. Sometimes it's almost too much to deal with. Marijuana works, but at current black market prices, I can only afford a few days worth each month. It costs nothing to grow marijuana outside, why do you want to force people to grow indoors increasing energy consumption, and the expense to patients.
see below . . .
Include guidelines for caregivers to cultivate for registered patients autonomous of the regulation on patients cultivating within 25 miles of a dispensary. This will help patients acquire medicine cheaper and decentralize this economy. It will keep the Dispensary Owners from over-exploiting the market from a business perspective, resulting in a decline of quality and integrity in their product.
See above
The draft rules may be improved by some sensitivity to the issue. It is difficult for those who have a strict materialist view of the world to appreciate that the most important component of the growing environment is compassion. The care that is transmitted to the plant is in turn transmitted to the

patient. Patients will most benefit from a policy that allows their medicine to be grown by those who care the most for them. The cost of the license may be lucrative for the State of Arizona, it is disasterous for the patient. This is akin to a patient saying "I want my grandmother's cake recipe" and the state replying "you asked for cake, here's Little Debbie". Plants are living creatures and have properties that science is reluctant to acknowledge. Reference "The Secret Life of Plants" - the magazine Popular Electronics included a schematic (in the 1960's) for an audio rate oscillator which responded to the "mood" of the plant detected with an electrode attached to the leaf. This machine was mass-produced by Jeremy Lord synthesizers in London as the BM-5 and Bio Activity Translator. These devices prove that plants register a discrete reaction to the thoughts of those around them. Industry is not anxious to admit that what they recognize as commodity has sentiment. American commerce would be drastically impacted by widespread knowledge of plant sentience, so this information has been supressed. Still, this is the most crucial point in the use of marijuana to treat illness. Unfortunately, a $5000 application fee is generally beyond the means of those who prioritize love over capital gain, and this policy will continue to alienate and make criminals of those who could most benefit from it, those people the policy draft claims to bear the interests of. It ensures that that which the state recognizes as a drug will still primarily be controlled by people who have no interest in seeing it as anything but a source of income and control, which is the cause of what many patients are suffering from in the first place.

By changing how ridiculously difficult it is to obtain a medical marijuana recommendation. Four visits and a one year relationship with the physician is completely outrageous and unacceptable. People like myself, who are suffering with chronic pain do not have time for all of these unnecessary measures. We need relief now! No other medication requires four seperate visits to obtain, so why should this rule be applied to cannabis (a substance that has caused 0 deaths in the history of time)? There is no point of four seperate visits. It simply wastes patients money and time. There is nothing a physician could gain from seeing a patient 3 more times on top of the original visit. If someone needs medicine, they need medicine. Time is not going to change that.

Here is an overview of a working business with 17 patient cards. I am an independent grower, am not involved in any way with other growers. I can legally grow 102 plants. (17pts.x 6plants) At present, I have 35 plants growing..I won't grow what won't be purchased. I monitor the amount purchased by a patient, from their income and a reasonable amount of product used, I don't have the problem of my patients diverting product. Some of my patients require an ounce per month, others will purchase a quarter of an ounce every other month. -Some don't purchase any at all for months. Each case is different. I am registered as a business in MT, will pay taxes on this business like any other business. I am glad to see Arizona joining this movement. Working in a pharmacy brought home how many people misuse and abuse prescription drugs. That is the REAL epidemic.

How will dispensaries get the marijuana they sell? According to the informal, draft rules all licensed dispensaries in Arizona will be required to grow 70% of the marijuana sold. The rest must come from either qualified patients, caregivers or other licensed dispensaries. The informal, draft rules require dispensaries to have an efficient inventory control program that ensures where all marijuana sold was grown and to whom it was sold.. Mr. Humble, it is not a good idea to have the dispensaries Do the Cultivation in the same place. There should be 2 or 3 Pounds in the dispensaries & eatables. The nursery should be in a different location. Making the dispensaries grow 70% of the product.. That would just be asking for trouble. way to much money in one place.. at $400.00 an Oz.=$6400.00 a pound, with about 70 plants or 70 pounds that would equal=$448,000.00. Sir that is a lot of money. To Tempting even for an honest thief. The nursery needs to be in a high security location.. Different from the dispensaries, which will be in a out of the way location. Thank You [redacted]

The rules should include mandatory testing of all medical cannabis products distributed to patients.

Testing should include quantification of cannabinoids (i.e., potency), verification of the absence of harmful chemical residues such as pesticides and fungicides, and verification of the absence of microbiological contamination by harmful yeast, mold, and bacteria. For the past two years I have operated an analytical laboratory in California that screens a wide range of medical cannabis products for safety concerns. While the vast majority of our samples are considered safe, we have identified samples with harmful bacteria and pesticides. Products with these residues must not be distributed to patients. We also accurately identify the total amount of active cannabinoids in flowers, extracts, and edibles. In doing so, patients know exactly how much of each product to consume in order to treat their symptoms. Moreover, doctors are now one step closer to being able to identify appropriate dosages. This is a critical step towards cannabis achieving true medical status. This is certainly most important for edible products. Patients never know how much of a given cookie or brownie to consume. By testing these products for potency, edible manufacturers can ensure that every single cookie or brownie they produce is of a known potency. Patients and doctors can regulate consumption based on these standard potencies. And the effects of a given cookie will be consistent from batch to batch.

R9-17-101 Definitions: 7. current photo - simplify this by using the passport standard for photos. There are widespread facilities to obtain these photos and the standards are clear 10. Enclosed - a one inch thick metal gate is unreasonable and unobtainable. please change to "a garage entry fire door - same standards as in home construction" R9-17-102 Fees first line - change to - An applicant GRANTED a license for a dispensary shall submit the following nonrefundable fees: it is entirely unreasonable to submit a $5000 fee for an application - when the criteria for acceptance of the application are not clear and the number of applicants is expected to greatly exceed the limited number of granted licenses. A reasonable nonrefundable initial application fee to cover administrative costs - such as $250-500 is acceptable R9-17-201 Debilitating Medical Conditions 9. define severe pain - i suggest that pain is entirely subjective and using a subjective pain scale score is appropriate. post operative pain needs treatment if the subjective score is greater than or equal to 5 on a scale of 10. define chronic - i suggest that chronic refers to a condition that recovery from or cure from is not an option or achievable. R9-17-202 13 e (ii) A standard statement needs to be drafted and used by ALL physicians to avoid any variations in the information received by patients and eliminate liability directed toward the prescribing physician. The statement needs to address the experimental nature of this medication. That it's use is not currently approved by the FDA and patient is assuming all responsibility for accepting this medication based on compassionate care usage. 13 e (iii) please define how the physician is expected to "continue to assess the qualifying patient and the qualifying patient's use of medical marijuana during the course of the physician-patient relationship" This current language is ambiguous and could lead to reprisals from the AZ BOMEX. I suggest that the patient is responsible to keep the physician informed of current address and contact information. To notify the physician in the event of any legal violations relevant to the use of medical marijuana. The patient is responsible for scheduling a yearly physical exam and review of therapy. The patient is responsible for notifying the physician of any change in their medical condition. R9-17-302 Applying for a Dispensary Registration Certificate B. 1. b. The physical address of the dispensary h. The physical address of the cultivation site and sections 5,6,7,8,910,and 11 - it is not feasible to lease or purchase property prior to receiving a preliminary dispensary certificate based on the large number of applicants and the limited number of certificates to be issued. Preliminary Certificates need to be issued and finalized contingent on meeting applicable zoning requirements and compliance with the sections cited above. R9-17-310 Medical director C 1,2 and 3 need to be standardized and issued by the Arizona Board of Medical Examiners to avoid any conflicts. All physicians need to be able to clearly understand what is expected of them and the programs that they over see. D. It is unreasonable limit the practice of a consulting physician. This must be changed to - "A medical director can not self refer a qualified patient to a dispensary that he is associated with." R9-17-312 Qualifying Patient Records please add a new paragraph E. this needs to assure compliance with HIPAA act. It should read - Patient records will not be shared with any other agencies, medical or non medical agencies or other physicians or entities without specific written consent of the patient. The Department of Health services has access to patient medical records to

verify compliance with record keeping guidelines only and will not share any information regarding specific patients with any law enforcement agency or representative of such agencies. If illegal activity is suspected, law enforcement will need to proceed with their investigation through court order and subpoena of only the information relevant to their investigation. R9-17-319 Denial and Revocation A. 2. e. It is unreasonable to restrict the practice of a physician. it is reasonable to ban self referral of qualified patients
I'm in the same predicament as many others. Well, my doctor belongs to a major clinic with many branch locations. She tells me that clinic rules prohibit her from recommending medical marijuana. I have a 3 year case history resulting from a terrible accident and I'm in constant pain. I can't afford the costs of seeing another doctor. I don't think my insurance would allow me to see anyone else. Please, please allow me to stay with my current doctor for most of my care andallow me to see another doctor annually for a medical marijuana recommendation. Thank you very much.
1.Allow caregivers that live within the 25 mile zone of a dispensary to grow for people that live outside the zone. The medicine from caregivers should be way cheaper for card holders than dispensaries. 2.Allow everyone that qualifies for a card to grow initially until dispensaries are up and running. 3. Make growing outside reasonable for all card holders & caregivers that live outside the 25 mile zone. Make the fencing requirements reasonable unlike the current draft rules.
Anyone with a valid medical marijuana card should be able to cultivate there own marijuana for medical purposes it isent practacal for someone to drive 24 miles to get the medicine they need there should also be unlimited dispensery's how are people going to make money on this if you only allow 124 dispensery's also they should be able to locate there dispensery where ever they want just because it's located within 500 feet of a school dosent mean the kids are in danger we should be educating them about medical marijuana and add anxiety depression epilepse and migrains you could also allow people to purchase up to 7 ounces of marijuana and also dispenserys should be able to cultivate marijuana at as many locations as the want also make marijuana edibal rules less strict THANKS
The fees particulalry for an infant industry seem high. Consider lowewr inital dispensary fees then a renewal after 3 years. Patient fees look high. Consider lower initial fees then a renwal at 5 years. language about discrimination due to local zoning rules,local permit fees and inspection fees should be incorporated.
I dont believe that the Arizona voters wanted medical marijuana to be treated any different than any other prescription drug. There seems to be some "special" rules for medical marijuana presciptions. Regulations to control medical marijuana are important so that people without a presciption for the drug do not have access to it. But, the ADHS drafted rules seems to want to make it extremely hard for patients to get access to medical marijuana. Definitely much harder than any other prescription. Why is this? There are oviously many other prescriptions prescribed by doctors that are alot more dangerous so why is this being treated so harsh. By harsh why the extra rules to get medical marijuana for someone with a qualifying condition? If a Doctor prescibes medical marijuana and a person benefits from it's use, Isn't that the intent of the voters? Why would a medical marijuana prescription have "special" rules? I'm talking specifically about the 1 year and 4 visit rule.
would it be possible to have a pharmacist or a person with a pharmacology/toxicology background be

able to fill the possition of medical director?
the extreme resrtictions and requirements for the dispenserys will make it difficult to obtain legal marijuana. there will not be enough dispenserys to supply patients with legal marijuana. they will be forced to obtain it illegally. which will make their perscriptions worthless. they'll still be breaking the law. relax the requirements for the dispensarys AND make them 1 mile, rather than 500 feet, from schools.
It seems in order to prevent corruption or loose interpretation of the law, that instead of each individual dispensary contracting with a physician to be on call, a pool of physicians selected by AZDHS should be set up to use as on-call medical support.
The rules are NOT easy to follow and or be implemented. First of all the rules are TOO strict. They are made up to profit the rich. A normal citizen does not have the start up fees and or monies to be involved with attempting to supply a dispensary and put up a business. The rules MUST be made to allow EASY access to the medicine in question. If there is no easy access then people will grow it their own way if it costs too much. I would propose the following: 1. Allow a patient to grow up to 10 plants in his/her home. Responsibly of course. In a room locked away from kids etc. (Responsible) 2. Drop the fees associated with a medicine (marijuana). They are not applied in other medicines. Remember the constitution "taxation without representation". The people wanted this. They voted.(Ethical) 3. Do NOT implement a patient identification process. This is singling out patients and discriminating them unnecessarily based on a medicine they use. (Think lawsuits on the way). We do NOT do that with percocet, oxycotin etc. The court systems are already bogged down beyond repair.(Unbiased) 4. This vote was "for the people" and should be implemented on the needs and wants "of the people." Suffering needlessly without money for certain medicine is wrong. (Moral) 5. keep the laws and rules simple. This draft (as written) is not what the voters wanted and or intended. It is a politicians nightmare and a lawyers dream. (Sensible) 6. Keep medicine available instead of making doctors afraid to write a script and patients scared to be a patient. The people WILL grow their own with or without governmental consent. The draft you have proposed is too strict and will have grave consequences on our legal system. The people and system of law enforcement does not have the time and or resources to deal with this. I know firsthand (retired police officer).(Understandable) ABOVE ALL, Do the right thing. Do not criminalize what the people want. Just use common sense in the wording of the laws. If it is not easily accessible, sensible and without all the nonsense to interpret, we will lose our rights to intolerant people who interpret and set up our laws using their own moral and ethical set of standards. Make the laws 1.Responsible, 2.Ethical, 3. Unbiased, 4.Moral, 5. Sensible, 6. Understandable
It needs to open up the smoking areas. Outdoors camping,fishing,bbq,etc. Pricing is another issue. Cost of the license and product is way to high! $150 just to register that should be reduced if patient is on any state or federal health plan.
Definitions 6. "Cultivation site" means the one additional location where marijuana will be cultivated by and for a dispensary. Should be 6. "Cultivation site" means the one additional location where marijuana will be cultivated by or for a dispensary. (This is because not all dispensaries will be able to grow correctly all strains that help a variety of conditions. Growers would need to be licensed with all security measures for a full dispensary, growers individually licensed, and individual license fee schedule. Said growers can provide up to 30% to more than one dispensary and help provide a better strain quality and variety at times.)
Is there a way to run the dispensing through existing medical pharmacies?
The rules have been drafted to only include the elite and I think that is a big problem. It is not fair and equitable to everyone. The fact that you have to have a dispensary and/or grow facility built and have a CO before applying is not acceptable. Only the elite can afford to invest $150,000-200,000 and then

gamble on whether their license will be approved. If they build the facility and don't get approved, what then? They just blew a ton of money on a pipe dream. This also insinuates that someone would need to have insider knowledge of how a dispensary/grow facility should be built to guarantee passing the inspection. Otherwise, why would they risk that much money. I think the rules should be written so everyone has a chance to participate. Require people to invest a small amount to apply ($5,000) but as part of the application process the applicant(s) must prove financial stability and prove they have access to the necessary funds to build the dispensary and/or grow facility. This could be in the form of a business plan or prospectus and should include the proposed floor plans et al as the draft rules indicate. Once approved, the applicant could be given a certain amount of time (3-6 months) to secure the funding, secure a location, and have the dispensary/grow facility built under DHS supervision...or risk losing their license.

At first the idea of a "medical director" sounded good but on closer examination we see several problems with that idea. It we were to have a director it would make more sense to us if there was only one director for the entire state, not a director for every few dispensaries. We're talking about a drug that in 5,000 yrs no one has died from a overdose. Used improperly it can cause upset stomachs and uneasy feelings. Patients do need to be warned about what to avoid but do not need a licensed doctor to tell them how to best use this drug. Most patients need very little consultation in the use of marijuana. Because it has been illegal for most of our lifetimes, it is not studied in medical school. Simply saying we need to hire a doctor to be available would most of the time end up being just an unnecessary cost that patients would have to pay although most will never hear that doctors advice. There are medical marijuana experts out here. Many of the future dispensary operators, the marijuana advocates, those of us that have written books, or worked in other states with medical marijuana. We have studied this subject for years. We propose the creation of a board of marijuana experts, cannabis advocates, AZHDS representatives, doctors, caregivers and patients who will create a study course including which medical marijuana books must be read and a exact test of knowledge on the subject of medical marijuana which would have to passed by any one becoming a "director". Possibly a simpler solution is having no director at all but every dispensary having a "compliance officer" who must pass such a test and always be available for the dispensary that they work at. We have the same issue with licensed pharmacists, they have no training in medical marijuana.

The 4 times to one Doctor thing has got to go..thats not right..Make it easy not hard for sick people..

i am a 47 year old disabled chiropractic physician, licensed in new york and florida, since 1987, and 1994, respectfully..... i have been a chiropractor since matriculation ended in 1987, when i was just turning 24, and since have built extensive experience with chiropractic and medical diagnostic businesses, from a founder/managerial perspective..... i recently moved to arizona for medicinal reasons--- the dry weather!..... having marijuana legalized for some of the condiitons i suffer from, will help with pain and anxiety levels, but more importantly, keep me off of opiates and benzo's and away from medical personel!..... please incorporate chiropractic physicians as primary doctors to "recommend" this very crucial medication! two reasons really---- number one is to help as many patients as humanly possible (even the patients that avoid medical doctors for reasons of holistic belief---- and just pure fear). i used to tell my patients, that if you really are serious about staying healthy, stay far away from medical doctors; with the obvious exception of emergenicies..... so this would increase carded patients- more tax money, and as you'l soon see below, reducing governmental spending substantially and number two is that the chiropractic community, i believe, would embrace this campaign and will improve their patient base. it would further elevate their standing as equals with the medical community, as someone who can inform their patients about going down the medical marijuana avenue, while recommending a totally natural substance, staying within the chiropractic dogma. .. chiropractic has been a tough sell with patients so inundated with medical advertisements for

dropping pills instead. this is acceptable for some strange reason?... it is estimated that merely 5% of the population are treated by chiropractors. if this number could even approach 10%, a realistic move, more patients would benefit from the maintenance of their good health while the chiropractors would benefit fiscally, ultimately reducing the governments obligatory net tab, when these people would go the normal medical route.....recommendations also add to the the tax base substantially. so the government saves a bundlet of money by by-passing the medical community, while the patients benefit immensely, decreasing the state and federal deficits.... again, i am totally familiar with all the intricacies of this subject from a business and personal point of view, and there would certainly be no losers if chiropractic physicians were enabled with this tool, as to keep the unsuspecting public informed, and away from extremely dangerous narcotics. how many accidental, or not, overdoses are seen in our morgues on a daily basis?....the egregious use of prescription pads by many unscrupulous doctors, who clandestinely keep their unsuspecting patients physically addicted to them; and a massive amount of opiates, in order to maintain fiscal solvency. they are looking for people (especially those with medical insurance that they know pays well) , to come in for office visits as often as possible, usually once a month for scripts, even though the medical doctors can write for narcotics in 90 day increments. are they just monitoring the situation more closely?.... i would like to think so, and am sure it is true in a very small minority of physicians, but the truth is, their concerns are about themselves and having you come back---- often! and the numbers back this up! prescription pills are the most abused drug--- period..... otherwise, if you just went there when you were sick, you'd probably see them once a year..... maybe!.....not good for their pocketbooks... in conclusion, you can plainly see that allowing chiropractic physicians into the pool of doctors that can legally recommend marijuana, benefits the tax base, benefits the chiropractic physicians, but most importantly, benefits patients in need. i urgently suggest this rule be amended in this all important draft, allowing no ambiguity as to the chiropractic physicians option to make these recommendations. thank you for your time---- [redacted]

Keep in mind it is the job of the department to regulate the Arizona Medical Marijuana Act not re-write it. There are a few issues in the preliminary draft that are rules being proposed that are not written in the act. Such as: 1)Dispensary must cultivate 70% of the medical marijuana it dispenses. 2)May only acquire up to 30% of the medical marijuana dispensed 3)May not provide more than 30% of the medical marijuana cultivated by the dispensary to other dispensaries. 4)In respect to a patient having to provide pre-existing medical conditions to receive a medical marijuana card. 5) Security storage of the surveillance 30 days. The department should consider changes to these restrictions. Some suggestions would be: 1)Dispensary should cultivate 0 – 30% of the medical marijuana it dispenses 2)May acquire 70-100% of the medical marijuana dispensed 3)Should be able to provide 100% of the medical marijuana cultivated by the dispensary to other dispensaries 4)May obtain a medical marijuana card with the recommendation of a physician 5)Security storage of the surveillance 0-14 days

I am applying for a dispensary license. I also have a vertebrae that was crushed in a car accident. The Medical Doctors told me I would be unable to walk or move much. I have used all kinds of holistic treatment which has in fact allowed me to move around. My point here is that without holistic help I would still be laying in bed. I think it is imperative to have Naturopathic Doctors on the list of Medical Physicians (NMD) I believe other holistic practitioners should be on the list if they have techniques that relieve pain. Restricting this to Medical Doctors will seriously restrict the possibility of someone like me and many thousands of others from receiving relief from pain based in Insurance and Pharmaceutical company preferences. This should be about the patients needs, not just big business.

Change the requirement of the doctor relationship, I thought doctors were trained, and could diagnose most chronic ailments, and if a person wants a second opinion they should be able to try what they feel is best for them, not DHS deciding what is best for a person, that should be left up to the patient.

It's very important that patients be allowed to grow in a fenced area. The fence needs to be reasonable.

No one could afford to build the 12’ wall or 1" thick metal door proposed, they couldn't move a 1" thick metal door. It is far better that someone breaks into a fenced area, rather than do a home invasion where people lose their life over marijuana. If you make people grow in their homes rather than outdoors in a fenced area, you will be responsible for the lives lost.
It would be wise to lift the 25 mile ban on growing marijuana and let the cities and counties implement their own ordinances regarding safe distances from schools and other establishments. It really does not matter where growing operations are conducted if they are to remain under lock and key at all times. The $5000 non-refundable application fee for dispensary licenses strikes me as highway robbery when the state will only allocate 124 such permits for the entire state. Thousands of people are going to lose their life savings "investing" in this fashion and will have no hope to recoup when they are denied licenses. The taxes reaped from the sale of marijuana alone will pay for expenses of the ADHS, no question.
Need enforced regular periodic reaffermation that an appropriate condition still exists.
It should be added or explained how caregivers & card holders can also grow within a greenhouse like the law stated. Greenhouses will only help in high altiltude areas but would be great for them. Also allow & explain how they can grow outdoors in a locked area other than what you described. I think making them grow in a 12' fence made out of the materials you listed & having to be covered is way over board. If you did it would limit those able to get high quality, natural medicine if the cost was way to set up was to high. The cost for indoor growing will be sunstamcial already, give them a better option for outdoors. Make it as easy & lowest cost possible for card holders & caregivers to grow medicine, indoors & out. Allow caregivers that live within 25 miles of a dispensary grow for patients that live outside the 25 mile area. It seems to have been written that way.
The second and third subparts of "enclosed" are not reasonable 10. "Enclosed" means: "b. An area surrounded by four solid 12-foot walls constructed of metal, concrete, or stone with a one-inch thick metal gate and a barrier covering the top of the area that is: " Twelve-foot tall SOLID METAL, CONCRETE, OR STONE is not reasonable. "i. Welded or woven metal wire mesh, with minimum wire thickness of 0.25 inches and maximum gap between wires of 1 inch; " sounds EXCESSIVE and does not allow natural light necessary for plant growth to penetrate. Even ii. Welded metal wire grid, with minimum wire thickness of 0.25 inches and maximum gap between wires of 3 inches; would allow less than 85 percent light transmittance and would be very expensive. None of this reflects any useful construction engineering standards. It sounds like you have prison guards designing a greenhouse.
Change 2801.16. the definition of ONGOING to eliminate protracted physician-patient relationships that predicate a qualifying patient's getting marijuana.

in definitions, (101), I find no definition, or common understanding for your term "caregiver". I looked in "c" and in "d", but found no def.?? please define.
Add language to the definition of "usable marijuana" that requires the minimum concentration of an indicator of quality such as THC content.
Make Medical Marijuana easily available to patients who have a medical history. Let the patient keep their regular doctor, if the doctor for some reason can not recommend medical marijuana. For example, the health adminstrator for a clinic prohibits the doctors from recommending medical marijuana. The patient who has a medical history can see another doctor for a recommendation and still be a patient with the first doctor. Maybe make it mandatory that the patient see the second doctor at least once every year to renew.
include registered pharmacist as part of medical director description or if there is a registered pharmacist on staff then requirement for medical director can be waived.
Comment on R9-17-107, Section E I think the timeframes here are too limiting for getting the information back to ADHS. Specifically the terms "from the date of the written comprehensive request" and " within 10 working days after the date of the comprehensive written request" in section E. It seems that ten workings days is not near long enough for a patient and/or physician to get the requested information back to ADHS. Scenario: ADHS writes a letter requesting additional information. The letter is dated 5/9/11. But ADHS doesn't get the letter in the mail until 5/10/11 (1 day down). Then it takes 2 days for the letter to reach the recipient via USPS (now 3 days down). Once the additional information request has been completed it takes another 2 days for the letter to reach ADHS (5 days down) and maybe another day for ADHS to open the letter (6 days down). That leaves only 4 days for the patient or physician to gather the information needed for the request and put together a letter. All this assumes that a) ADHS is 100% efficient in getting the letter created and mailed off in 1 day and is 100% efficient in opening their mail once the request has been sent back (and can anyone really guarantee that?), b) the USPS is 100% efficient in delivering the mail (really?) and that there are absolutely no weather conditions (like the 54 inches that Northern Arizona received in one week in January 2010) that would (and did back then) slow the delivery of mail especially to remote areas of the state - (believe me I know this for a fact), c) the patient is physically able to work on getting the information within 4 days (these people have a debilitating medical condition which by it nature means they're not working at full speed) and/or d) the physician (with their workload) can get the information gathered in time (what if the physician is out of town or otherwise unreachable for part of the time). ADHS also needs to take into consideration that many, many Arizonans live in remote parts of the state where even getting their mail can be a challenge. It seems unfair that ADHS has 30 calendar days to review a request after receiving it but a patient with a debilitating medical condition has only 10 workings days from the date of the comprehensive written request to respond. Arizona residents are given much more time to just renew their vehicle registrations. If ADHS is giving itself 30 calendar days to review a request then that's exactly what it should give to the patients. Comment on R9-17-202, 5, F. e., i. and ii. The comments I'm making on this section are based on my very recent experience as a patient being treated for cancer. While I can't speak for other debilitating medical conditions I do think I can speak adequately in the area of cancer treatment. I think the requirements in these two sections (i and ii) are extremely limiting to really benefit cancer patients going through chemotherapy where medical marijuana is extremely beneficial in combating the sometimes debilitating nausea caused by chemo drugs and the debilitating pain that a lot of patients suffer from the neulasta shots. The requirement in Section i would be impossible to meet for many, many patients for two reasons: 1) because of the insurance industry and 2) because the diagnosis and treatment of cancer can and usually does occur within a very shot time period. For example this year I had to change my primary physician because the doctor moved to a clinic that did not accept my insurance. Many people have to change their primary physician either on a yearly or bi-yearly basis either because their employer has

switched insurance companies in order to save money (and your current physician does not accept your new insurance company) or because the physician makes changes in which insurance companies they will accept for payment. The State of Arizona employees have long enjoyed the luxury of having only to deal with Blue Cross Blue Shield for employee insurance coverage. And most physicians accept BCBS. But it's not that way for many other people and especially those of us in remote areas of the state. Many of us in remote areas have to travel far or switch physicians often in order to find someone who accepts our insurance. So to require that the patient be seen by the physician for a least a year and have had 4 visits to that physician is extremely unrealistic. A patient with a debilitating medical condition should not be denied medical marijuana because they had to switch physicians due to insurance. And the requirement to have 4 visits can be prohibitively costly for low income patients living in remote areas that have to travel a long ways to visit the doctor. In addition, medical conditions such as cancer can and usually do occur very quickly. By the time a patient could see their physician 4 times they most likely would have already started receiving chemotherapy and as such be suffering from the effects that could be helped or alleviated by the use of medical marijuana. So what's the point then? For example I was diagnosed with breast cancer on January 20, 2010. I had my surgeries in February and then met with the oncologist for the first time in early March 2010. I started Chemotherapy on March 25, 2010. I had 8 treatments every 2 weeks thereafter. Up until my first visit with the medical oncologist I had never met him before. Under section i I would have had to have 4 visits with him before my first treatment on March 25th in order to qualify. And I couldn't go to my primary physician because a) I would see him for the treatment of breast cancer and b) I haven't seen him for a year because I had to switch physicians due to insurance coverage. And if I had waited to accumulate my 4 visits I would have been through the worst part of the chemotherapy where medical marijuana would have provided me the most benefit. Section ii also makes a lot of wide and vague assumptions that in many cases will be impossible to meet. I am again speaking as a patient who underwent chemotherapy treatment. I understand ADHS has to make certain that recommendations for medical marijuana aren't written by some physician running a prescription mill, but to expect a doctor such as a medical oncologist to accept all responsibility for the patients care of the debilitating medical condition is a bit unrealistic. Case in point - many times patients who have certain reactions to the chemotherapy drugs end up going to their primary physician for anti-biotics because frankly the oncologist may not know what to prescribe. But the primary physician isn't always a part of the overall cancer treatment plan and doesn't need to be. I wouldn't go to my primary physician for treatment of my breast cancer. And will all oncologists be willing to assume this responsibility? It seems to me that ADHS could accept medical documents such as Ops reports, doctors notes, pathology reports, etc. that documents and verifies a patient's condition. These reports usually come from a variety of medical sources and preclude one physician from writing a false recommendation but could be funneled through one physician for verification. This already happens in the treatment of cancer. While I understand that ADHS has to do it's best to make certain that medical marijuana isn't abused by the wrong people (and I am in total support of that), it is the goal of ADHS is to implement the medical marijuana law. And as part of that ADHS has to make certain that the patients whom this law is targeted to should be able to obtain medical marijuana when they need it and not make it so hard as to make it impossible for the patient. Otherwise what good is the law. In addition to thinking like a governing body, ADHS also needs to think like the patient. Think about these requirements from a patient's perspective.

Leave being a doctor to doctors, not to the state. Remove the 4 visit rule most people do not get to see the same Doctor over and over this will only accomadate rich people.

You can lift the 25 mile growing rule, so sick people like myself that are on disabilty can grow for themselves. I cant afford marijuana at street prices let alone the dispencery prices. I once lived in cali and they dont donate much marijuana.

With regard to medical oversight at a dispensary, Naturopathic physicians should be included. Naturopaths are state licensed primary care physicians with prescriptive rights including controlled

substances like morphine, vicodin and testosterone. They are qualified and free to act as medical directors in all other clinics and facilities. Their training in both botanical medicine and pharmaceutical medicine makes them both appropriate and qualified to be medical directors of a medical marijuana dispensary. It just seems illogical not to include them. On a similar note, there is no mention of Naturopathic physicians in the draft rules any where. They are included in answers on the FAQ and in the "Definitions" section on the web site, but they are not mentioned in the "Definitions" section of the draft rules or any where else in the draft rules. Nor is title 32, chapter 14 mentioned any where in the draft rules.

With regard to the doctor patient relationship for qualifying patients, the rules are lacking in clarity in the second part of R9-17-202 (5)(e). This issue will likely harm those patients with the greatest need for and benefit from medical marijuana. R9-17-202 (5)(e)(i) clearly states that the physician "Has a professional relationship with the qualifying patient that has existed for at least one year and the physician has seen or assessed the qualifying patient on at least four visits for the patient's debilitating medical condition during the course of the professional relationship; or" The problem is that if the above stood alone, the patients in greatest need would be harmed. For example, consider a patient with advanced cancer who is suffering greatly. Other medications don't work, but the patient has discovered – on their own – that marijuana provides significant relief from their debilitating condition. As such, the time frame for a doctor-patient relationship of at least 1-year and 4-visits addressing the debilitating condition does not make sense. In the above example, perhaps a majority of patients with advanced cancer may not survive a year's time. Thus, it's unacceptable and unethical to require the time frame laid out in R9-17-202 (5)(e)(i). Does R9-17-202 (5)(e)(ii) help to protect such patients or preserve the physician's medical judgment? It's hard to say because the language is so unclear. R9-17-202 (5)(e)(ii) states, or.. that the physician "Has assumed primary responsibility for providing management and routine care of the patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the patient's medical record maintained by other treating physicians, that may include the patient's reaction and response to conventional medical therapies; The above section states the physician must have conducted "a comprehensive medical history and physical examination, including a personal review of the patient's medical record maintained by other treating physicians..." This must always be a requirement. But it's in the section that refers to a second option from R9-17-202 (5)(e)(i). In other words, that language can't be an "or" option, it always must be a requirement. The (ii) section should contain specifics that protect patients with medical cases that do not fall into the minimal 1-year and 4-visit time frame described. The (ii) section should also preserve physician's ability to make a clinical judgment. It would make practical sense for the physician who recommends medical marijuana to include the patient's complete medical history in order to establish the legitimacy of their qualification. This should include not only visits with other doctors, but also licensed health care providers who have treated the debilitating condition. If other licensed health care providers are not included in the language of the law then patients may be unfairly discriminated against simply because they chose to treat their debilitating condition by other means such as acupuncture, chiropractic, physical therapy, bio-feed back etc. Or they might be punished because in spite of their suffering they refuse to take dangerous and highly addictive drugs. Thus, the complete medical history, rather than a single doctor-patient history, should be allowed to satisfy the 1-year and 4-visit minimum for establishing the legitimacy of a debilitating medical condition. That should be clearly stated in the law. There must also be language that allows the physician to recommend medical marijuana for patients with an acute onset of a debilitating medical condition which would make it unreasonable – such as someone not expected to survive a year – or unethical for a patient to suffer for 1-year in order to establish a doctor patient relationship.

Yes,

As a veteran under care at the VAMC in Phoenix, my primary care physician is a US government employee, and is forbidden to reccomend medical marijuana. He would if he could, but he can't! This could make it difficult for me to find an MD who could reccomend marijuana medication under the proposed rules regarding a doctor knowing me as a patient,with a long term relationship. I will have to find a new doctor, who must evaluate me from a VA cassette disc, in regards to my surgeries, lab tests, x rays, MRI's, CATSCANS, medications, etc. Will the rules require me to build a new relationship with a new doctor. Do I have to wait a year, and have four or five visits. WILL A NEW DOCTOR BE ABLE TO LEGALLY DO THIS? I live on social security, I can not afford to pay for new testing, new lab tests, new MRI's, CATSCANS, etc. I understand the need to vet patients, to eliminate the recreational patient, but please don't penalize me. Thank You.
R9-17-102 Registry and Renewal Fees- These all need to be increased. 1. Renew the Reg. of a dispensary- proposed $1000, increase to $2500. Renewal should be reqired on an annual basis. 5. I.D. Cards- fees A. Qualifying patient- proposed $150, increase to $250. Required annualy. B. Designated caregiver- proposed $200, increase to $500. Required annualy. C. Dispensary agent- propased $200, increase to $500. Required annualy. 6. Renewing registry I.D. cards- same fees- required annualy. 7. Amending and changing cards- proposed $10, increase to $25. 8. Replacemant cards- proposed $10, increase to $25.
GET RID OF THIS ONEROUS AND UNREASONABLE REQUIREMENT
DELETE; 15. "Medical director" means a doctor of medicine who holds a valid and existing license to practice medicine pursuant to A.R.S. Title 32, Chapter 13 or its successor or a doctor of osteopathic medicine who holds a valid and existing license to practice osteopathic medicine pursuant to A.R.S. Title 32, Chapter 17 or its successor and who has been designated by a dispensary to provide medical oversight at the dispensary
The requirement regarding the Medical Director needs refinement. The description for a medical director sounds more like a description of a pharmacist. We all want the marijuana dispensaries to be professional and medical, more like a pharmacy than a store selling a commodity. The limitation on the number of dispensaries is based relative tho the number of pharmacies. The connection to the pharmacist is natural and should be followed through by expanding the definition of medical director to include pharmacists. One could argue that a pharmacist is far better to serve as the medical director than any physician who would agree to be one. Having a pharmacist on the board of directors of the dispensary would be even better.
Preventive measures for recreational users should not be the emphasis. Those who choose to use recreationally will find a way to access the drug. Those who are applying for medical usage cards and are prescribed marijuana should not be force to jump through complicated technicalities when they are trying to be compliant and obey the law (and pay necessary fees) If it becomes too difficult medical users will revert back to illegal methods of procuring the drug which will make the whole law pointless.
Please make it more affordable & reasonable for patients & caregivers to grow outside. To keep the cost down this would be a good step so patients get the medicine they need @ low prices. I think a good chain link that is 8' tall, with maybe barbed wire on top & a good gate/lock would be appropriate for most besides dispensaries that would need more security. If the wording in the draft was only meant for dispensaries, then maybe clarify it. Not for profit or not, dispensaires prices will still be very high for most truly medical users that are not used to medicine costing that much. people that illegally use it are

already used to those prices. Allow patients to grow their own medicine until the dispensaries are up and running. So maybe for the first year of the program even if a dispensary would eventually be open within 25 miles of them?
-Make it less burdensome to be a medical marijuana patient in the first place. It will be important to maintain oversight as the system comes into being, however, it should not cost a critically and chronically ill patient the proverbial arm and a leg to get their medicine. The costs are quite excessive, $150 a year to the state, multiple doctors fees (a required 4 visits a year to the same doc, what if it costs $100+ per visit?); I understand that the point is to avoid an abusive program such as those that have popped up in other states, but, again, oversight!
R9-17-201. Debilitating Medical Conditions There are quite a few more medical conditions that should be considered. Any type of medical condition that causes you not to live a normal life should be considered.
It would be a boon to patients if dispensary agents could deliver to them & maybe use 3g or 4g phones for verification & documentation. One concern I have is for smaller dispensaries, I don't plan to run one at this point but I do plan on having them as clients to whom my organization provides medical marijuana for resale. The location change fees could put the smaller operations in small, rural areas at risk. I don't question the need for it at all, but can we work on thinking of a different way to cover this expense than a flat fee that would put a disproportionate burden on the little guys? Maybe put the fee on a sliding scale proportionate to the size & revenue of the operation?
My doctor surprised me yesterday and said the administrator of his clinic won't allow him to write a recommendation for med marijuana for me. Please allow sick patients to keep their established doctor and get a med marijuana recommendation. I'm afraid for my health to lose my doctor, but I need med marijuana. If I can't legally get med marijuana easily I will have to continue buying it illegally. My spine was broken in several places and I'm in constant pain. I'm tired of taking pain killers that are making my health worse. Help me and others like me that can prove through xrays, etc. that we are sick. Help those who have proof that they have health problems. Allow me to keep my doctor and allow me to get a med marijuana recommendation from another casual doctor, one which I can see yearly, one I can show my med records to, one who can examine me yearly and make a legal recommendation. Thank you.
Re: R-9-17-301 Need Clarification as to what qualifies as a Dispensary? Prop 203..36-2801...11. (States) "NONPROFIT MEDICAL MARIJUANA DISPENSARY" MEANS A NOT-FOR-PROFIT ENTITY under R-9-17-301 it appears that an Individual, a Partnership, LLC , Joint Venture or Coop can be a Not for Profit enity? ---------- Not-for-profit organization Definition An incorporated organization..... which exists for educational or charitable reasons, and from which its shareholders or trustees do not benefit financially. also called non-profit organization. Read more: http://www.investorwords.com/3353/not_for_profit_organization.html#ixzz197Tw5UsK
Changing the medical director from a physician to allow a on call pharmacist or registered nurse instead. Mainly for the cost to the patient would be lowered and also because a pharmacist/nurse is more appropriate to answer questions and teach patients regarding medicine. Remember the person will be doing a job that they will have to research and learn about. As no school teachs about the strains of marijuana or the certain effects of 1 versus another.
The patient physician relationship should be shortened and the stringency of the rules eased up to facilitate the meds reaching patients faster. An honor system of the medical field and their hippocratic

oath should be reasonable
500 feet from schools still seems too close. The major concern I have is what rules govern the patients on how they use the drug- In other words, will I be at the park with my kids or out in my back yard and be forced to smell someone's second hand Marijuana smoke? That really concerns me, not just smell wise, but health wise for my family. A solution to this problem would be to only sell it in forms that can be ingested instead of smoked. What rights do I have if something like this happens? Who is responsible to enforce how this affects neighbors? The police don't have time for that.
LEGALIZE IT!
1) There is excessive reliance upon the social security number- an identification number that is not intended for such tracking purposes. This identification should not be used for anything other than "administration of any tax, general public assistance, driver's license, or motor vehicle registration law within its jurisdiction" (See 42 U.S.C. § 405(c)(2)(C)(i)). 2) Section R9-17-313 (B)(3)(a) requires onerous record-keeping of questionable utility. It is difficult to assert that knowing the type of substrate used for growth, the watering schedule, etc. improves the safety or security of the product in culture. Superfluous record-keeping serves no purpose. 3) R9-17-314 (A)(5) addresses "inorganic" pesticides without an appreciation of the risks associated with organic pesticides, such as nicotine sulfate, rotenone, natural pyrethroids, and neem. (The toxicological effects of tetranortriterpenoid liminoids such as azadirachtin that are derived from neem are not good; while it is not a mutagen or carcinogen, its reproductive effects- including considerable reduction in fertility in rats- merit further investigation, particularly for use on products that are commonly consumed by inhalation.) Similarly, "nonorganic pesticides, herbicides, and fertilizers" as well as "chemical additives" are not defined in the draft rule. Moreover, a listing of all "chemical additives"- ranging from the hormones used to root cuttings to the silver nitrate employed in ethylene-sparing treatments to induce the production of "feminized" seeds- is onerous. The multitude of fertilizers alone makes this a difficult proposition; will the dispensary have to label each individual component used in each individual product throughout the lifetime of the producing plant, or will they have to list the individual commercial products- leaving it to the recipient to figure out what the individual (and often proprietary and hard-to-find, even with the MSDS information) commercial products contain? 4) In the draft regulations, no viral indexing is required to demonstrate crops are free of tobacco mosaic virus TbMV or TMV), nor is there any proposed regulation of consumption of tobacco at cultivation sites, or handwashing, or sanitation to preclude the possibility of transmitting TMV from smoked or oral tobacco to plants under cultivation. 5) The rulemaking seems to be fixated upon seed production of crops, which is a rarity in commercial grow operations. Tracking of plants grown from cuttings (clonal propagation) is not addressed at all, which will lead to confusion when the number of plants does not reach parity with the number of seeds sown. Similarly, there is no rulemaking concerning the tracking of breeding efforts, documenting the production of new hybrids from existing stock.
let whoever wants marijuana get it
Any Arizona physician may in a single visit prescribe "speed," e.g., Adderall, to a kindergartener without 4 visits spread out over 1 year. Arizona physicians may prescribe to a kindergartener a drug that can kill that child by heart attack, stroke, seizures, or other "side effects. Cancer, HIV, Hepatitis C, and ALS patients often do not have 1 year to live. The cannabis specialist takes over the primary care of the patients qualifying condition, is done nowhere else in medicine. Nowhere else in medicine does a specialist take over a patient's primary care. Deadly and addictive drugs such as the opiates are prescribed in a single visit by Arizona physicians and despite the best efforts of physicians, some of those deadly and addictive drugs are illegally diverted, but that does not cause or demand 4 visits, 1 year of visits, or that the pain specialist assume primary care of the patient.

Don't make so many rules. Treat it like booze, but make it easy to spend money in AZ. We need the tax revenue.
I am very concerned that these rules are in violation of HIPAA Laws and patient privacy. If there is a relationship between a licensed Doctor and a patient, then HIPAA laws will have to apply. There are no exceptions..... Patients, and perhaps even doctors, will surely sue the state if these laws are disregared. Please respect patient and doctors rights and re-write your rules to be in line with the HIPAA Laws.... thank you.
Firstly, many doctors are being told they can not recommend marijuana by their bosses. Don't force patients to drop their primary doctors just to get a marijuana script. Allow a patient to continue seeing their regular doctor and once a year see a marijuana doctor. The key is medical HISTORY. If a patient has a documented medical history that corresponds with the law, than that patient is eligible...end of story. Also you are opening a can of worms for lawsuits especially since may people are locked into their doctors because of insurance requirements. Don't punish the patient, punish the doctor if he or she is writing bad scripts.
Where do I begin? You obviously fell in love with the Colorado model of regulating dispensaries but you missed your mark because the people of Colorado did not vote on an initiative that set up dispensaries in their state. The state of Colorado decided to expand their medical marijuana program and then imposed the rules to follow. In Arizona we had a People's Initiative (Prop 203) where over 250,000 signatures were gathered and the voted on and passed. Everything you propose in rulemaking must follow the guidelines of the now state law -- the Arizona Medical Marijuana Act. The rules you are trying to implement are in quite a few cases in direct violation and spirit of AMMA. What don't you understand about the word -- minimum requirements? Having video surveillance cameras installed in all the dispensaries is a direct violation of AMMA and your insistence of putting those in the rules is very disturbing. Either you follow the law (which you as a government official are tasked to do) or you don't and the lawsuits will follow. I will personally do everything in my power to involve the ACLU into this process and move this to an expensive and protracted court battle which will cost the state of Arizona millions of dollars and years of delay. Is that what you want for our state? The Arizona Medical Marijuana Act put the structure together to have dispensaries and it's very restrictive and in your zeal to make it nearly impossible for the little guy to open a dispensary you have created a complete mess in your rules. That's nice to say that only Arizona residents of at least two years can fill out the dispensary application paperwork but currently all the big time dispensaries around the country (Harborside, Canna Mart, Today's Health Care) are putting together packages that they will be the stalking horses for the Arizona residents to shoot in their applications. You need to put in the application process what out-of-state entities are financing or helping with the process since it is not fundamentally fair to everyone to have a few well-heeled dispenaries come in and game the system. If you don't think this is happening you are totally out of touch since I just got back from Denver where I attended a convention Kush Con where the big boys were there and trying to recruit everyone from Arizona to be part of this "scheme" to game the system. This is wrong and you can't now say you are ignorant of this because you are being told. Don't believe me then give [redacted] a call since you are speaking terms with him and ask him what out of state dispensary he'll be aligning with for his dispensary?
By creating strict rules and regulations you are serving the interest of those who profit from an illegal enterprise. Why not regulate the use with a more liberal objective and allow state surplus with respect to funding rather than those who profit illegally. Bounding the ability for someone who can benefit makes no sense to me.
I think that the draft could be improved, if the guidelines were more clear. The layout made it easy for me to miss the parts that I wanted to learn about.

I don't like the idea that a person who lives within 25 miles of a dispensary would not be able to grow their own medical marijuana if in fact they have a medical marijuana card. If everyone with a card were allowed the option to grow their own, then the number of dispensaries may be less. Also, by being forced to buy from a dispensary rather than growing ones own does not seem right, it in fact adds profit to the dispensaries pockets and weakens the consumers/patients choice to a quality grade medicine.

Mandatory Testing of all Harvested Cannabis

The ballot measure, 36-2801.01 says: "The public may petition the department to add debilitating medical conditions or treatments...." The draft rule, R9-17-106, says: "An individual may request the addition of a medical condition..." Putting the cost and burden of petitioning for addition of a medical condition on an individual, as proposed by the draft rules, is clearly not justified by the ballot measure which says the public may do so. The rule should be changed to provide that either an individual or any member or group of the public may petition.

Charging $5000.00 to apply will lead to lawsuits, $5000.00 for the permit is fine but keeping the $5000. from those you dont award a permit is wrong Forming the dispensary prior to awarding the permit will also lead to lawsuits for detrimental reliance. How is someone sappose to invest 25 to 50 thousand in a project to maybe get a permit. Doctors on staff, pharmacist on staff, not needed nor workable, the patient needs the meds at reasonable prices

The rule requiring each dispensary to retain a medical director to be on-site or on-call during all hours of operation should be eliminated. The reasons it should be eliminated include: 1. 36-2803 of the ballot measure deals with rule-making. It specifically lists the subjects that should be dealt with in rule-making. Nothing listed states or suggests that the Department is justified in requiring dispensaries to retain medical directors. Something of this significance would have been included in the ballot measure or the ballot measure's list of subjects for rule-making if it had been intended by the drafters of the ballot measure. 2. The ballot measure, generally, and the rule making charge in the ballot measure, specifically promote the goal of allowing patients to obtain medical marijuana with as little unnecessary interference as possible. 3. The most significant duty given the medical director by the rules is to see that educational and self evaluation materials are provided to patients by dispensaries and that dispensaries have guidelines for refusing to provide marijuana to a patient. These goals could easily be accomplished without the necessity of retaining a medical director. Even if it were desirable to have a medical director involved in preparing these materials, there is no justification for the requirement that the medical director be on-site or on-call during all hour of operation. The ballot measure specifically provides that medical marijuana may not be consumed at a dispensary. This would obviate any need for a medical director to deal with any potential medical marijuana related emergencies. 4. Any benefits that could result from the requirement of a medical director are clearly outweighed by the expense burden that will be imposed on dispensaries and necessarily passed on to patients by the requirement. The clear intent of the ballot measure is for patients to be able to receive the benefit of medical marijuana without unnecessary burdens. This rule is an unnecessary burden. It could be particularly burdensome to dispensaries serving low population counties where the demand for medical marijuana might be lower than in higher population urban areas. This rule could easily make the difference between a dispensary being financially viable or not. It could lead to the unintended consequence of driving many dispensaries out of business and allowing the business to be concentrated into a relatively smaller number of large volume dispensaries that could more easily afford the financial burden imposed by the rule. 5. If the rule is retained it could be made less burdensome by allowing medical directors to serve more than 3 dispensaries and eliminating the requirement that the medical director be on-site or on-call during hours of operation. The duties of the medical director listed in the draft rules primarily relate to developing patient education and patient self-monitoring materials for distribution by the dispensary to patients and guidelines for refusing to provide medical marijuana to impaired patients. If these materials are needed, they could be developed by the medical director

without any necessity that the medical director be available on-site or on-call. It is difficult to see how there is any relationship between benefit to the patient and the requirement that the medical director be on-site or on-call during hours of operation. The educational and self-monitoring materials developed for one dispensary could easily be used for another dispensary. If there is some benefit that justifies the need for a medical director, there is no reason that a medical director would not be able to serve 10 or even 20 dispensaries. This would significantly reduce the financial burden to each dispensary. 6. The ballot measure specifically authorizes naturopathic and homeopathic physicians to evaluate and recommend patients for certification by the Department for eligibility to obtain medical marijuana. There is no justification for allowing only medical and osteopathic physicians to serve as medical directors. This limitation will likely increase the financial burden to dispensaries and patients.
The draft rules should allow the addition of ailments that are supported by medical research as treatable with medical marijuana, such as: 1. Attention deficit hyperactivity disorder, also referred to ADD or ADHD, a biological, brain based condition that is characterized by poor attention and distractibility and/or hyperactive and impulsive behaviors. 2. Hypertension, the medical term used to describe high blood pressure.
Instead of making patients wait until a Dispensary grows it's first crop, why not supply dispensaries with Marijuana that was confiscated by law enforcement while it was being smuggled into the US? Just until crops are ready for harvest.
Of the draft rules, some infringe on a patient and doctor relationship. I have only seen my doctor 1 in the past 3 years. I have arthritis, bone chips and the labrum is shredded, documented by an MRI. I am in constant pain but refuse to take prescription pills due to the inability to function normally while on the medication. I believe that my doctor and I have the right to explore alternate forms of relief of the pain, and the way the draft rules are set, I would have to see him 4 times before I would be able to try this remedy. DHS seems to think that they personally have the right to tell me what is good for me and what is not, DHS seems t be over stepping the rights of patients and doctors with this view. If these are the requirements for any prescription medication, then fine, but the rules you are proposing are not the same. Requiring a doctor to be on-site or on-call to answer questions seems to be interfering with the patient and doctor relationship. Providing education and information material to the patients as to the effects, effects of combining with other drugs or alcohol, and ways for help if the patient is needing assistance is what should be required of the dispensaries. As for the amount of marijuana each dispensary may grow and sell, the 70/30 split seems a bit excessive, and a 50/50 or 60/40 split. I would encourage more cooperation between dispensaries, increase communication that would encourage good relations with the public and DHS. I say this because the rules as written seem overly restrictive, interfering, and harmful to the patient.
The question that continues to bother me is the development of independent medical marijuana dispensaries in lieu of using existing pharmacies or designated pharmacies for the purpose of fill orders.
I just learned today my doctor will not prescribe me medical marijuana because the hospital to which he

belongs is telling him that he can't. I'm not changing physicians. Does that mean I can't get medical marijuana? Allow a patient to have a primary doctor and at the same time be able to see yearly a medical marijuana doctor. But with the caveat, that the patient has a true history where it is needed.
Please, Please keep the preditors and marketers like [redacted] the PI/Cop out of this. They are in this for the Money only selling dispensaries for 150,000 dollars, stating their group already have a 20,000 sq. ft. grow operation in progress in Phoenix and if you want a chance for a dispensary license you need to come up with 10,000 dollars for his business plan! The worst part of this is that this group of opportunities seem to have had all the first draft issues covered in their classes in late November, 20 days before it became public? HOW CAN THIS BE? These are very shady people HOW COULD THEY HAVE HAD THIS MUCH INFORMATION?
The little guy especially folks that suffer from the allowable card qualifications should be highly considered as dispensary operators. So in my and others that I've discussed this with feel that independent legal firms should review and make suggestions of qualified licensee's.
Make it easier for other states with similar legislation not be penalized and judged as Arizonans. Making it easier for people with Debilitating Medical Condition or chronic pain too move to the dryer climate and still get help.
Hopefully, there will be a standardized presciption formon the DHS website for the necessity of medical marijuana using the outline existing criteria. Also, there needs to be a more liberal criteria than a 1 year relationship and 4 visits between the patient and the doctor.In a state such as ours,there are many out of state patients who come to be care for by family members and may have a terminal or chronic condition that would be excluded from care by the above criteria.Would an oncologist, neurologist or physiatrist review and out of state doumentationof the condition also provide sufficient justification if the original criteria could not be met ? Lastly,will there be a centralized seed dispensary? How will the potency of the leaf be assesed and by whom ?. Will the dispensary be responsible for analysis and which agency will do the oversight of the potency? When the marijuana is incorporated into food, is the amount in the food counted against the 21/2 oz Q 2 weeks or is above and beyond the amount dispensed ? Will ther be standardized pricing or will the dispensaries be in competion of each other ?
Require that tenants inform landlords/property management companies of medical marijuana use. Provide landlord with copy of state documents.
Please require only one visit. Even If I had insurance and Im uninsured for the first time in 51 yrs! Insurance would probably not pay for the one let alone the 4 DR visits the State may require.

xxxx

relationship,which might limit someone's ability to be obtain a pot recommendation for the same condition from a pro-pot doctor.
Coverage on Rural Area's outside of Maricopa County pertaining to Dispensary's and grow site's.
An annual $150 fee for applying for a registry identification card is outrageous and is de facto a denial of said card, status and aid to the many poor people in the State of Arizona. The rules as they stand will merely serve to drive that person to purchase their marijuana from an illegal source, which is what the State is supposedly trying to eliminate. This fee works against the purpose of the Medical Marijuana law. In addition, the fees paid to a physician also severely limit or prohibit many people from complying with the statutes and rules governing the Medical Marijuana Act. There does not appear to be any provisions for people who are otherwise qualified to have the fees reduced in order to avail themselves of the relief the Medical Marijuana Act alleges to provide. Overall, it appears that the State of Arizona does not wish the People's Initiative to succeed. It further appears that the State of Arizona is making the statutes and rules so prohibitive that the majority of the people needing and already using marijuana illegally will continue to do so.
if dispensaries are to be non-profit, clarify what type of non-profit, 501 c3 or what? It only mentions "non-profit in one place, page 31, #13, and nowhere else. VERY confusing.
Shouldn't have to see a Dr 3-4 times if you have a condition already listed....and is sick already. Get the medicine to the people when they need it. Less red tape, the better.
There should be a clearer definition of severe and chronic pain that would qualify. Like conditions such as Rheumatoid arthritis or Migraine headaches. What kind of doctors are going to be qualified to prescribe medical Marajuana.
How are people who need it going to afford to paying $300 to $400 an oz. Patients should be allowed to grow their own and do away with the double standard. People will still buy the cheaper Mexican and keep the cartels financed. No to finger printing of the patients to avoid the cowboy sheriffs and deputies from harassing patients.w
R9-17-316 - The rule is not clear about the location used to infuse marijuana into an edible food product. If the marijuana can only be infused into a food product at a licensed dispensary, it should be clearly identified in the rule. If marijuana is to be allowed to be infused at a food establishment licensed by a local health jurisdiction there will are multiple issues that aren't addressed in R9-17 or the State Food Code R9-8. The issues include security for marijuana a "controlled" substance; security of marijuana at a remote location (food commissary) and does marijuana meet the definition of a Food additive' as stated in A.R.S. § 36-901(7).";or a food as defined in the 1999 FDA food code?
I believe the draft can be improved on several fronts. Here are a few suggestions: 1) The whole 70% cultivation by the dispensary itself is completely off base. Innate in this particular rule is that it assumes a manufacturer of a product should also be the marketer and end seller of the same product. As a "traditional" pharmacy is concerned, they are allowed to solicit and carry several brands of products without a stipulation on what to produce in house. This allows them to carry the best products they feel their end customers would benefit from. This should also be the methodology for a dispensary. A dispensary owner may be well versed in WHAT products would benefit their patients, but may not know step one in the actual cultivation of that product. In the end the patient will suffer. I feel that this draft

is treating the new law as half criminal and half legal in its approach. If the intent is to help the patient, this needs to be looked at fully in the same light as a traditional pharmacy. Half way doing anything will not benefit anybody. Cultivating and Dispensing should be two completely separate businesses unless a dispensary so happens to be versed in cultivating. This separation will also benefit the state of Arizona in the sense it creates more jobs. Land and/or buildings will have to be purchased/rented and people employed to take care of the cultivation to really get a good product to the patient. 100% of the dispensaries product should be allowed to come from a cultivating caregiver registered with the department. 2) Another point that really stuck out to me involves the inspections. In R9-17-306 letter B, it states that the Department should have remote access to the dispensary's electronic monitoring system. This really worries me. There are already plenty of checks and balances written into the law as far as security is concerned to where the Department can review tapes upon request. I believe this last part goes beyond what should be allowed and creates an intrusion into the day to day business function of the dispensary. Once again, this draft treats the Dispensary as half pharmacy and half criminal. These businesses will be privately owned, tax paying entities with enough oversight as it stands. Allowing the department remote access into a private business seems to be a direct violation of the business owner right to run his business effective and efficiently. 3) The last part of the Draft that i saw as counter intuitive was the requirements for Edible Food Products. Borrowing from my explanation of why cultivation and dispensing should be separated, the way the draft reads is that a dispensary must bring product to a food establishment and have them prepare their edibles. This is completely obtuse on several fronts. Once again this draft assumes that any eatery will be versed on what it takes to prepare a proper edible that not only has a taste element, but the proper amount of medicine to really benefit the patient. There are people who are well versed in making edibles and they do not necessary work in restaurant establishments. If the dispensary is to contract out a chef to create a viable product, the limitation of having it be a food establishment should be expanded. For instance, stay at home mothers or fathers could actually sustain a business of creating edibles. Once again job creation. Same inspection rules would apply as far as the Department making sure the place where the creation taking place is clean and sanitary and so forth. It will generate revenue for the state again as well because, the independent chef would have to apply for a certificate and pay a fee in order to do business. Job creation and patient quality can all be improved with these few suggestions without sacrificing oversight. This is a new industry Arizona has passed a law to create and should be regulated as such, but i think there is a fine line between regulation and treating the industry as a criminal enterprise. Thank you.

The draft rules can be improved by not putting unnecessary and unreasonable rules into your language. The draft rules can be improved by allowing everyone to see and participate in a REAL BLOG.

Oversight of allowable home grown marijuana and limits. ADHS should include provisions of how this will be enforced especially given the many, many remote places in Arizona. Specifically address requirements for emancipated minors to access medical marijuana. Prohibit medical marijuana from being smoked in or near a dispensary. It is likely that family (including minors) and friends will accompany authorized users into a dispensary. It is a risk to expose these persons (especially minors) to marijuana and second hand smoke. In addition, there is no proven, available air cleaning device that can remove the effects of second hand smoke. ADHS must not accept any claims that dispensaries will install smoke-cleaning equipment. The equipment does not exist.

Your working days to approve everything is way too long. That weighing harvests part is bad too, it will be all wet and mostly water weight. You should just weigh finished product. Weighing the waste is rather idiotic too. Don't ask what type of soil, many growers use homemade soils. Don't ask what the water schedule is, that has no bearing on anything.

Prop 203 provides that qualified patients can grow their own medical marijuana if they live more than 25 miles from the closest dispensary. The law does not specify how the 25 miles is calculated. I've reviewed the draft rules and I don't see anything in them on this subject. I suggest you add a rule

specifying that the 25 mile radius circle exclusion zone distance will be calculated "as the crow flies" from the center of each dispensary. I also suggest that you specify that the 25 mile radius exclusion zone can cross county lines. If these details are not specified, it will be more difficult for law enforcement to deal with the exclusion zone. Whether a patient was inside of or outside of the 25 mile limit would have to be handled on a case by case basis and might depend on odometer readings etc. There could also be an argument about what route should be used to calculate the boundary of the limit. Specifying it "as the crow flies" will make it cut and dried. The boundary of the 25 mile radius circle could be set by GPS from each dispensary. Including the language specifying that the 25 mile radius exclusion zone will apply regardless of county lines will prevent a patient who has violated the law from using this defense.

A non refundable asking price of 150 dollars just to be applicable to receive a prescription medicine is a lot to ask of some patients, especially those who rely on disability income.

It creates a monopoly by limiting competition with limited dispensaries and the fact a patient would be required to drive up to 10 miles to get medication. Competition will provide cost and quality control and keep the market competetive. Patients need to be able to grow to keep costs down. Opening the market will provide more jobs as well as more revenue for the state. Dispensaries should not be required to cultivate 70% or greater of their product. This is again a monopoly for them and limits dispensary agents from competing.

a few things... 1- the requirement to have the storefront build out an possess a certificate of occupancy is not right. This is a blatant capitulation to big money as they are the only ones who can risk this kind of money on an effort before they know if they will even be rewarded with a license. This needs to go away. 2- the patient/doctor relationship is a huge disservice to the patients in need- the actual ones this law was written to help. you are asking them to change their doctor if they do not believe in medical marijuana. this is a big mistake...for example there are a lot of doctors- primary care and specialists who will not prescribe pain meds. So that doctor remains the primary doc or specialist but the patient goes to a pain clinic to address those symptoms. the docs stay in contact and manage the overall care of the ptient. There is no requirement for a patient to leave their current doc who will not presecribe pain meds if needed. This regulation as is is quite onerous. 3- the medical director requirement will do NOTHING but drive up costs for the patients...A doc could charge $5,000-$6,000 a month x the 3 dispensaries they are allowed to concult for and make $180,000 to $200,000 a year for doing nothing. I think that DHS should create the educational materials needed (paid for by the dispensaries) and require them to be available at all times in each dispensary. Makes a lot more sense than requiring a doc to be on call for $200,000 a year.

If you want to prevent law suits, please have your legal department review this. In Leary v. United States, (1969), the U.S. Supreme Court ruled upon the constitutionality of the Marijuana Tax Act. Dr. Timothy Leary, a professor and activist, was arrested for the possession of marijuana in violation of the Marijuana Tax Act. Dr. Leary challenged the act on the ground that the act required self-incrimination, which violated the Fifth Amendment. The unanimous opinion of the court was penned by Justice John Marshall Harlan II and declared the Marijuana Tax Act unconstitutional: “Compliance with the transfer tax provisions would have required petitioner unmistakably to identify himself as a member of [a]...’selective’ and ’suspect’ group, we can only decide that when read according to their terms these provisions created a ‘real and appreciable’ hazard of incrimination.” Most legal medical marijuana patients want to comply with the law, but if any law or local ordinance requires disclosures of any kind, it is not constitutional and will not be tolerated. Although California offers a photo ID to patients, those cards have only a photo and a code number which allows law enforcement to determine if the card is valid. No personal information is allowed. The consequences for anyone who is viewed by law enforcement as a member of a “selective” and “suspect” group associated with cannabis can be as severe, and incriminating.

I am on AHCCCS. I live in a very small town serviced by North Country Clinic. My doctor says a marijuana recommendation would be beneficial for me. My doctor says the clinic won't allow him to make a medical marijuana prescription for me. I like my doctor. I don't want to switch doctors. I can't switch doctors until the next enrollment period. I'm in a great deal of pain. I have terrible muscle spasms. My bowells do not work right. I have terrible nausea. I can't eat most of the time. I have been illegally buying marijuana so I may be able to eat. I do not smoke it. I ingest it. I am poor so all my money goes for my healthcare. I depend on others to help meet my needs. I can't travel well. There is only one doctor here. Please make clinics and hospitals not interfere with their doctors. Say that they can not prevent their doctors from recommending marijuana to their patients. If you can't do that, than allow patients to keep their primary doctors and be able to get a marijuana doctor. Allow me to visit the doctor once a year to get my card. The marijuana doctor can have access to all my files to make or not make his recommendation. Do not make me spend many $ by forcing me to see my marijuana doctor many times. Keep my yearly fees down. $150 is a lot of money to apply for a card. Keep dispensary costs down so my marijuana won't be expensive. Don't require a doctor for a dispensary. that only raises my costs. Thank you.

I'm a 41 yr. old unemployed construction worker without any health insurance so couldn't afford to see a personal Dr. since 2007. All I have is proof of 3 emergency visits to the local Hospital in the last 2 yrs cause of nausea and stomach cramps from what was diagnosed as acid reflux disease, was so severe I had to go to emergency room eventhough I knew I couldn't afford to pay. The pain only happens when cannabis was unavailable to me. I moved to Az. from Ca. in 2007 where I used marijuana for my depression. Since moving out here to Az. I've relapse and gained over 70lbs cause of it. Please add acid reflux disease so I can control my nausea and not have to go to the expensive emergncy room that can't afford to pay any way. It's unfair for those who don't have health insurance nor personal physician cause they can't afford it not be able to grow their own. It would save the state lots of money from emergency visits.

Requiring a physician-patient relationship to have been existing for at least a year with four visits is asking too much. This cuts out any person who just became sick, people who couldn't afford four visits to the doctor, or people who changed doctors after one, two or three visits. There must be a better way to determine who is really eligible for medical marijuana and who is faking it. I believe one examination from a doctor is all it should require to obtain the right to medical marijuana, but we have seen how this method has been exploited. So, what about two visits, between a certain amount of time, maybe a month. A year is far too long for a person to suffer without a potential cure to their sickness. (That is why I think one visit is enough... Because a person should get help as soon as possible). Why not only allow doctors who meet a certain requirement to be able to recommend medical marijuana? If they are a doctor in the first place, they should have good enough judgment to tell whether or not a person needs medicine. I still think one visit to a well-qualified, honest doctor is all it should take. Also... In my opinion, it is not necessary for dispensaries to have a 'medical director' on-site, or on-call at all times. Patients already have doctors who should provide them with enough information on the type of medicine they need. This rule is requiring people who are applying to open a dispensary to hire a physician to basically look over the daily operations of the dispensary. All general questions will be able to be answered by anyone knowledgeable enough to run a dispensary. I can see how it could make handling questions easier, having the knowledge of a 'medical director', but requiring him/her to be on-site or on-call at all times is certainly unnecessary. Although I can't think of one, but, If any emergency would arise, the patient and dispensary should refer to the patient's doctor who recommended the medicine. I would suggest completely abolishing this rule, or have city medical directors that patients and dispensaries can refer to.

There is only 124 licences being handed out. How can the dept of health expect people to go out and buy, or rent land not knowing what licences will be available and in what countys they will be availble. 5,000 dollars plus property rental is too much to gamble and lose. Why not make the application process two parts. 1 applicants pass all the legal requirements, the dept of health does all the checks and makes sure the applicant passes. 2 next you tell the applicant what area is still open to set up a dispencery, give the applicant 90 days to get set up in the physcial location. after 90 days you can inspect them, if they are not serious, take the limited licence back, and try another applicant. if they are almost set up, work with them I am a person who is very passoniate about medical marijuana, but i am not a millionaire, and dont have 20,000 to just throw away. the direction you are going in now insures only the extremely wealthy will be able to do business, and drug dealers, who have money and a front man.
including language that allows a certificate to be issued while exact location is solidified, pending approval by DHS. Limit the number of dispensary certificates any person, company, entity, etc, can have (1, one)
I think it is unfair that you have to have the physcial location of the dispencery before you apply for the application. you are excluding the folks who are not wealthy, but may be very passionate about the cause. All of the resrtiction garuntee,s that only the wealthy will be able to open the dispencery's and the patient will suffer, because their marijuana providers will only really care about profit. How can the average person afford to pay the money to buy or rent a location with out being gaurnteed a licence. Second if a patient has a relationship with a doctor who is anti marijuana, or one that is scarred of losing pain med business to marijuana, they will not want to write the recondmendation. The patien will have to switch doctors, find two pro marijuana doctors and then visit them 5 times in the next year, just to get a marijuana card. The way 203 was written excludes the average person and, the average patient will not be able to afford the expensive medicine. It will still be cheaper on the street.
Having qualified in another state for a medical recommendation. I'm looking at this from a patients perspective. If I qualify as a patient I should be able to go to the doctor to get a recommendation and then go to the pharmacy the same day to pick up my medicine. Don't tell me it's going to take a year to form a relationship. How an arthritic or bed ridden patient is going to get to the dispensary. deliveries? I don't see how a dispensary or caregivers will be able to grow enough to supply patient needs. 150.00 registration fee is too much for lots of poor and retired people. Should be like a drivers license and just like a drivers license there should not be an annual renewal fee and if necessary a very low fee.
I have chronic pain and the doc has told me to use home care measures. I follow his advice and I do not see him on any type of steady basis because of cost and no insurance. How then would I qualify ???
1) medical director requirement, 2) selection process for dispensaries 3) allow growers to grow and dispensaries to dispense 4) not make patient sever relationship with primary doc if needs to solicit outside recommendation for marijuana
The use of a Medical Doctor is not clear. The draft implies that a Medical Doctor will not be able to practice medicine if he/she becomes involved in a Medical Marijuana dispensary. Your draft also asks if

a Pharmacist will be on site. Is that a requirement? Page 34 G: 5 working days. How is that to be handled by the mail. I think there should be consistency and make it 10 days to address issues. Page 41 -- Does a Food Establishment (manufacturer of brownies, etc.) have to comply with the same rules as a dispensary requiring finger printing of it's employees? Page 34 - Alegations. Does that mean that the Dept of Health will only investigate allegations where the person gives their name? How will those tips be used? Will they be handed over to Law Enforcement?
My problem is that I am being treated by the VA in San Diego because it is closer to Yuma and the care at Tuscan is terrible. The doctors there can't write scripts for medical marijuana since they are federal. I can't get a California card because I am not a resident. I can't afford to establish a doctor on the outside of the VA for a year prior to recieving a permit card. I have a good relationship with my doctors and have to see them once a month now. I now take morphine and percocet now and would like to be able to receive a permit card without having to jump through too many hoops.
do you have to get a patient and caregiver if the caeregiver would be obtaining the marijuana for the patient? the cost is way to high if that is the case. the patient should be able to designate who could get it for them. why is the cost so high for the patient, renewal for dispensaries less, why not the same for the patient. What if the caregiver is an immediate family member, shouldn't that include the patients card?? replacement cards should be more. If you apply online how do you get the pictures???
Article 1. General R9-17-101 16. A The physician-patient relationship has exists for at least one year and the physician has seen or assessed the patient on tat least fo0ur visits for the patient's debilitating medical condition during the course of the physician patient relationship I am a 30-year Disabled Veteran currently rated at 20%. My disability history is documented with chronic pain of my right shoulder and I have received treatment, over the years, for that pain. I understand that the VA will not recommend medical marijuana. Improvement: There are no rules related to Veterans The exception for the rule can state if the applicant is a Veteran with Honorable Discharge, has a disability rating with a history, and can show medical documentation then the doctor patient physician relationship is waived.
I do have a concern about the $150 fee for patients to register and to renew with no option for a waiver. When you read the list of qualifying conditions, many are likely to leave a person disabled which generally means very limited financial resources. They will, no doubt, have to pay for the marijuana out of pocket and to add that high a fee seems prohibitive.
Re R9-17-202 I believe that the rule, as written, is far too restrictive and is not within the letter and spirit of the law that was passed by the voters. It is perfectly legitimate for the Department to write reasonable rules in such a way so that they can prevent young, healthy stoners from getting recommendations for a card. The rules should be written in such a way that they will not unreasonably impact the ability of deserving patients to be able to get a card. The clear intent of the ballot measure passed by the voters was to allow deserving patients to get medical marijuana cards without being burdened by unreasonable regulations and resulting expense. It is a balancing act and the 1st draft of the rules significantly tilts against the rights of legitimate patients. The effect of the rule will be to significantly reduce the number of doctors who will be willing to be involved in evaluating patients under the law. It will also increase significantly the fees charged by the few who are willing to participate. Requiring a doctor who does not have a 1 year/4 visit relationship with the patient to assume responsibility for medical management of the patient is completely unworkable. The choice of physician should be freely made by the patient. If a patient is forced to choose between sticking with his or her current physician and not getting a card versus getting a card but having to change doctors or get an additional doctor, they will likely forgo the card. It is not reasonable to force them to choose. There

are numerous reasons why a patient would not be able to allow a recommending doctor to assume responsibility for their care. The most obvious is insurance coverage. If the recommending physician is not covered by the patient's insurance, he/she will not likely be able to afford to change or add the recommending physician. Here's another situation. Let's say a patient has received a diagnosis 3 months ago of an aggressive breast cancer. The treating doctor doesn't know anything about medical marijuana and doesn't want to get involved. (this will be the situation with most doctors) For this reason, the patient goes to a doctor who has educated him/herself concerning medical marijuana and is willing to evaluate the patient. The doctor reviews the medical records and does the comprehensive evaluation and offers all of the information to the patient as required by the rules. However, the recommending doctor is a family practice specialist and is not qualified in any way to undertake the ongoing care of the patient. Consequently he/she cannot certify that he/she "has assumed primary responsibility for providing management and routine care of the patient's debilitating medical condition..." Consequently, the patient who is entitled in every way to receive the medical marijuana card doesn't get it because the rules have been radically skewed in such a way as to prevent a few undeserving people from receiving recommendations. My suggestion for revising the language of the rules is below

Will Humble-- I know you are a busy man with many responsibilities. I know your department has put much thought into these regulations to prevent recreational smokers. I am a "Travelling Nurse" and I see the poorest of poor patients. It is better to err on the side of the patient, instead of trying to be so restrictive that no one benefits from this law. I see paraplegics, quads, patients with every type of illness where their nausea is so bad that they can not eat. For many of them MJ helps the patient function so that they are able to eat. Many of the doctors I have spoken to are willing to recommend Medical MJ but the hospital or clinic to which they belong prohibits them from doing so. Some doctors are afraid they will be prosecuted or they might jeopardize losing their medical license. You must understand that there are many cases where the patient needs to stay with their existing doctor even if that doctor cannot or will not recommend Medical MJ. I have patients who are locked into their current doctor due to insurance requirements. If they go to another doctor they lose their coverage. I have patients who live in rural communities where there may only be one doctor. I have patients who are unable to travel or can not travel long distances. I have patients who have established long term relationships with their doctors. Their doctor may believe Medical MJ will help their patient, but many doctors do not want to write a recommendation for a myriad of reasons. Do not put any restrictions on a patient seeing any doctor for a Medical MJ prescription, except making sure the patient has a documented history that would warrant Medical MJ. Make it easy, not difficult, for those who are suffering. If a Doctor chooses to be "liberal" with his or her prescriptions give the doctor a "hefty" fine, take away the doctor's license or send the doctor to jail, but allow the poorest of the poor to see their regular doctor and concurrently see a doctor for their Medical MJ recommendation. Also keep costs down for the poor. $150 each year for a Medcal MJ card is a lot of money for someone who has no income, or who draws a $600-$700 check for social security disability. Having a doctor on call for the dispensary will only drive up costs for Medical MJ for the patient. A pharmacist is all that is needed. Make dispensaries safe, but do not add extra rules that will raise the price for the patient who already is struggling to survive. Thank you Will and staff for your hard work, but remember the poor patient should always be on your mind when you are setting up these rules.

It is not clear what the medical grade percentage is. I have been told 15 to 18%. The rules do not specify who measures the potency.

change the smoking areas.its medicine not toxic fumes. outdoors should be ok as long as not near schools churches. some people like outdoors and would need to use it. hotels etc need to be put in also.

It's ok to make rules so only those who truly need medical can get it, but make sure those who truly need it can afford it. Please let legitimate patients grow in a reasonable fenced are so they can afford to grow their own. No one on disability that I know could afford a 12' wall, or even open a 1" thick metal gate.
smoking areas and pricing are my 2 biggest complaints.id cards should not cost $150. that is expensive.
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R9-17-302.B.1.j. Who besides someone that has more money than brains would spend $50,000 or more setting up a fully operational dispensary and grow facility without at least being granted a preliminary approval period pending inspection and compliance?(60-90 day period) The language is already present to obtain the detailed floor plan and location of the dispensary based on commercial structure/s that could be secured with a contingency lease for a fraction of the expense of building everything out without a legitimate reason. Requiring a full build out for the consideration of a license excludes even the upper middle class from being able to participate in this program. These are the people here in Arizona, especially in this economy that truly need to see the benefits from this new industry the most. I do understand wanting to keep under funded, low budget operations from attempting to get into this and cut corners which would cause public and patient safety concerns. Anything beyond that however seems an obvious attempt to unethically steer these licenses only to the very wealthy, and in total honesty if you stay this course the AZDHS should expect to see a class action lawsuit in order to remedy this disservice. Having access to the necessary funds to participate in this and to do it right should be all that is required, as opposed to the exclusivity of having access to these large amounts of funds that are simply disposable. Steering dispensary licenses only to the very wealthy would not to be in the best interests of our communities and the legitimate patients this industry needs to serve. Someone with the passion and dedication to put their life savings and home equity on the line to make sure their organization is compliant to the letter of the law and dependent on their clients satisfaction, should in my humble opinion be what you're looking for as an ideal candidate for a dispensary license! R9-17-302.B.5. Should be obtained during the preliminary approval period. R9-17-302.B.15.d. For blatantly obvious reasons the amount should be declared and then should then be obtained during the preliminary approval period. R9-17-302.B.16. The fee should submitted and kept if a preliminary license is granted(if they receive a preliminary license and then fail to comply the full $5,000 could be forfeited), only a responsible and ethical $1000 fee for processing the application should be kept if no license is granted. 120 granted applications is $600,000 then add the apx. 1000 applications that will not accepted at $1000 each, and that's an additional Million give or take. To distribute the dispensary licenses as fairly as possible and attempt to avoid litigation in the process, I would simply suggest setting up one or more (due to the time constraints) unbiased panel/s of 3 or 5 judges and scoring dispensaries on a variety of relevant issues. Maine's Department of Health and Human Services just did this to meet the needs of having a similar MMJ law pass, and they also had to distribute dispensaries in an very similar situation where demand outweighed the available supply. Maine consulted with New Mexico to put their program in place and that's one of the strictest medical marijuana states in the Nation. R9-17-107.B. The License fine, but there absolutely needs to be a process for distribution of preliminary licenses pending approval. R9-17-307.C You might wish to address multiple dispensaries sharing a growing facility via subletting. Within strict boundaries there might be some benefits to this on a small scale, but the line will be thin! Unless all municipalities place responsible zoning ordinances on the overall sizes of these operations, they will likely become violent crime targets. R9-17-310. The Medical Director Should also be allowed to be a retired Doctor, Family Nurse Practitioner, or possibly a physicians assistant ? These positions would seem to suit the needs of medical experience necessary to

advise in this capacity without being able to personally recommend Medical Marijuana. There seems to be an obvious conflict of interest by having someone capable of approving recommendations serving a dispensary in this capacity. The superfluous expense of requiring a dispensary to an employ any of these individuals when a patient should already be under the supervision of a licensed Doctor might cause an undue hardship to the dispensary and could possibly open the door to litigation against the AZDHS? Not something I would participate in, just a potential unintended consequence that seems like a possibility to me. I'm not going to beat a dead horse. I know everyone is upset about the restrictions you have designed for patients. Please do your best to minimize unintended consequences that will ultimately cause time spent suffering and a financial hardship on those in legitimate need of this. No human being that has seen what I have and gone through losing a loved one could deny the medicinal properties of marijuana. Please try to toe the line of keeping recreational drug users out of the system without punishing valid patients in the process. THC is only one of the active cannibinoids and If we can create a strain that provides medicinal benefits without intoxication, we will.

It seems to me that a patient car only use his/her medical marijuana at a private residence. Now this on the surface seems reasonable, however, it is not. Take for instance a patient that has a wasting disease, who must use marijuana to stimulate appetite. This person who has been stuck at home unable to travel due to the fact that the only medicine that helps ha been illegal. Now that person wants to see the great State of AZ, and reads the rules and finds out that unless they are going from one private residence to another, they may as well stay home cause they can't use their medical marijuana in ANY public place, inside or outside! They can't stay in a hotel, cause they can't use marijuana, they can't even go in their own car and use it. Tell me, is this not an effort to improve the quality of life for these people? I think it is reasonable for a person who may need to use their marijuana outside of a residence to have certain places designated "smoking" or "treatment" areas if you will, where they can medicate themselves without harassment of any kind. For goodness sakes people, some of these patients are homeless, where do they go?

R9-17-102. Fees 5a.Qualifying patient, $50 I feel that the $150 fee is way to high and will force many potential patients to stay in the illegal market. The goal is to help people and with this tough economic times we are in, we should avoid burdening the patients with high fees.

As a representative of an employer in Arizona, it would be very helpful to have guidance in the final rules, through definitions or otherwise, of how it can be objectively determined that an employee is either "impaired by marijuana" or "under the influence of marijuana" as those terms are used in the Act.

Good job on program implementation thus far. However, one major cause for concern is the fact that the regulations listed below would appear to force an applicant for a dispensary registration certificate to commit financial resources to a building lease or purchase before the application would be approved. As R9-17-107 (B) and R-9-17-302 B(5) is written, one would have to have a building space before the application would be considered “complete”. R9-17-107. Time-frames B. “A registration packet for a dispensary is not complete until the applicant provides the Department with written notice that the dispensary is ready for an inspection by the Department.” R9-17-302. Applying for a Dispensary Registration Certificate B(5) “A copy of the certificate of occupancy or other documentation issued by the local jurisdiction to the applicant authorizing occupancy of the building as a dispensary and, if applicable, as the dispensary’s cultivation site; For example: This inspection would obviously cover the building’s security system. Is it fair to force dispensary applicants to invest in installing a suitable security system before knowing that their application would be approved? I think an approach that would work would be to give a preliminary approval, based upon review of the application, building and security plans. The applicant could then proceed with confidence to secure the space and implement requirements to finalize the application. Also, I noticed that there is no provision for the application fees to be refunded in the event an application is not approved. Does the department plan keeping these fees? Your thoughts. Thank you.

In regards to whom can recommend Medical Marijuana.. Not all Doctors agree/ disagree with medical marijuana due to our countries long history of classifying it as illegal. This presents a problem (in some cases) for the patients who want to use their family practice Doctor but aren't able to due to the prejudice behavior from said Physician. If a Patient is truly medically qualified and is willing to trade the Prescription narcotics for cannabis that patients SHOULD Have an opportunity to do so. If not... patient should have the option to see another physician and follow up with that new physician once approved. I'm personally a cancer survivor (in remission) and "suffer" with painful Osteoarthritis (classified as Sevier) in my Knees, hips and back. Every minuet of every day Is a living nightmare! For people like me this is a God sent as narcotics me very sick - Please consider the big picture here.. That is those of us With TRUE and SEVIER (chronic) issues shouldn't need to jump through hoops to get a little relief.
allow users to use in other places than just thier homes or ,(as in my case),i would not be able to go camping or fishing,or participate in other family outdoor activities.
The rules on prohibition against a qualified patient or caregiver from cultivating if they are within 25 miles of a dispensary is discriminatory. The statute is effectively allowing dispensaries to have a monopoly on cultivation and charge whatever prices they want- essentially discriminating against lower income patients. If caregivers and qualified patients are required to be licensed and registered with the same rigor as dispensaries, then why not allow them to cultivate their own medicine more cost-effectively than a dispensary? The language of the statute is very ambiguous and has room for loose interpretation: "A designation as to who will be allowed to cultivate marijuana plants for the qualifying patient's medical use if a registered nonprofit medical marijuana dispensary is not operating within twenty-five miles of the qualifying patient's home." Operating when? 24-7? It does not explicitly prohibit qualified patients from cultivating within 25 miles of a dispensary - it is only implied. Nor is there language anywhere else in the statutes that has an explicit prohibition against personal cultivation if within 25 miles.
change the 25 mile rule so people can get access to cheap meds . cost to grow 30 a zone cost to purchase from dispensary 250-500 a oz . cant say that is a non profit organization making profit like that
The draft can be improved by including a section that allows for a compliance audit to be conducted by the Department and non-compliance or failure to report revenues and remit taxes will result in revokation of license. Also, compensation expectations should be outlined to prevent not for profit revenues from turning into excessive owner salaries.
the part that says the patient must have at leat one year with the doctor and four visits for the same problem is ridiculous!! my diagnosis was made in a single visit. why should i have to go back 4 times?? this is only going to cost everyone more money and make insurance go up. Besides after a diagnosis is made why would the doctor even agree to see you 4 more times? what is the point? who would even think that this is necessary. this must be changed! this is what the people wanted, you can't try to regulate this law out of existence!!!!
with reference to the growing for the dispensaries I feel that if you have land zoned for growing and do not get a dispensaries lic. The license person could sub contract for a grower. Also the big question is HOW DO WE GROW WITH OUT SOME STEELING THE PRODUCT? I feel it can be grown out doors and securing the property with a 10 ft chain link fence and using green houses. This is a lot better way than

growing inside where you have to use lights. [redacted]

For R9-17-201, there are 13 conditions that would allow a doctor to "recommend" medical marijuana. The ADHS has no business interfering with doctors' professional judgment of the best medical treatment for their patients, regardless of their condition. The state should not interfere in the doctor-patient relationship by limiting the categories in which medical marijuana can be administered. A recommendation by a licensed and practicing doctor that the medicine is likely to be beneficial for the patient, in the doctor's best judgment, should be sufficient. R9-17-201 should be changed accordingly. We need to have stronger language in the rules barring the state (or any state agency) from surrendering the registry list to the federal government (i.e., Department of Justice). This could potentially be used by federal agencies to prosecute or discriminate against lawful medical marijuana users.

I work for the state of az in family assistance, i administer ahcccs, seeing as many ill people as i do i believe that $150. yrly for the card is going to be very hard for many people on fixed income to afford and they seem to be some of the people who will benefit most & need this most. maybe there should be special considerations or income limit guidelines, for disabled persons on social security. but i do not belive that ahcccs should pay for the card or the medical marijuana. Thank you

In California, the "L.A. Weekly" has pictures of strippers dressed as nurses advertising Medical Marijuana Cards for $35.00. Since medical marijuana is a drug, shouldn't it fall under the rules and regluations of drug advertising? Requiring the dispensaries to grow their own marijuana is a sketchy trend. Collecting taxes in a "cash only" industry is difficult. Fry's, Safeway, etc... don't grow their own food. AZ should break supply and distribution into two components. Once marijuana is certified organic, origin is known, meets all AZ State quality criteria, it should be commercially packaged and get a stamp just like a pack of cigarettes. Arizona could charge per stamp, just like cigarettes. This type of arrangement would make Arizona grown marijuana a hot interstate export/smuggle item. Why buy potentially toxic cartel marijuana when you can purchase safe and effective AZ certified marijuana? Loose marijuana lends itself to fraud. How can you protect the consumer if every batch is different? Pre-packaged marijuana would be easier to regulate and tax. We know that other States will soon follow with their own medical marijuana votes. Arizona farmers could capitalize on this trend by becoming a highly regulated and transparent grower of this product. The State of Arizona will hear the cash register ring with every export. Separate production and distribution.

Forcing patients to wait a year to receive the help they need seems reckless. I understand that you are trying to limit fraud, but by doing so you are hurting the lives of desperate people in pain. For example, I've just been diagnosed with Cyclic Vomiting Syndrome. Some mornings, for inexplicable reasons, I wake up extremely nauseous. In a recent bout, I vomited for a total of eleven hours, with at least four episodes per hour and as many as seven. The pain is entirely unbearable, but unluckily for me, under the current provisions, I will probably be unable to receive medical marijuana because I haven't had a doctor in Arizona. I'm originally from New Jersey and I attend a University in Arizona. This is a new condition that I've developed in the last nine months. No medications do anything because there isn't a cure for what I have. The only relief I have been able to find is Cannabis. When I wake with the extreme feelings of nausea, one "hit" of cannabis is sufficient to assuage me from suffering for the next ten hours. CVS makes me unable to work, or study, or live a normal life, unless I have Cannabis. But under the proposed rules, I would most likely be condemned to suffering, instead of treatment. Please consider putting in a provision that would allow someone like me to get treated properly.

ARTICLE 3. DISPENSARIES R9-17-301. Individuals to Act for a Dispensary Regarding Requirements When a dispensary is required by this Article to provide information on or sign documents or ensure

actions are taken, the following shall comply with the requirement on behalf of the dispensary: 1. If the dispensary is an individual, the individual; 2. If the dispensary is a corporation, two officers of the corporation; 3. If the dispensary is a partnership, two of the partners; 4. If the dispensary is a limited liability company, a manager or, if the limited liability company does not have a manager, a member of the limited liability company; 5. If the dispensary is an association or cooperative, two members of the governing board of the association or cooperative; 6. If the dispensary is a joint venture, two of the individuals who signed the joint venture agreement; and 7. If the dispensary is a business organization type other than those described in subsections (2) through (6), two individuals who are members of the business organization. ========== I thought dispensaries had to be non profit corporations???

How will caregivers and patients be able to supply 30% of the medical marijuana to a dispensary since almost all patients will be within 25 miles of a dispensary and therefore not allowed to grow? Will dispensaries be able to 'contract out' to caregivers to supply that 30% even thought he caregiver lives within the 25 mile zone? I mean within the 60 plants for 5 patients limit of course. A little help for those who don't want to go to the big dispensary or want the caregiver's MMJ would be nice. And who in their right mind would 'give' their hard work to a dispensary? How is that supposed to work? -==========- Won't the 25 mile halo cause some dispensary grows to be huge, while forcing patients with little money to have to buy from them instead of being supplied by himself or his caregiver? -==========- Is there any clarification about caregivers getting a fair price for their work in growing and supplying a patient with MMJ? They have expenses and time invested in growing quality MMJ and should be compensated for the product they provide. I know some people think it's easy, but I've researched it enough to know that there is a lot of work in such a grow. The law says no fee or comensation for caregiver services. Does this mean that you would charge the going rate for the MMJ, but could not charge for the assistance in helping the patient obtain and use his MMJ? -==========-

You that are in charge of writing these proposals, please keep in mind for whom this bill was made legal for! Not another dept to collects fees to be used for who knows what, and I'm sure you don't know either. The people REALLY needing this medication are probably like me and strapped to the bone with existing medical bills that are delenquent, not to mention having to house, and feed themselves being a struggle in itself. It is ridiculous that correspondance has to be done "electronically". How about the people in NEED that have NO access to a computer? Do we let them fall by the weigh-side? It should be no more in cost than that of an AZ Drivers Licence or AZ Identification card. Otherwise this is blatant exclusion of those entitled to this medication, just because they are unable to afford a card or even apply for one via a computer! This has to be addressed firstly! [redacted]

Think like a criminal! Ask a couple of criminals how they would get around this law.

You mentioned that you wanted this to be 100% electronic, but nowhere in the draft does it state if the AZDHS applicaton for Registration card will be in paper form or electronic? Also, how will AZDHS receive patients recommendations that they receive from their physicians? Do they send it to the AZDHS or does AZDHS require Online Verification of Doctors Recommendations. There seems to be a blurring of the lines of what you (Will Humble) want the new rules to require and how you will accomplish this. Also, does all of the requirements needed for a patient to be registered have to be on the Doctor's recommendation i.e. Date of Birth, Doctor's e-mail address, etc. or will this be on the AZDHA application? Your wanting to "make this a better program" than existing states is making this a very confusing process, to say the least. Leave your politics and personal opinions out of it Will Humble. If you can't complete this process without confusing the public, then we need another administrator who can. Please address, Will Humble. Thank you.

The Medical Director can only provide Medical direction for 3 dispensaries. There is no mention about the cultivation site and if a cultivation site away from the dispensary can cultivate for how many--(3, 4, 5, 6???) dispensaries. I have been talking to quite a few people regarding this and it seems that the people that have headed up this inititive give the impression that they are going to help their orgainizers cultivate for many dispensaries. I think there should be a limit to how many dispensaries a site away from the dispensary is permitted. If that doesn't happen, I don't know how you can prevent diversion. I also get the impression that out of staters think that because they have the experience, they can hire someone here. Because the plants have to be bought in Arizona, how will those plants be provided?
Include a process for how a patient can ask for increase in the monthly alotted dosage.
I would think that it would be better if dispensories did not have to grow their own marijuana and could simply purchase all of it from licensed growers and food processors.
i think the smoking areas rules need to be improved. what about patients who like to spend time outdoors? its not gonna hurt anyone out in the forest,lakes,campgrounds,etc they have open pit fires that burn wood. as long as not taking part of a motorized vehucle or poses a firearm it should be permitted. even public parks should be permitted as long as your so many feet from other people or not near children.
i think the smoking areas rules need to be improved. what about patients who like to spend time outdoors? its not gonna hurt anyone out in the forest,lakes,campgrounds,etc they have open pit fires that burn wood. as long as not taking part of a motorized vehucle or poses a firearm it should be permitted. even public parks should be permitted as long as your so many feet from other people or not near children.
I live in rural Apache County. I went to my doctor today (the only doctor within 30 miles of my community). He told me that he wishes he could recommend medical marijuana, but that his bosses have set policy that no one in any of the clinics to which he belongs may recommend medical marijuana. It will be a hardship for me to have to go to another doctor as I don't have a car. I don't have a job as unemployment is very high and there are no jobs here. I don't know if I'm allowed to change physicians as the open enrollment period has ended. If I go to another doctor and make the new doctory my primary physician, I will lose my health care coverage. There needs to be a way to protect me and others like me. I would like to stay with my current doctor. Either Health Care Providers need to be prohibited from not allowing their physicians to prescribe medical marijuana or patients should be allowed to see other doctors for their medical marijuana and still be able to keep their primary physician. The rules of your doctor/patient relationship and primary physician need to be changed.
Cannot find rule provisions addressing 36-2804.02(f), specifically the 25 mile radius, when a qualified patient is permitted to grow their own plant and then later a dispensary opens within that radius. Will the patient be required to cease growing at their home or will they be "grandfathered" in and permitted to continue growing? Can this be addressed through the renewal process?
eliminate all of them and make it legal would like to know if my pain management dr can write my reccomendation for me

As we are dealing with medicine that is also a plant, it would seem reasonable to allow cultivation as an option to purchasing from a dispensary. From what I have seen in TV news and documentaries, buying high quality marijuana is expensive and it is doubtful that insurance will help with the cost. Cultivation could be a real cost saving to people who, because of their debilitation, may have limited financial resources. As with growing vegetables, growing one's own medicine, gives user control over quality and offers some cost saving. Psychologically, however, the process of cultivation gives a sense of value and purpose to a life that may not have that much else going on. I recommend that the dispensaries sell seeds of specific strains, just as they will with the cured flowers. I would think that there will be controls in place to track each sale, and an agency in place to investigate potential abuses. The sale of seeds could be monitored in a similar way. Perhaps a nominal fee and a special registration could be required to grow a limited number of plants.

I disagree with such a high fee for each registration card. Many people who are seriously ill, cancer patients and people with chronic debilitating pain, are unable to work and have been denied or are not elligible for SSD. I have chronic debilitating pain and have not been able to work in more than a year because if my symptoms. Although I am personally unsure about using medical marijuana I know that it would be very difficult for me to find an extra $150 to purchase a a registration card. I also do not know the costs of the medical marijuana itself, but after paying for $300 in perscriptions a month additional high fees would keep me from being able to afford an alternative treatment that is not covered under insurance. This is actually the same reason I have been unable to look into other alternative therapies. I also highly disagree with the doctor/patient relationship rules. While I understand the reason behind wanting to make sure this system is not abused, many doctors are refusing to prescribe medical marijuana because they are afraid it will harm their professional image and reputation. I have a dear friend who has been fighting cancer for 5 years. He has gone through several bouts of chemo, and he just came out of remission again and was told he may have to go through another round of chemo. He spoke with his oncologist and the doctor stated that although marijuana has been proven to help cancer patients and that it is a treatment that could help my friend, that he will absolutely not prescribe medical marijuana to any patient because of the fear of stigma associated with marijuana. I believe there must be some other way of controlling prescriptions and still keeping this treatment available to patients who can truly benefit from it. Requiring a doctor to perform a thourough medical history, including reviewing medical records from other providors for a minimum of the last year up to the last 5 years could be a beginning alternative.

The voters have approved the use of medical marijuana but the limitation placed that the doctor has to have seen you for 1 year and or take over your treatment for your chronic medical condition is going to make it impossible to obtain a card. My doctors have stated that they see the positive effects of medical marijuana and feel that I would benefit from the use but are afraid to give a recommendation because of the fact that the federal law still sees it as against the law even though the President has stated that the DEA should not restrict doctors from giving a recommendation for its use when a state has passed a law for its. I take over 40 pills a day and 2 injections a month. I suffer so much pain from my nerve damage that I take 285 ml of morphine a day. I am on social security disability for this issue and also suffer from sever muscle cramps and nausea that causes me to throw up my medications. I currently can only hold down cream of wheat and a small amount of peanut butter a day which has caused a large loss of weight. Even the recommendation I have received from a Arizona state board certified MD for the use of medical marijuana appears to be no good now due to the current draft of ASR 36-2801 i. and ii. I cried when proposition 203 passed to see help so close. Now my wife cried when I told her of the current draft. I understand that there can be abuse by people who are not ill but this part of the draft appears to ignore that those of us who are ill cannot afford to change doctors because of other doctors fears or buy any or tolerate any more pills. How strange that I can get over 100,000 ml of morphine a year (thank God!!!!) to control my pain but not one ounce of marijuana to help hold them down even with all my records and the recommendation of a Arizona state board certified doctor. I beg you to rewrite the section that will let someone with my documentation get the medical marijuana they

so badly need.
I am on social security disability due to rhuematoid arthritis and fibromyalgia. First of all the pain medicines I take are ms contin, vicodin, lyrica, soma, trazadone and others. I am tired of taking so many pills the long term effects of the damage is unknown. I will tell you that I have tried marijuana and it helped tremendously. I could eleminate most of these pills by smoking or eating the marijuana, I would improve my quality of life. Being on social security I have to watch my pennies and $150.00 for my card is hard for me because I have to pay rent, buy food etc.. I would suggest a little help for those on social security. Thank you
The fees for qualifying patients seem quite excessive, $150 a year for them to get their medicine?! I understand that this state system does not pay for itself, but perhaps you could be more lenient on the patients by increasing caregiver and dispensary agent fees.
Our motto is "patients first". As a dispensary we will be offering compassionate discounts to the poor as we know of many patients who will benefit from the use of Medical Marijuana but can not afford what ends up being the final retail price of this medicine. It's not a cheap medicine, not after the costs of producing it indoors in safe, secure environments. We do want this to be just a "rich mans" medicine. It should be more easily accessible to the poor. The very poor should pay very little. We need to have compassion for those who need the relief that marijuana brings but are to sick to work. The $150 fee for a patient to obtain a card is way to high of a price. It should be $35 We, as dispensaries could pay an additional $115 on our permit fees to help cover lost revenue from fees. I'm sure you'll find all of us willing to do that. Or do what we at Green Leaf Relief plan to do and charge $150 for patient fees except allow those who can prove hardship a big discount.
i think that the dispensaries need to be REQUIRED to be set up as non-profit corporations...not LLC's etc...you're asking for trouble with people with profit as their main motivation
All members shouldnt have to be residents for 2 years, maybee the president of a non profit or the llc, but whay all members, other states that have been doing this for years and we need there expertise.
It requires that a person with a debilitating condition require to see a doctor for 1 year prior to recommendation. My sister has Lupus and moved here from Los Angeles just months ago and is still looking for a new doctor. This would leave her out of the program! along with many others... Also, Anxiety as an ailment should be added. I personally have panic disorder. The episodes cause nausea, but for relieving the attack, it's necessary.
Get rid of the fee for the card. People already have to pay for the 4 doctor visits and for the med marijuana (including taxes,) out of pocket because insurance isn't going to cover something that is illegal on a federal level. Also someone in that much pain will probably not make that much money.
I think Cancer and other terminally ill patients should be exempt from the 4 doctor visit rule. My grandmother just died of cancer and she went from diagnosed to dead in a matter of months. A key legitimate use of medical marijuana is to help patients on chemo. Patients do not wait to start chemo they do it as soon as practically possible. Also terminal and cancer patients should be able to apply for a card on a sliding scale as $150 can be prohibitive with all the other cancer related cost. There should

be an option to expedite processing for those with cancer and for the terminally ill. A Caregivers if they are a licensed medical professional should be able to maintain a card agnostic of their patients. Register patients to a caregiver NOT caregivers to patients, Requiring a caregiver to pay 200 for every patient or patient change is a terrible ideal. Put rules in place to prevent abuse.
I possibly overlooked it, but I want a provision to collect sales tax, city and state, for the sale of all marijuana, and dispensaries should pay the "usual" taxes and fees associated with any other small business in Arizona, in addition to the licenses that you have included in the draft rules. My experience in Colorado was that the entire medical marijuana industry was very profitable financially for all who were involved. These businesses need to pay the state of Arizona every applicable fee, license, tax, excise tax, property tax, luxury tax, and any "piece of the pie".
--The $150 cost per patient cards is too high. I think $50 would be more appropriate --Asking the dispensary to grow 70% of what they sell is very demanding. I think the growing requirement should be eliminated. The dispensary should be allowed to purchase from any registered grower. --Cameras in growing areas is a little bit of overkill --Your patient-doctor requirements are too strict. You are making it too difficult for legitimate patients to get a prescription. I realize that you are trying to create a safe and friendly environment for patients and providers, but please don't make the process overly difficult for the parties involved.
Requiring a Doctor patient relationship of one year needs to be removed. Many Doctors in the Kingman area are not willing to reccomend Marijuana to any patient due to Federal Marijuana laws. This results in many patients delayed for another full year of suffering. How is this beneficial or fair to those living in pain? Providing a Medical history through records from the patients personal doctor to a new doctor for a recomendation is fair and sensible. This maintains the integrity of the past relationship as well as providing the Recommeding Physician all relevant information to make an informed decision based on actual history included in the patients records. The 25 mile parameter allowing patients to grow at home needs to be removed. This is very discriminatory. The Patient base is largely comprised of fix income individuals. The dispensary pricing is far above the patients ability to afford. Allowing a patient 25 miles and one foot away to grow at home. While the nieghbor may be forced to pay outragous prices or going without all together is blatantly unfair. This law is intended to Help patients have an avenue to access Marijuana. How can a patient have access when forced to pay prices that cannot be afforded by the patient? Growing at home for all card holders is the simple fair solution.
If this is truly for medical marijuana there should be NO dispensaries. The "medicine" should be distributed by a pharmacy along with all the other prescription drugs. I am originally from California and dispensaries are notorious for selling pot to anyone that walks through the door. This WILL happen in AZ. Secondly, no "patient" should be permitted to grow any marijuana plants. By letting them do this, they have an opportunity for a secondary income. There is no way that the state can regulate how much these individuals grow and what they do with their product. If marijuana is the only answer for these individuals then they will find family, friends or an associate that will drive them to the nearest pharmacy to get their medicine. Finally, there needs to be stringent reviews when applications are submitted to approve new treatable conditions. There should be evidence to support such approvals or we will become like California where doctors are giving out medical marijuana cards to any Joe walking in the door. My sister and her friends all have cards. They are in their early 20's and they got them for complaints as simple as menstrual cramps.
Wondering if it would be possible to have a private cultivation facility with out having a public

despensory that mainly supplyed public despensory's, agents, caregivers and delivered directly to qualifying patient residents.
by not having 2 doctors , and having to wait a over a year for medicine with four visits. this is down right wrong to put people that need a better quality of life to wait that long. some doctors won't get involved with this, leading people to find new docotors. what if you just moved here? what if you dont have a year to live ? what if your docotor fired you cause he now wants a retainer fee? what if you are a visiting patinet? normal prescribtions are filled the same day to easy peoples suffering , for the state to force people to wait over a year is again very wrong. prop 203 was voted on and passed by the people the way it was written, why are you changing it so much?
See below
Comments from a provider licensined in Minnesota and practicing at a federal facility where I will NEVER have to Rx Pot. What were the voters thinking? ... sorry I am concerned that the language outlining the relationship between provider and patient is burried in the section about how to qualify as a patient (R-17-202 section F.5.e. i-ii.). I think the language should be more prominant so providers know they must be the patient's primary provider or treating specialist. Also I think there should be language in the rules about what specific purpose the Pot is fulfilling like to promote weight gain, stimulate appetite, etc. Finally the language about the physician checking for interactions with other drugs and supplements is problematic... where does this information exist? And the Risks and benefits? Does the state plan on publishing an official Risk and Benefit statement for
F. A REGISTERED NONPROFIT MEDICAL MARIJUANA DISPENSARY MAY ACQUIRE USABLE MARIJUANA OR MARIJUANA PLANTS FROM A REGISTERED QUALIFYING PATIENT OR A REGISTERED DESIGNATED CAREGIVER ONLY IF THE REGISTERED QUALIFYING PATIENT OR REGISTERED DESIGNATED CAREGIVER RECEIVES NO COMPENSATION FOR THE MARIJUANA. How is a dispensary supposed to get medicine if it cannot reimburse growers for their costs? Given that a “caregiver” can only serve up to 5 patients, with each allowed 12 plants, even if a dispensary is considered a caregiver, which I’m not sure if the Act does, that doesn’t allow for much production. It may be in the text somewhere, but I don’t see how a dispensary is going to get its medicine given these criteria.
Write the rules to reflect the spirit of the referendum? It seems to me that you are intentionally making it difficult to qualify by requiring that a patient have an ongoing relationship with a doctor for longer than neccessary. At present, Drs. can prescribe various narcotic drugs for pain without the lengthy (one year) Dr./patient relationship you are proposing for recommending medical marijuana. This seems unjust and suggests an attempt by the state to alter the will of the people.
Slightly less repetition.
Start over. This draft of legislation is not designed for sick people. The fees and administration associated with the whole procedure is impossible and places an undue burden on these sick people. The law should not be given the right to rule on or over what a patient and doctor decide are appropriate measures for their specific ailments. Additionally: Article 1; Definitions: "public place" includes condominiums and other multifamily dwellings. -Restricts a patients rights to administer medical marijuana in their own home unless they have land around it. The dispensary and cultivation businesses must be separated and be allowed to compete. Patients should be allowed to choose which dispensary and dispensaries should be able to choose which clutivator they buy from and how much.

Get rid of the ridicules $5000 application fee, it needs to be refundable!! because how do I know that you just rubber stamp NO to everyone to make 5k off each applications sound like a scam and abuse of powers, with only 124
WHERE CAN I START? OH, HOW ABOUT THE REQUIREMENT TO LIVE 25 MILES AWAY FROM A DISPENSARY IN ORDER TO BE ABLE TO GROW YOUR OWN. THE SICK AND AND TERMANNELY ILL CAN`T LIVE THAT FAR FOR THE MEDICAL FACILITIES THAT THEY NEED TO BE ABLE TO DO THAT. SHOULD THEY BE ABLE TO DO THAT, THEY WOULD HAVE TO BUILD A FORT KNOX TYPE ENCLOSURE TO DO SO. I UNDERSTAND THAT THE STATE HAS ALL KINDS OF RESOURCES TO DO SOMETHING LIKE THIS. BUT THE AVERAGE CITIZEN DOES NOT. OH, WAIT A MINUTE. NO, THEY STATE DOESN`T HAVE THE RESOURCES EITHER. THE STATE IS BROKE AND RUNNING IN THE RED. BUT THEY HAVE SHORT TERM MEMORY LOSS AND FORGOT THAT FACT. I AND THE REST OF ARIZONANS THAT DON`T WORK FOR THE STATE, KNOW THAT WE DON`T HAVE THE ABILITY TO LIVE BEYOND OUR MEANS. BUT I DIGRESS. THIS WILL LEGALLY LOCK THE ILL INTO THE DISPENSARY CASH COWS, RATHER THAN PROVIDE A WAY FOR THE ILL TO PROVIDE FOR THEM SELFS. AGAIN, KUDOS TO YOU AND YOURS ON THIS BRILLIANT PART OF THE PLAN. WHAT IS THE FEAR HERE ? THAT A LARGE COMMERCIAL MULTI MILLION DOLLAR CORPORATION GROW SITE MIGHT BE ATTACKED BY CRIMINAL ELEMENTS? CHRIST PEOPLE, WE DON`T HAVE THIS TYPE OF SET UP FOR PLACES THAT COULD BE USED FOR IMPROVISED WEAPONS OF MASS DESTRUCTION. THE SINGLE INDIVIDUAL GROW SHOULD NOT BE SUBJECT TO THIS LUNACY. AND MEDICAL MARIJUANA SHOULD HAVE THE RIGHT TO GROW THEIR OWN, 25 MILES OR NOT. PEOPLE HAVE STORES OF HOME BREWED BEER AND WINE. AND PLENTY OF STORE BOUGHT LIQUOR SETTING AROUND. NOBODY SUGGEST LOCKING THEM UP. PHARMACIES DON`T HAVE TO HAVE SUCH A STRUCTURE MEETING THESE REQUIREMENTS.
Relax patient physician relationship length.
So that the industry is not flooded by persons with limited or shallow community roots, it would help to have a residency requirement of 5 years. The longer a person stays in one city the greater the likelihood that they have an interest in insuring the well being of that city and state. Like most industries, this one will eventually reveal what professionals show an ability for retail/sales/marketing and who is better at cultivation. A rule requiring that 70% of all medicine sold come from one's own culivation site will encourage hiring from the existing black market. An nice example is that each cultivation site will employ at least three folks. 3 x 124 = 372. It is safe to assume that there are not 372 persons in our state that can operate a commercial cultivation site AND not be currently involved in the black market. The existing lanuage will draw those willing to break the law into the industry.
40 plus pages!? You people are ridiculous! We need to reform our system of law!
I am writing this as a patient...I feel the 1 year patient/doctor relationship is not fair, nor is it in the best interest of individuals who truly need medicinal cannabis. A lot of people have doctors with whom they have had longstanding relationships, and while patients and doctors do not always agree 100% over care, patients value these relationships with the doctors and do not want to leave them. A lot of doctors will not write recommendations for a number of reasons- from philosophical to logistical to prudence. The regulations the way they are written either require the 1 year relationship or require these patients to leave these doctors who know their conditons, history and in a lot of cases husbands, wives, children etc., and move onto another doctor who will take over the primary care of this condition in order to receive a recommendation. I do not understand how the state can require an alternate doctor to take over the primary care of a condition for someone who is quite happy with their present doctor/patient relationship...Going to another doctor for medicinal cannabis is akin to going to a separate doctor to manage pain because a lot of doctors refuse to prescribe pain meds. I think an MD who cares about their license and ability to continue practicing medicine in AZ would be quite able to decide the benefits of medicinal cannabis for a patient through an examination of the individual and possibly a review of

their medical records etc. Doctors have had to screen people for years who have attempted to “fake” conditions to receive pain meds etc. without needing a year and 4 visits to do so. Possibly speak with some doctors at Pain Clinics to determine their processes/procedures for accepting new patients and prescribing opiates etc...This scenario makes a lot more sense to me than requiring a patient to transfer the primary care of whatever horrible condition they may be dealing with in order to secure a recommendation. I hope this is one area in which you reconsider the present regulations the way they are drafted. Thanks for your consideration.
electronic monitoring that allows authorized 24/7 virtual access by the Department. Seems like this would be an invasion of privacy considering these are legitimate medical patients. What kind of guarantees can the department provide as far as unauthorized access. Will video logs be stored how will they be recorded? If they are being recorded and saved doesnt one need permission from the person being recorded? On-going means the physician has seen the patient at least 4 times in one year or is beginning a course of treatment and will continue to treat the patient. A person with a debilitating disease may be seeing a doctor who refuses to write a reccomendation. Therefore the patient will have to find a new physician and they have to be seen 4 times by that new physician in order to be approved for medical marijuana. This a serious issue and would delay a person with medical necessity from getting their medication. In turn putting the patient through more pain or whatever their issues they are dealing with. We need to come up with a better idea to not delay
Medical Director. It seems that the definition is exactly what a pharmacist is trained to do. A pharmacist on the board of the dispensary should not only satisfy that requirement, but should be instead of needing a doctor at all. A doctor is already involved when writing the prescription
make it $10,000 non refundable keep the rif raf out of Arizona (californians, and colorado) 5 to 10 years required Az. residency
1, Besides treatment for pain, please include this as treatment for anorexia related to AIDS therapy and disease effects, as some patients describe this therapy has greatly improving appetite. 2. If patients can only grow some plants when a qualified distributor is more than 25 miles away, it creates a financial burdet for payment, as many patients are low income and in patricular, patients with AIDS. Patients can grow their own plants and reduce use of prescriptions meds.
#1. Do you charge people fees for opids of drinking alcohol? No. So do not charge patients $150 to get medication. That is what the marijuana is now, medication. #2. Nurse practitioners licensed to prescribe medications, including class I-IV will also be allowed to prescribe Marijuana. it is a controled substance and we have been prescribing it, I have prescribed it for my patients. Why did you just include MD's and Osteopathic physicians?
Think of the patients that need the help. Don't make it so hard for them just because you are worried about recreational use. People can buy marijuana in Arizona any time they want. Help the people that really need the help!
The department lacks the jurisdiction to enact these regulations. The MMA section entitled 'rulemaking' makes no mention of the physician patient relationship or physician certifications. The physician standard of care has already been defined elsewhere in the administrative code, and by the Arizona

Supreme Court. Also, the MMA allows the department to add qualifying conditions, not to take any away. These regs are longer than the act, and clearly not informed by legal analysis. It also might be wise for DHS to brush up on HIPAA Laws before Arizona starts getting sued left and right for patient privacy laws.
I must see my doctor 4 times a year? And pay $250 each time? Are you joking? I have Chron's disease. Somedays I don't even leave my house and you want me to go see a doctor 4 times a year just so I can get my medicine. What a joke. Once a year is enough!
Specify if a dispensary / cultivation location must be built prior to submitting an application.
This would be a good web page to read http://www.cannabismd.net/contaminants/ when considering allowing visitor cards to use dispensarys
The requirement that a doctor who has been treating a patient for a long period of time is not fair to the patient. My pain doctor has been treating me for well over a year. I have peripheral neurapathy from cancer treatment and my spine is collapsing (two discs are almost non-existent). I have almost constant pain. He has no problem prescribing hundreds of oxycontin and vicodan, but he is not sure about prescribing marijuana. I am not able to function on the narcotics he prescribed. I have tried marijuana and it makes the daily pain management easier and I can function. The reason he is unsure about marijuana has to do with his DEA license and his insurance. Why should I be penalized for this?
If dispensary has food and beverage for sale, clarification is needed regarding a food establishment license and who is responsible for issuig the license. Physical Plant set backs should also include parks and religious structures.
The intent of the draft rules seems to be to deny care to as many patients as possible. The rules are clearly overly difficult to meet. Sections requiring a medical doctor in a dispensary are obviously intended to do nothing but subvert the intent and the letter of the proposition passed by Arizona's voters. The requirements for a 1-year relationship and 4 visits with a doctor in order to be prescribed this medicine is more stringent than any other medicine - even dangerous drugs, like oxy-contin, morphine, etc. This is, again, clearly to attempt to deny the people of Arizona medicines which they have decided is beneficial and not as dangerous as many, many others. It would be best to treat medical marijuana as your department would any other phramaceutical - no more ambitiosly, no less.
R9-17-316 completely breaks the chain of custody of the medicinal marijuana. The food processing facility should be licensed and regulated just like the dispensary if the product is given into their sole control at any point in the infusion process. Revise or remove this allowance.
Since there is no cost to purchase any other prescribed drug in AZ besides the cost of purchasing the drug; the "fee" for the card should only be the cost of delivering the card to the patient. It should be no more than a driver's liscence or an auto plate at the most. Make sure you don't make it prohibitive to grow your own medicine for those who live outside the area of distribution. I shouldn't be penalized for living in Page.
R9-17-307, Subparagraph C Initially all dispencaries will be in violation of these guidelines because no medical marijuana dispencary will be allowed to bring medical marijuana plants into Arizona for cultivation. Please add a sub-line that allows medical marijuana plants to be brought into Arizona from out of state cultivation cooperatives and collectives. Secondly, R9-17-307 restricts how much an Arizona dispensary may purchase from another Arizona dispensary. No where in proposition 203 does it

permit a limit on quantity to be sold between dispensaries.
Take out the 70% cultivation requiredment for dispensaries and licenese growers and let the market bring prices down.
I only have one doctor.....
I am confused on the process for dispensary's. It looks like there is an initial application then a second one. When is the fee to be paid? It seems to me the only dispensary's that will be able to open are ones that are financially backed by drug dealers. I would like to open one, but the expense of getting a retail location, the cultivation site, rent, utilities, the application fees, etc....It takes about 90 days for the application, then it takes about 4-5 months to grow marijuana. How could a "normal" person fund this for almost a year without any money coming in? I am sure it will be [redacted] near impossible to get a business loan since it is still illegal at the federal level. This just seems like another way the illegal drug dealers get richer. I would love to open a dispensary, but how? These guys probably already have every thing in place. I hope there are heavy background checks into where the money is coming from to fund these dispensary's. I read in ARS 36-2801 "A nonprofit medical marijuana dispensary may receive payment for all expenses incurred in its operation." If I start a dispensary, will I be able to receive money to cover my initial startup costs until money starts coming in? If so when does it come in, monthly, quarterly, yearly, etc and how is it obtained?
Although the state law says that MJ cannot be smoked on site at either a dispensary or cultivation site, it seems a bit unclear as to the relationship between the dispensary and the 'food establishment'. The rules make it sound as if a food establishment...a restaurant...could be supplied by a dispensary with MJ tea or MJ brownies, to be distributed through their restaurant. OR, is it trying to suggest that a bakery could be provided with MJ by the dispensary in order for the bakery to make the brownies to sell at the dispensary? It was a bit unclear to me.
The origenal initive says that it does recongize visitor cards but makes no provision for acquiring medication from a dispensary. Visitors if they have the paper work to back it up should be aloud to pay the fee for a dispensary card. I know that the state of Arizona does not want to cause denial of medication to anyone, or cause them to deal with the black market. It would be a good thing if their were provisions made for visiting card holders to get their medication. Thank you from [redacted]
The information required under R9-17-302 B. 9 & 10 should be accessible to Police agencies, but otherwise should be made confidential and remain inaccessible to the public via Public Records Requests. This detailed information could be used to compromise the security arrangements of facilities. Cost to replace lost identification/registration cards should be higher.
I'm a service connected disabled veteran with degenerative disc disease. I have severe muscle spasms due to this condition. I'm very discouraged to see the health department is going to require me to see a doctor willing to subscribe marijuana to me for a year before I am eligible. I currently am being seen by a VA doctor for my condition and although the VA recognizes the use of medical marijuana my doctor is restricted from prescribing or recommending it even if he wanted to. There are many other veterans in the same situation and I plead with the health department to ammend this part of the rules completely or at least make veterans under VA doctors care exempt to the one year waiting period. Please!

The AzMMA requires this 18. "WRITTEN CERTIFICATION" MEANS A DOCUMENT DATED AND SIGNED BY A PHYSICIAN, STATING THAT IN THE PHYSICIAN'S PROFESSIONAL OPINION THE PATIENT IS LIKELY TO RECEIVE THERAPEUTIC OR PALLIATIVE BENEFIT FROM THE MEDICAL USE OF MARIJUANA TO TREAT OR ALLEVIATE THE PATIENT'S DEBILITATING MEDICAL CONDITION OR SYMPTOMS ASSOCIATED WITH THE DEBILITATING MEDICAL CONDITION. THE PHYSICIAN MUST: (a) SPECIFY THE QUALIFYING PATIENT'S DEBILITATING MEDICAL CONDITION IN THE WRITTEN CERTIFICATION. (b) SIGN AND DATE THE WRITTEN CERTIFICATION ONLY IN THE COURSE OF A PHYSICIAN-PATIENT RELATIONSHIP AFTER THE PHYSICIAN HAS COMPLETED A FULL ASSESSMENT [NOTE: "assessment," singular, not plural; 1, not 4] OF THE QUALIFYING PATIENT'S MEDICAL HISTORY. So, one full assessment, specify the qualifying condition, sign, and date-done! Without the authority to do so, Az DHS proposes: R9-17-202 5e. A statement, initialed by the physician, that the physician: i. Has a professional relationship with the qualifying patient that has existed for at least one year and the physician has seen or assessed the qualifying patient on at least four visits for the patient's debilitating medical condition during the course of the professional relationship; or ii. Has assumed primary responsibility for providing management and routine care of the patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the patient's medical record maintained by other treating physicians, that may include the patient's reaction and response to conventional medical therapies;

If you pay special attention to Section 36-2803 "rulemaking," you will notice that the AzMMA does NOT give authority to the Arizona Department of Health Services to define-or redefine-the patient-physician relationship and does NOT give the authority to amend the AzMMA language, e.g., adding "ongoing" to "patient-physician relationship." The Arizona Voter Protection Act specifically DENIES authority for such usurpations "Ongoing" when used in connection with a physician-patient relationship means: a. The physician-patient relationship has existed for at least one year and the physician has seen or assessed the patient on at least four visits for the patient's debilitating medical condition during the course of the physician-patient relationship; or b. The physician assumes primary responsibility for providing management and routine care of the patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the patient's medical record maintained by other treating physicians that may include the patient's reaction and response to conventional medical therapies.

There is mulitple problems with the patient-doctor relationship. I have a few issues My docotor will not reccomened and I now have to find another docotor willing to help my quaility of living. Now I must find a docotor willing to and wait for a year for medicine. This is very unfair . If you want to go see a doctor today for pain , they give you vicodin. You then get your medicine filled that same day, for the state to delay the treatment of the quality of a patients life seems wrong. If you just moved here and needed a new docotor you would have to wait a year , this is also wrong. so many people move here to get treated for problems. How dare the state try and delay medicine to people in pain. The law was voted on , and now the state is trying to alter the law past what people apporved. No where in 203 does it state a delay in medince. per 36-2801-13 , a qualifiying patient is one that is diagnosed by a physician a having a debiltating medical condition.. the law was approved by the voters that section 36-2801-3-b states in treatmentof chronic pain. i have pre existing medical condition that causes serve back spasms , it is documented in my medical file threw mulitlple doctors , showing physical treatments and mulitlple prescribtions , which in term raised my life insurance policy. so again for the state to try and say they will make me wait a year after seinng a doctor is just morally wrong. the part about having to have second docotor sign off was not in prop 203 , that was from a law that was not signed into effect in 1996. so this is also a delay in medicine for a patient to force some one to see the same docotor for four visits is also wrong, in a time where people dont have extra funds . i propose 2 visits to the same docotor over a month period and only one docotor to reccomend. but even this was not voted on , doest seem right to have so many drastic changes proposed. please reconsider or rewrite the

regualtions proposed to be patient friendy.
It seems a little impractical to force potential dispensary. and growers to have a location selected and secured with a lease for the application process . that means a potential owner would have to spend a great deal of time and money securing a location and lease before you have been approved or denied by the state for a license it would make more sense to give a potential owner an approval based on application but with the condition that any potential location meet the standards set forth by azdhs before operating , as well as a final inspection before approval of operation , The guide lines for a dispensary. to have a physician onstaff or to be available for consultation during all business. hours also seems a little impractical , the first time Arizona approved a medical marijuana law in 1996 one of the basic issue s was the fact that a doctor would have to wright a prescription for the marijuana because a doctors right to prescribe medicine is controlled on a federal level this would have endangered that doctors ability to practice medicine , in other words isn't it putting a doctors credentials in jeapordy to ask him to be that closely associated with this type of buissness.. The rules regulating how long a patient would have to be under the care of a physician also seems verry restrictive in many cases a cancer patient particularly a terminal patient may not have a year of life left, ,I think it would make more sense to trust the doctors to make a recommendation the same way we trust them to prescribe any medication , also many of the regulations that you have in this out line seem to jeopardize doctor patient confidentiality? To the laymen it would seem much easier just to police it by carefully watching the numbers it is easier and less expensive just to police the dispensary / grow facility threw careful auditing of the product . the other issue is that the policies outlined in this initial draft are going to make the cost of operating a dispensary / grow facility so expensive that it will drive the cost of the product up verry high , even potentially driveing the price up over medical prices in other states like California or colorado , "that would definitely be bad for the patients that could bennefit from this product . an onstaff doctor could potentially add an additional 100k a year or more to operating costs the policy of haveing to rent or lease 2 facilities instead of operating a grow facility and dispensary at a common location also adds cost by making it necessary to pay for two separate facilities as well as splitting employee and security cost . this doesn't seem to have any bennefit to the state , the potential buissness owners or the patients , it will make it more expensive for the state to police these facilities, it will make it more expensive for potential owners by increasing the operating costs and that increase will translate to higher prices to potential clients
Qualified patients and caregivers may grow marijuana when they live more than 25 miles from a dispensary. This section is nothing but an opportunity for the big money dispensories to control the flow of medicine. All qualified patients should be allowed to grow thier own medicine. This section will increase prices for those already strapped with medical bills. The only place that a person can grow is 25 miles from a dispensory is stupid. How is a person to afford the estimated $400.00 per ounce that is $2000.00 per month. Foolish languange.
1. allow home delivery 2. lower fees for those whose only income is social security or less 3. prevent boards and clinics from not allowing doctors to write marijuana recommendations 4. keep costs down at dispensaries 5. no doctor required for dispensaries 6. make infusion easy as it is the safest for patients 7 make doctors accountable for writing good recommendations without penalizing patients 8. make it easier for caretakers to help take care of their patients with fewer hurdles and less costs.
The 25 mile rule is nothing but a scam by Dispenarys to force them to buy only from them. How is this legal????? Every patient should have a right to grow for themselves or assign a caregiver no matter where they live, so they are not forced to pay the insane prices that the dispencary is going to charge (monopoly prices). I know these places are "non-Profit", but lets be realistic. There would not be so

many people jumping up to start one out of the kindness of thier hearts. insurance will not cover the cost of medicine, so we should at least be responsible and not let these companys that wrote and passed the law profit like this. It should be a option, but not forced.
the smoking places needs to be improvised! people like to camp fish hike etc. patients should also be able to smoke in designated smoking areas. pricing needs to be a key issue. this medicine is for the terminally ill and sick which usually means fixed incomes and wont be able to spend thousands on medicine that these non profit dispensaries will be charging. owners are not gonna work or do all this for non profit theres gonna be high fees and charges involved and hows this any better. patients who qualify for medical marijuana and are on social security should pay discounted fees for everything!
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I dont believe that it should take a year to get to know your patient unless they are a new patient to the system.i think if somebody has years of info from a previous town or state confirming from other doctors that the current doctor can contact and has access to it shouldnt take over 3 months.Also its clear on the fact that you can grow up to 12 plants if you live 25 miles away from a dispensory but what if you live closer to a dispensory and need to grow 1 plant either do to not being able to drive cause of seizures or anxiety disorders such as social anxiety? Also if this goes into effect will medicaid help pay a portion of the prescribed treatment?
You are making it impossible for non- profit organizations from bordering states to become foreign non-profits operating in Arizona. There are MM operations in New Mexico that are non-profits that should be allowed to apply for a license in Arizona. Yet, everyone involved in your program has to be an Arizona resident. If a non-profit organization operating in New Mexico has been granted a license to operate a MM dispensary, they have experience and have been through the rigorous processes put in place by the New Mexico Department of Health. I understand not wanting other states to overwhelm your program, however, dispensaries will create jobs and revenue for the Arizona Department of Heath Services. Why wouldn't you want viable non-profits from other states contributing to the good of Arizona? Please reconsider allowing foreign non-profits to apply.
The draft seems ok, but will all the required information be available on one form to be filled out by an applicant and doctor? Also agree with the $150 fee, but is that paid only before issuance of a card or at the beginning of the application process? If paid at the beginning, if an applicant is denied, is the $150 refunded?
My opinion is that your bars are too high. To get an ailment approved and added to the "List from God" of the illnesses covered would be like moving mountains. Besides, each state is different. Mr. Humble said the Colorado experience would be looked at closely in preparing Arizona's guidelines. Yet Colorado rightly includes Parkinson's on the accepted default illness list, but Arizona does not. Although a majority may not feel constant pain, there are those smaller numbers will. The bar for adding acceptable conditions is too high. This fails to account for the human element and is contrary to the spirit of 203 since it errs on the side of denial, rather than acceptance. The argument that medical marijuana may fall into the hands of youth is a non-starter. It's easier for a kid to get weed than beer nowadays. To get a new disease approved, what does "...peer reviewed support that cannabis is effective..." mean? Just because it hasn't been thoroughly peer reviewed doesn't mean it doesn't provide relief from other, more obscure disorders. Neuropathy and other neurological syndromes, some yet to be identified, let alone studied, cause constant pain that severely limits what one can do.
Medical Marijuana is a proven safe and effective treatment for many thing not just major problems. I think the rules are limiting the use to much. If you do research of the history of Marijuana you will find that no one has ever died from using it and it's much safe than tobacco and alcohol. It's a good treatment for PMS cramps, upset stomach, depression, trouble sleeping, anxiety, pain, headaches.
Just making sure Recreational users don,t have access to this program.
I believe it is inhumane to require patients to have a one year relationship with their physician. I am not a doctor, but I have never heard of such a requirement for any other drug. This rule would require a year of suffering for every patient who has a qualifying condition. Many cancer patients do not have a

year of life left. Persons who contract a chronic pain condition or injury need medication immediately. I think this rule is fundamentally flawed and puts patients at risk. In reading through the seven pages of patient requirements, I was left wondering if there is any other medication used that requires such a complicated process. When a doctor writes a prescription for any drug, it is usually done with some efficiency. The doctor knows which medication to prescribe and the pharmacist tracks and dispenses the medication. The patient typically just has to go to the pharmacy with very little waiting even when the prescriptions are for dangerous narcotics, opiates and amphetamines. Marijuana is a proven safe and effective medication that, in my opinion, should be made readily available to patients who need it. Finally, while I understand that it is important to implement strict guidelines regarding security, owner and officer qualifications, systems and locations for dispensaries, I feel that the rule requiring facilities and systems to be in place and ready for inspection when the application is submitted is setting our already fragile economy up for turbulence. I think you can expect several hundred and possibly thousands of applicants. This means that once the 124 dispensary licenses are awarded, there will be at least hundreds of facilities that have been modified for specific use going unused and or leases defaulting, millions of dollars and hundreds of man hours wasted. I believe the two year residency, the not for profit status, the quality of business plan and owner/ officers qualification requirements, coupled with the scrutiny of a state appointed board, is sufficient to choose qualified applicants without requiring facilities to be in place. I think that if time tables were arranged in a way that would allow qualified applicants to have ample time to develop facilities and systems, it would reduce loss among prospective dispensary owners and the influx of unemployment that is sure to occur when hundreds of prospective dispensary owners who have assemble their staff and facilities ahead of time are not granted licenses.

Use the language that is within the proposition. By going outside of the four corners of the actual law itself, you open yourself up for massive lawsuits and clarification from the courts. For example. There is no way that the courts are going to let stand having a continuing medical relationship with the doctors and at least four visits. This eliminates any chance of getting a second opinion from a second doctor who is not your primary doctor for treatment. It appears that all you want to do is punish those who are sick with Cancer, MS or Crohn's and force them to wait another year because their personal doctors who treat them have prejudice against marijuana or simply think it is more profitable to treat with say Chemo therapy instead of alternative forms of treatment. I would think every single doctor in Arizona who favors helping those who are in pain and suffering, from banding together and suing you. Don't forget, they have the money and the State does not. It's broke. Since when do you have a group of Nurse Practioners and beaurocrat's trying to regulate the Doctors? They have their own board called the Board of Medical Examiners and they also have rules in place for disiplinary actions against their own Doctors.

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The definition of “public place” could be improved. The draft lists some child care sites as examples of public places (i.e., child care centers and group homes), but not all public child care. Child care homes certified by the Arizona Department of Economic Security (DES) receive public funds, are monitored to ensure that State rules and regulations are observed and have files documenting these inspections which are available to the public.

if there is a medical licensed person on the staff, board of directors or who will be actively involved in the dispensary, why the redundancy of a medical director... the patients have already been scrutinized by the recommending physician, az dhs, and their usage tracked, why have a titular medical director? why limit sales to other dispensaries to 30%, what if sales are not up to par and there is extra growth, is the dispensary supposed to know exactly how much they need each month?
I do not like the two year residency rule. There are a number of qualified candidates for dispensary officers and corporate directors who have a lot of experience in other states like Colorado.
I don't like the having to see that same doctor for up to a year part. I have changed my doctors in the past a lot. It makes since, but what If I changed my doctor recently so that means I have to see him for at least a year before I can be prescribed medical marijuana. I feel that having medical records of your disease and or pain for up to a year would be good enough. I know that I will in fact be changing my insurance thus making me see different doctors in a few months. So I'm going to have to wait a year for the help of medical marijuana? I really think this has to go into more thought.
I personally think the cost for a medical card could be brought way down. Maybe to $50? Cancer patients are already spending most of their money on treatment and what not. Medicine should be easy and affordable for them to access. Also I believe, ANYONE in pain should be able to get a prescription. Medical Marijuana relieves pain, and pain is the same for everyone. No matter what sickness. The physician should NOT be held accountable as well.
$150 per year for a patient registry card is pretty steep for people who may already be unemployed due to an illness. Especially considering the medical marijuana itself will have to be paid for by the individual (no insurance or state aid will pay for it). Will there be exceptions or price reduction for people who are on ACCESS or ALTCS? Also, please don't make it so hard on the people who need MM to get a card, by making them and their doctors jump through so many hoop, simply because there may be a few people who might "abuse" the system. There are thousands of people who will benefit greatly from the use of MM. Let's focus on making access easy for those who are in the greatest need. Like my friend who is in the later stages of Multiple Sclerosis, already taking Marinol and Lyrica - neither working well. He wants to stop taking them for nerve pain and spasticty, because Lyrica can cause liver damage. Marinol gives him a bit of relief, but makes him stoned and doesn't provide the anti-inflammatory benefits of the natural cannabidiols found in MM. He is anxiously waiting for the day that he can use MM to help make his life easier and slow the progression of the Multiple Sclerosis. The card cannot come too soon. Let's hope he can afford it!
AzMMA does NOT give authority to the Arizona Department of Health Services to define-or redefine-the patient-physician relationship. Right now any patient can choose any physician for whatever reason the patient chooses to and if the physician deems fit they can prescribe medication of any kind for any reason necessary in that doctors medical opinion. This is legal after ONE VISIT where the patients medical history and present condition are assessed. Medical Marijuana cannot be treated any differently or it will be considered discrimination as such and AZDHS will be charged accordingly for any violations in such event. You cannot legally deem a four visit one year relationship with a doctor, the only grounds as a qualifying "relationship". There are many patients whose "primary care" physicians are bound by federal guidelines, such as Veterans whose care is through the Veterans Administration, that explicitly forbid them from giving any patients a recommendation for Medical Marijuana. As you can see this is a massive conflict of interest.
As we all know that this will generate revenues that state Officials should not be allowed To touch,transfer,or use in any state emergency. This revenue has to be earmarked back into research and development only. Build a facility in each county for this R&D.Have processionals maintain and survey what types or brand of medical Marijuana works best for each individual medical issues. And

lastly let's have braintanks and thinktanks set up in each county.to partake in a. Question and answer meetings. Locally then have a mastermind meetins twice a year to generate new ideas on prodocol,rating systems. To keep the Dispensories in check 24/7 on video to a moan hub or central hgts.
The high cost to patients and patient caregivers is unacceptable. Cannabis used for legitimate medical purposes is no different than any other medication, patients should not be expected to bear undue cost to register to use the drug. The lack of recognition for the use of cannabis for the treatment of psychiatric disorders is shocking, cannabis has been helpful in the treatment of Autism, severe anxiety, and attention deficit disorders, just to name a few. The definition of activities of daily living should be expanded to include work and school and travel to and from those locations. Life is more than sitting at home in bed, the law fails to address quality of life improvements.
Must be under a doctors care for one year? You guys must be kidding !! I have been seeing the same Doctor for more than 4 years. now I must change to a new doctor how does not know my case because my old doctor does not believe in medical use of cannabis. My pain doctor will not recommend me because I would stop taking the opiates that he has me hooked on. Can you really tell me that opiates ,that I have to take even if I am not in pain at the time, are better than pot that I only have to use when needed.
You should not require a dispensary's principal officer or board member to have been an AZ resident for two consecutive years prior to the application. The only requirement should be that they are a current AZ resident. Many young adults may stay in AZ after school to pursue a career in this field, but they may have not been residents because they were from other states. Others are moving down to AZ for other reasons, but may decide shortly after being in AZ that they want to pursue a career in this field also. The two year requirement is not reasonable.
The draft rules could be improved to allow for individuals who have had a patient-physician relationship to seek a doctor to recommend medical marijuana in the event that their physician takes a stance against marijuana. I have Rheumatoid Arthritis, severe chronic pain, and history of chronic muscle spasms, and finding a doctor to prescribe narcotic pain killers was very hard. There are many doctors who refuse to prescribe because they "just don't," and others who feel it's a liability concern. I am more than sure there will be many doctors who will take the same stance when it comes to medical marijuana, and as an individual who could possibly be effected by this "patient-physician relationship" clause, feel there should be an alternative measure implemented to cover those patients.
I am a current resident of Arizona, but I have not been living here for the last 2 years. I don't think that this should disqualify me as a candidate. I have extensive knowledge in eastern medicine and years of schooling in horticulture. Include producer contracts with dispensary owners. All medication should be accounted for. Receipts of transactions and where the produce originated from.
I think the fees are a bit to much.
As you must know or will soon find out, their are a lot of physicians treating patients including oncologist that will not prescribe marijuana as a medicine do to the feds or they just dont feel comfortable writing for it. Many of their patients have less than one year to live. They will never qualify for the meds since the draft says they need to be with a doctor for 1 year. For the patients with any of the diagnosis that is qualifying for marijuana, criteria will need to be set for them to visit a doctor who understands the referral process and be willing to prescribe after proof of their illness is obtained.Medical marijuana is a benefit for the patients and they should not have to jump through hoops to obtain it. As far as the 70 percent grow by dispensaries it will never work. Most dispensary owners will have no clue on how to grow the different strains of marijuana let alone produce anywhere enough.Dispensary owners should

have the right to outsource to a grow facility that brings in the expertese to quantify and qualify the grows. For some states dispensaries are closing do to lack of medicine. The public should be able to put requests in for new diagnosis quaterly instead of biannually. The dispensary cant be a LLC. since it is a nonprofit which places it as a corp.
In general, any language that creates additional "hidden" requirements should be struck and rewritten so as to minimize the burdens placed on patients, especially since many patients will be afraid and confused about the legality and popularity of seeking treatment to improve their lives and receive relief from pain. Extra care should be taken in language so as not to create any "loopholes" or other opportunity for patients, caregivers, or physicians to be harassed or victimized. Specifically the rules concerning physician responsibilities should NOT include any language making a physician responsible for any one else's failure to comply with the rules, since that would create an opening for harassment and victimization of physicians without any relationship to reality. Physicians are not responsible for, and are physically incapable of, and legally not allowed to, monitor what their patients do after they leave the doctors office (even patients that currently receive controlled-substance prescriptions legally such as methodone) . That just isn't realistic or possible, and could only be included as an attempt to victimize and harass physicians and patients. Don't put in anything that could be construed as a precedent for invading privacy. We need responsible medicine not socialist medicine. Remove the language that puts responsibility for implementing the rules on physicians. They are private citizens not government employees, unless they will be compensated by the government for this work. They should not and legally cannot be forced to work in government employ without compensation. Instead hire some people to do that job. The requirement for physicians to have had one year relationship and have had four visits OR say they take over primary care responsibility is spurious and obstructive. A patient has to make changes to their entire health care support structure and change primary care givers? What problems does that create for patients as far as insurance, record keeping, health care data collection and etc that is not really necessary? A doctor is a doctor. Patents that receive methodone are not required to wait a year to take advantage of a pain-relief medicine. There should be no spurious requirement such as that. Unless a precedent is being set to have more requirements for other controlled substance prescriptions? Are heroin addicts going to have to follow the same rules before being prescribed methodone for drug addiction symptoms? Sounds a little bit like an attempt to harass physicians and patients out of spite by someone who disapproves and wants to obstruct proper, rational implementation of this proposition but don't have guts enough to say it openly. Take out those spurious requirements. Doctors are not paid to do the government's job or to be "psuedo-secret-police" or something. They are just doctors. Let them do their job and don't allow rules to place obstacles in the way of patients receiving treatment. Doctors don't work for you they are private citizens.
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I think the requirement to have a the docor relationship for 1 year and the 4 visits is outrageous. You

dont need to have a relationship for 1 year to get other care from doctors so the only reason that is in there is to limit or cause others to wait a year before getting the help they need because YOU dont want to help people at all! All you want to do is make this totally outrageously restrictive and unreasonable. The RULES are unreasonable PERIOD.

the doctors you nthink that have beeen around and paracticed western medicine will not approve any reccomendations . for onew it take s away from that patient needing to see his xdr every month isa where dr make there money , if i getr MM i wont need to take 5 piulls im taking now every month and if i have MM why would i have to go back to my dr to get pills that i dont need because theMM takes care of my ailments. Why would a Doctor recomend MM to his established patient if he gets nothing out of it and he loses a customer or patient what evever you want to call it. ASnd why would Doctors with established practices our PCP now recomend MM when he know nothing about it it he is educated in western medicine pills which im now addictred to becuasew i have hernuiatesd disk yet he already said he will not be reccomending to any patient, i have cancer and my oncologist says the same thing he wont reccomend it to any patients so because established dr who have no expierance with alternitive medicice why would he even consider recommending it to any patient he doesnt know the laws yet and why take a chance on a law suit on something that will benefit him none all he does is lose a patient so the rule has to be changed that you may see any doctor that believes in alternative medicine and most of them doctors are just opening up here face it no regular Dr will take the chance and why would he because he loses me coming in for a refill every 30 days so he loses money and he takes the chance of law suit because he know nothing about their western medicine Dr they give pills out which im addicted to know because of it but with my MM i can quit taking all the addictive narcotics. So if you have legit ailments like me cancer and herniated disk with significant nerve damage with all my records within last year from same dr who admits im in need oif heavy narcotics for chronic pain and i have cancer and getting chemo now there has to be a rule that a patient with overwhelming medical conditions should be able to go to a doctor who believes in MM and doesn't stand to lose money like the PCP do if they recommend MM to their patients it obvious don't make it so difficult to obtain if you have proper medical records that are current. And there should be some fast track program for cancer patients dying and in pain and also has herniated disk with nerve damage which i have all my medical records that would support any doctors decision to approve MM and all records are within year what more do you want itys like getting a second opinion. Youi can see a new dr tomorrow and walk out with percocet firts visit so why would a non a addictive plant and safer then narcotic addictive pain pills be any differnt all the sudden we have to see a dr for a year. No doctors are supporting this prop thats what Mr humble was counting on so there would be a small amount of card holders which bmakes your black market bigger quit throwing a tempure tantrum because the prop won and you were against it may you get rectal cancer like me and get sick and go through [redacted] and lets see how fast you try MM then unless you have been their you dont know [redacted] it so obvious watching Mr humble he looks like a kid that got beat in a game and he is changing rules so the winner has a hard team winning again its called a cheater it passed 3 times get over it and give the MM to people who need it and yes some will sleep through trhe cracks but that should be on you holding your doctors responsible with fines and taken away thier license, If a patient has medical records from the past year he should be able to go to any doctor and have them make a professional opinion based on medical history. like me i know im getting my card im dying of cancer and in constant chronic pain so i hope you change that dr patient one year rule or modify ofr i will fight you all the way. Quit making people do dolphin tricks to get theMM it passed get over it and i can only hope you get cancer and you need theMM just cause you healthy doesnt mean the rest of us our the law passed e3 times just do you job and make it available without making patients do somethging you know wont work and thats get a reccomendation from your current doctor, only doctors who belive in it will be able to perscribe it so you need to change tha rule now i get second opions all the time and i askd my dr to reccomend it he said know and said all dr he knows wont touch it so you are handcvuffing patients and you new that the dr would support it so your ego can claim some small victory i promise advaCATES wont let you get away with it, Medicalk records doint lie and as long as its only a year old you ashould be alowwed to see a doctor who supports MM and will clearly see someone

dying should be recomended for MM what do you want me to do establish a relatiuoship witha doctor for a year when i might die way beforee a year think let people with legit ailments die in peace and get ioff your bureaucratic soapboxMR Humble you look foolish trying to fight who gets it you were so proud to estimate 10-20 thousand patients will receive it compared to the 100,000 perdicted well hope your proud you just cause 80,000 people to go to black market and do illigal drug dealing your lost and you wont measure quality i wish my pharmacist jsut gave me my pdercocet without knowing the dose you say you dont want to make the same mistakes but your changes are going to hurt the program not help it and the one that you went overboard on is having to know your dr a year and see him at least 4 rtimes ya i have that dr but he is agaisnt it so i suffer because he is against it open your eyes Mr Humble quit pouting it passed now deal with it
More definition is needed for what constitues a "Designated Caregiver". More definition is required for defining exactly what Non Profit is. More deniftion is required for off-site cultivation. Does a Commerical building qualify? How large is the space allowed to be. How many Dispensaries care the Off-Site cultivation center serve? Where are the Use or Sales Taxes defined - We want the State of Arizona to have a revenue stream from the sale of Medical Marijuana. More definition is required for tracking the "seed to dry" process - Seed Lot #'s, a statewide "Inventory numbering system" for each strain and published retail pricing. Can Dispensary Kiosks be used within the Dispensary? Is a "Medical Director" required to be an M.D., a D.O., a pharmacist or some other designation?
Squeeky cleam owners, not even a DUI
Keep them out of typical strip malls. Put them in comercial industrial areas
The draft rules can be improved by adding more information regarding the requirements of the cultivation facility. How can the draft state that you need a physical address of the dispensary and cultivation including a certificate of occupancy before a permit is issued? Shouldn't the address and c of o be done after the permit is granted? The hours of operation for the cultivation should not be mandated. The hours should be left to the discretion of the permit holder. What role will a physician play at the dispensary. Will the physician be required to be at the location physically or just available for consultation via phone? Will the physician be required to carry mal practice insurance?
The part where a patient has to have a relationship for 1 year with their doctor, I think is frankly ridiculous. I have suffered from leg spams and cramps for almost 9 months now, I've been to the E.R. for the constant cramping, they gave me an liquids and sent me on my way. I barely got insurance about a month ago and have barely been diagnosed with neuropathy from type 2 diabetes, I am confident I would qualify for a Medical Marijuana card, but I have not had a relationship with my doctor for more than a month even... And the part: “The physician assumes primary responsibility for providing management and routine care of the patient’s debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the patient’s medical record maintained by other treating physicians that may include the patient’s reaction and response to conventional medical therapies.” What if my doctor does not assume primary responsibility for fear of federal law? Would it not be much easier if the primary care physician gave a recommendation alone? And doesn't this simply allow other doctors to set up shop as "Marijuana Friendly Doctors" that are willing to "assume primary responsibility" and will end up making a killing on patients since the patient is going to have to visit said "Marijuana Friendly Doctor" regularly? This is what you were trying to avoid in the first place isn't it? Also, I don't know if the Department has the power to change the rule that if you want to grow your own plants you have to live 25 miles away from

a dispensary. Medical Marijuana is very expensive when purchased at dispensary's, please don't forget allot patients including those suffering from HIV/AIDS, Cancer and other debilitating diseases aren't able to work and are usually on some kind of benefits or assistance. I would rather pay APS an extra $8.00 or $10.00 dollars a month to grow my plants, instead of paying $250.00 an ounce, that's $750.00 for 2 1/2 ounces! That is abuse. Allot of people don't make that every 2 weeks even. The patients should benefit, not the dispensary's. In my opinion $100.00 an ounce is still too high. Think about it. An ounce is not much. Perhaps you could add an exception to the rule, if the patient is a low income patient they should have the choice whether or not to grow indoors at home after approval from DHS?
You need to state how the dispensary licenses will be initially allocated and in the future how a waiting list will be established to use licenses that become available. I think the ability for a licensed pharmacists to the medical director should be considered. The requirements for the Dispensary Medical Director are similar to what a pharmacist does every day. The cost for a dispensary to hire a pharmacists vs hiring or retaining a doctor should be considered to the end cost to the patient.
The law states that a naturopathic or homeopathic physician can recommend marijuana. They should also be allowed to be a medical director. They are more qualified than an MD or DO as they base there practice on natural herbs. An MD is less qualified as to the risks or benefits of marijuana than a naturopath, so it makes no sense that it is MD's or DO's only. I think it is good that the medical community is involved but the medical director should be expanded.... The type of medicine recommended is completely up to the physician. How can you quantify the number of visits or doctor patient relationship as to marijuana versus any other drug? As a doctor, they have 6-8 years of schooling to make the determination as to what they recommend or prescribe. The pharmaceutical companies are allowed to advertise on TV so patients go in and ask for something specific. If they don't get what they think they want, they go to another physician anyway, or take what is recommended. At the end of the day, the physician is suppose to know what is best. That can happen in one visit, 6 visits, over 5 years or who knows what else. A marijuana recommendation , regardless of times visited or patient history is really about what the physician thinks is best. No additional rules should be required, that is why they have a license....
Physician must have either an MD or DO degree to be licensed under 3 separate health professional boards in Arizona: allopathic (title 32, chapter 13), osteopathic (chapter 17), and homeopathic (chapter 29). Prop 203 authorizes allopathic, osteopathic, and homeopathic physicians to recommend medical marijuana, and also includes naturopathic licensees (who unlike the other 3 medical professions, do not require an MD or DO degree as a prerequisite for licensure). ADHS draft rules specify holders of MD or DO degrees as qualified to serve as dispensary Medical Directors, but only names licensees under chapters 13 and 17, while leaving out equally qualified MD's and DO's licensed under chapter 29. The discrepancy between physicians given authority to directly authorize dispensing, versus those indirectly tasked with monitoring such functions, is peculiar and without foundational basis. This discriminatory interjection is unexplained and inviting of legal challenge. If ADHS intent is to give special status to MD and DO graduates on the basis of educational background, it is a matter of due process to include MD and DO graduates duly licensed under the Arizona MD (H) license (title 32, chapter 29). The AZ Homeopathic Medical Board has successfully completed a two-year, legislatively-supervised process to make its credentialing and oversight processes the most modern of any AZ medical board, and received a maximum 10 year renewal.
change the doctor patient relationship, I am a 54 year old veteran, fighting colon cancer, i have had 2 surgeries in two and a half years to remove more than half of my colon. I do not use Medical Marijuana but there is current research from the University of Texas that concludes when cannabinoid compouds are intoduced to cancer cells in the colon tumors shrink. If my cancer returns a third time

the best that can happen to me is the full removal of my colon and a colostamy bag for the rest of my like, the alternative is eventual death within a year. Here is the problem: my Federal Government Veteran Hospitol Doctors are not allowed to write a recommendation for Medical Marijuana. I also know numerious Veteran AIDS patients who are not expectected to live more than a year, they should not be sedated with morphine and made vegatbles when Medical Marijuana can inprove thier quality of life in their last months we owe to our veterans and all humanity to do what is right.Your Draft makes me have to form a longer than needed relationship with a doctor and involves too much red tape, why don't you cut all the bureaucracy and apply the rules or regulations to help those of us truly in need of an alternative to dangerous FDA drugs. The people have spoken, please do not play God with our lives.

How will dispensaries get the marijuana they sell? According to the informal draft rules all licensed dispensaries in Arizona will be required to grow 70% of the marijuana sold. The rest must come from either qualified patients, caregivers or other licensed dispensaries. I THINK THE MEDICAL MARIJUANA DISPENSARIES HAVE TO BE SEPARATE FROM THE GROWING MEDICAL MARIJUANA DISPENSARIES OF COURSE FOR SAFETY AND FOR KEEP MORE TRACK OF THE PRODUCTIONS AND WHAT'S SOLD (SO YOU CAN KEEP TRACK ON TWO BOOK INSTEAD OF ONE). AND I BELIEVE THE GROWING IS GONA BE MORE SAFE AND APPART FROM ANY KIND ARGUMENT AND PROBLEM WITH NEIGHBORHOOD IN A BUILDING IN A RURAL AREA.

How about multi level qualifications and dispensed amounts? I think it would be the rare person who would need 2.5 ounces per 2 weeks, I also believe that it should be easier to get lesser, there for less abusable, quanities. A Physician might easily hand out a prescription for 12 pain pills but would use a much more stricter set of guidelines for 2 and a half big bottles every two weeks. Many medications have differing effects depending on the dosage and not just the amount of the effect, a different effect. Other drugs have what is called a narrow theraputic index. It takes just the right amount to work, any less and there is no effect, too much and strong side effects occur. Theo-dur is one, it, in the appropriate dose can dramaticaly ease shortness of breath, a bit too much and the patient goes wacko. Titration of any treatment is important. Consider the patient who would be helped by a puff or two, say every few nights or once a month. why give them 2.5 ounces every two weeks, when much less would be appropriate. Please consider different qualifications for different amounts, keep it being used for the right reasons.

what is the purpose of limiting the 30% sale to outside dispensaries, it is setting itself up for 124 amateur growers in the state vs getting better quality and consistency by allowing growers to sell their extra .

Please strike the required 1 year Doctor - Patient relationship from the rules. It doesn't make any sense.

People who have knowledge and process of the product.

As in California, the price of the issued state card has become a hindrance for patients to comply with the law. Arizona's rules concerning medical marijuana are following the same path. California expected to issue upwards of 100,000 cards but only a little over 12k have been issued while the estimate of medical marijuana patients is 350k,.. Most respondents say that the price of $66 - $103 is the deterrent. MMC issuing counties have seen a decline in re-issuance for the card drop from 20%-60%. This is not to say that patients are not continuing to treat with medicinal marijuana but they are foregoing obtaining the state issued card due to price. The initial issuing price to obtain a Medical Marijuana card in California was $13.00. After raising the price to "$66-$103", this is beyond the means

of the majority of patients. Take into account the price of the medical marijuana, this is NOT covered by any health insurance, so the patient is forced to pay the prices at the dispensaries leaving little to pay for what amounts to another tax from the state, which is a reoccurring annual fee. Arizonan's passed the Medical Marijuana bill to help patients NOT TO fill the coffers of the State of Arizona by those who can least afford to fill it. It is apparent that the State of Arizona see's this issue as a boon to their budget woe's when it is SUPPOSED to be for PATIENTS! Make the card affordable, $15 dollars a year for each patient and keep it at that price. THEN unlike California you will get a much higher compliance. Stop trying to make it so expensive, complicated and difficult to comply with the law and ALLOW THE PATIENTS TO BE TREATED!!!!!!
Why are you discriminating against the poor? If a person makes less than $10000, their fee should be waived or at least reduced. Why are you requiring a doctor be available at a dispensary when no doctor is required at a pharmacy? This will increase costs of producing medical marijuana, which will make medical marijuana cheaper to buy illegally than legally. Don't impose unnecessary rules on dispensaries to drive up costs.
I am from Colorado and have been seen for years about my back by different physicians and surgeons. I have had a laser surgery and cortisone shots at Mayo, but i have not needed to see an Az. doctor but once at Mayo because I already have a new MRI and short of more surgery, there is nothing they can do other than prescribe painkillers. My problem is straight forward and does not require multiple visits at this point. I have a medical MJ license in Colorado. I would like to see a rule that qualifies someone like me who has an MRI and a list of doctors I have seen and their prognosis, to qualify me for a license here without four visits because they already know the problem.
The fee for the card is overly expensive, and the setup for the dispensaries insures that overhead will be high. Marijuana will be expensive. There should be no fee for the card. The marijuana should be free for qualified patients.
to keep it local and in state,,, undisturbed,,, a price cap explorative tool that heavily favors the patient could be put in place for the first three years before shaping a more permanent structure in pricing and dispensing in advocacy that further develops patient access rights that will control the market and price here in arizona. what i suggested under the limits they are considering would allow a top gross of a little over two hundred grand a year per dispensary. never work. set yealy production rates at two thousand pounds per year both patient and provider will do fine ,,, price caps and all
If your implement the rule for doctor patient relationship;"Has a professional relationship with the qualifying patient that has existed for at least one year and the physician has seen or assessed the qualifying patient on at least four visits for the qualifying patient's debilitating medical condition during the course of the professional relationship" You will be keeping Veterans who desperately need this medicicne from aquiring it. VA doctors are held to federal law, whichs keeps them from recommending Cannabis. So for Veterans we have find another outside doctor to recommend our medicicne that could take over a year. That is devestating to loads of Vets. The fact that PTSD is not listed as a qualifing condition is non-compassionate towards veterans. We need PTSD added to the law.
add anxiety and depression to the list of qualifying conditions, also people should not half to live more than 25 miles away from a dispensery to cultivate there own marijuana anyone with a valid medical

marijuana card should be able to cultivate up to 12 marijuana plants for medical purposes.

I think the rules could be improved by the same exacting measures seems to be the structural base of the draft's construction however separate the patients in a way that is also more exacting. By this I mean to incorporate the use of medical codes. Mine is ICD-9-CM Diagnosis Code 759.89 as of this year. Very serious congenital condition which Mayo published a paper listing the nine most common areas of pain. There must be a distinction between those with incurable pain causing maladies and those that may find a better approach to wellness without the use of medication that doesn't destroy their bodies. Folks like me will not be able to afford prices that will be in place at the dispensaries. We will need to grow our own for economic hardships. Make growing available to any patients with incurable pain causing symptoms. Some considerations made for patients with economic hardships,,, weather self grow or let a pooled resource evolve somehow. If what I understand the rules of 250 pounds per year per dispensary is correct this greatly under estimates the number of patients whose quality of life can be improved. The DHS could make home grows and the immediate availability based on IDC-9-CM diagnostic codes. An applicant home grow process could be put in place for those with conditions that are not incurable.

The requirements for qualification for a Medical Marijuana card proposed under R9-17-202.F.5. seem contrary to the intent of the measure in excluding a large population of chronic (pain) sufferers of which I am a representative member: those persons who have suffered debilitating pain for decades and long ago abandoned traditional medicine and therapies as ineffective. The language used in the Draft appears to require such patients to return to traditional therapies for at least one year (unless they have decades-old records on file and can convince a MD/DO to assume responsibility for past treatments) before marijuana may be legally used. Patients of this type are acquiring and using marijuana now, and will continue to do so regardless of DHS' rules, but the INTENT of the voters was to decimalize these activities and this onerous requirement defeats this intent. On a personal level, after decades of resistance to the idea, I have been seeing a chiropractor weekly ($100 per week) for several years, where I receive an hour of therapeutic massage followed by spinal manipulation. Chiropractors, however, are not included in the measure as medical professionals. (My MD grandfather would wholeheartedly agree with this exclusion, but then he'd have preferred to run all the chiropractors out of town on a rail... As a scientist, I have to say I'd have excluded homeopaths and naturopaths BEFORE chiropractors, but I did not draft the measure.) My use of marijuana is minimal in that the weekly therapies I receive generally reduce pain and inflammation sufficiently for me to function. From time to time, however, my discomfort peaks to a level where I can't eat or sleep without using a small amount of marijuana. This use totals approximately 1 ounce per year, yet I am exposed to criminal and substantial civil penalties in acquiring and using the medicine, as well as suffering the guilt for financially supporting drug cartels. I have considered growing a plant to eliminate exposure to, and support of, the criminal enterprise, but the legal liabilities are potentially WORSE if discovered and I have two young children (9 and 11) in my home whom I do not wish to expose to marijuana (a plant is much harder to secure than a baggie). I understand DHS' desire to minimize the issuance of cards for trivial and non-existent conditions (nonsense cards), and I support such efforts, intellectually. The harsh realities of chronic and debilitating pain such as mine preclude any definitive mechanism for excluding nonsense cards AND DHS' proposed onerous rules will be far from 100% effective as well, but these same rules WILL be effective in excluding real patients (for at least one-year). I recently retired and, as such, live on a fixed income while raising two children who hope to get advanced degrees like their Dad. I made a respectable living as an inventor/manufacturer in Arizona for many years (resident since 1968) and I have taken myriad steps to minimize my cost of living in retirement (smaller and well insulated home equipped with solar panels), secure some reliable fixed income (annuities that mature beginning in 2019), and have taken advantage of Arizona's 529(k) plans. I do not, however, have medical insurance for myself due to pre-existing conditions (although I am trying to get it under Obama care). I was hoping to be able to REDUCE my substantial medical care costs, in retirement, by reducing the frequency of physical therapy and increasing the use of marijuana, preferably provided by LEGAL home

cultivation... Explain what criteria will be used to select the 124 dispensaries. Will the selection process be such that dispensaries are as evenly distributed as possible to minimize home cultivation? Will they be distributed on a basis of population density instead? Will there be a selection process that considers the quality of the service proposed, for product purity and consistency? It appears that security and divergence prevention are paramount in the draft rules and, while these issues are clearly important, safety and efficacy of the product receive short-shrift. Transportation from cultivation sites to dispensaries also appears to be a hole in the otherwise high security system proposed. While requiring armored cars is probably overkill, loading and unloading within a secure area should be required and, to reduce in-transit diversion, weight in and weight out should be recorded, preferably by USB-linked, calibrated scales (although diversion in trimming remains an issue). Requiring a MD/DO medical director appears to go beyond the intent of the voters.

When starting chemotherapy or going to any specialists for treatment of pain, anorexia, AIDS, glacoma we the patients do not have a two year history with the Doctor. I think you are being too strict on this

A registration packet for a dispensary is not complete until the applicant provides the Department with written notice that the dispensary is ready for an inspection by the Department. MOST OF US HAVE A CONTIGENCY LEASE AGREEMENT WITH THE LANDLORDS BASED ON GETTING A LICENSE BECAUSE WE DO NOT WANT TO BE PAYING RENT ON A SPACE WE ARE NOT GOING TO USE IF NOT SELECTED. ALSO IT TAKES 8-12 WEEKS TO SET UP A GROW ROOM, MAKE SECURITY AJUSTMENTS, AND BUILD OUT OUR SITES WITH PERMITS, INSPECTIONS, ETC.ITSHOULD BE BASED ON THE BUSINESS PLAN AND DOCUMENTATION, NOT THE ACTUAL SITE. If the dispensary is a corporation, two officers of the corporation PROP 203 STATES THAT WE FILE AS A NON PROFIT CORPORATION, HOWEVER YOU ARE ASKING FOR TWO OFFICERS. THIS SEEMS PREJUDICIAL AS SOME DISPENSARY OWNERS ARE SINGLE WOMEN AND DO NOT HAVE SOMEONE THEY WANT TO PARTNER WITH BUT YET WANT TO FILE AS A NON PROFIT CORPORATION. THE CORPORATE COMMISSION ONLY REQUIRES ONE DIRECTOR. A registered pharmacist will be onsite or on-call during regular business hours; b. The dispensary will provide information about the importance of physical activity and nutrition onsite A REGISTERED PHARMACIST ON PREMISE OR ON CALL? WHAT IS THE PURPOSE FOR HAVING TO PAY FOR THIS SERVICE OR TO ADD THIS? MOST PHARMACISTS KNOW NOTHING ABOUT THIS DRUG OTHER THAN WHAT THEY MAY OR MAYNOT HAVE READ. A dispensary shall provide the Department with authorized remote access to the dispensary's electronic monitoring system THIS IS TOO VAGUE. PLEASE EXPLAIN THE PURPOSE OF WHY YOU NEED REMOTE ACCESS TO THE "MONITORING SYSTEM' OR IS THIS REFERING TO THE LINKED AUTHORIZED VERIFICATION SYSTEM AT THE DEPARTMENT? Employ or contract with a medical director; Medical Director A. A medical director may only serve as a medical director for three dispensaries at any time. B. During hours of operation, a medical director is: 1. On-site, or 2. Able to be contacted by any means possible, such as by telephone or pager. AGAIN WITH THE ADDED EXPENSE. WHILE MANY OF US HAVE ASKED DOCTORS TO BE ON OUR BOARDS, WE DO NOT NEED THEM TO WORK FOR US AS EMPLOYEES. THIS IS AGAINST THE ARTICLES OF BEING A NON PROFIT. BOARD MEMBERS CANNOT RECIEVE FUNDS FROM THE CORPORATION EXCEPT FOR EXPENSES INCURED. I DO NOT RECALL ANYWHERE IN PROP 203 WHERE IT STATES THAT A DOCTOR BE ON SITE OR ON CALL. DOCTORS WILL BE RECOMMENDING MEDICAL MARIJUANA AND WORKING ON THE SITE? Denial and Revocation of a Dispensary Registration Certificate A principal officer or board member CANNOT BE Is a physician currently making qualifying patient recommendations THIS IS A CONTRIDICTION OF THE STATEMENT ABOVE. IF WE EMPLOY A MEDICAL DIRECTOR, HE CANNOT MAKE RECOMENDATIONS? Has not provided a surety bond or filed any tax return with a taxing agency; WHY WOULD WE BE FILING TAX REURNS ON A BUSINESS THAT HAS NOT EVEN STARTED? AND IF MARIJUANA (MEDICAL OR NOT) IS ILLEGAL IN THE EYES OF THE FEDERAL GOVERNMENT THAT WHY ARE THEY ABLE TO TAX IT? (JUST CURIOUS) The Department shall revoke a dispensary's registration certificate if: 1. The dispensary: Acquires usable marijuana or mature marijuana plants from any person other than another dispensary in Arizona, a qualifying patient, or a designated caregiver; SINCE NONE OF THE DISPENSARIES HAVE YET TO BE IN OPERATION AND WE HAVE NO CAREGIVERS AS

YET, WHERE WILL THE SEEDS OR PLANTS COME FROM?
I actually voted against this, but I am concerned that something the majority of Arizonans voted for is not being implemented in a fair way. Example 1: The Dispensary has to keep track of the "Watering Scehedule" of the plants. Why? Example 2: Board members must not be delinquent on child support, taxes, or student loans. Although I don't agree with people who are delinquent on these obligations, I am curious as to what other State issued licenses or permits have the same requirements. If it applies to all State permits or licenses then it is ok, but if it is only related to Medical Marijuana permits, then it is completely wrong. Example 3: Perhaps the most illogical one of all. According to the Dr. patient relationship you have outlined, If I was diagnosed with cancer tomorrow, I would be ineligible because I would have to be under the prescribing Dr.'s care for 1 year, and 4 visits. One way to accomplish Dr.'s from abusing the system by arbitrarily writing recommendations for a fee, is to not allow them to advertise a specialty of Medical Marijuana Recommendations. Tobacco companies are not allowed to advertise, so precedence is set already. This would allow legitimate patients easier access and make it harder for people trying to cheat the system by just having to answer an ad to get a card.
As long as Arizona Government is involved, nothing will ever be regulated effectively >>One of the top priorities during the implementation of the Arizona Medical Marijuana Act in the coming months is to ensure good rules are developed (called Administrative Code) so medical marijuana can be regulated effectively.
The patient and caregiver fees are unreasonable. In the case of a patient that is unable to travel whose spouse is the only caregiver, the combined fee will be $350 per year, every year. Combined with the cost of the medicine itself, this will force many patients to choose between buying medicine or buying food. Special consideration should be given at least to stage IV cancer patients. There is no cure for these patients. Fees for these unfortunate patients and their spouses should be significantly reduced or eliminated. The proposed fees give reason to think that only the rich will benefit from medical marijuana. The proposed fees give the perception that the state intends to balance its budget on the backs of cancer patients.
I had a chance to re-read through the actual law, and the proposed rules. Mr. Humble and staff have taken a huge liberty in increasing, and decreasing the law. It almost seems that stuff they didn't like or agree with that they added more restrictions, or just added/invented items. I think they forgot we the people voted on Prop 203 the way it was written. Not to have it so restricted that some, or most people wont be able to benefit from the law, which goes against the whole intent of the law. I thought the first thing about required allotted days was interesting, that they had turned the time limits for them to approve applications, and certifications into working days from just days. I'm sorry but the statue says days, and not working, or business days. I'm sorry, but the ADHS does not get to rewrite, and nit pick something that they may not agree with. You must take the law the way it's written. Days and not working/business days! The main issue I have with their proposed rules is the restricting access to the law by trying to define what a patient- doctor relationship is. This part conflicts with Prop 203, as far as any doctor who is licensed to practice medicine MD, DO has the right to recommend MMJ. And the law doesn't say anything about having a relationship with your doctor for at least a year, and have had 4 visits. That same requirement doesn't apply to any other health standard in the country. Or any that I could find by looking up requirements for prescriptions/recommendations. Again, Mr. Humble and staff are taking a huge liberty in defining what they think should apply to Prop 203, especially when it doesn't apply to all other aspects of health care. Also, the part that the MMJ doctor has to become the primary care doctor for the qualifying condition. Most people's doctors won't be so willing to put their names, and required by rules their license number on a patients application. And who not agree with the new law. So your telling me that I can't get relief from something that could help for at least a year? Talk about pain and suffering. The ADHS motto is: Leadership for a Healthy Arizona. Again not all doctors are qualified specialists who have completed some required fellowship training to take on ALL aspects of

healthcare. As required by law in Chapter 17 Tile 32-1800 Sec 21. I did find the section on the video cameras amusing, and the location of the hand washing stations. I was thinking... isn't that planning and zoning and who ever deals with building permits. And one issue I couldn't understand was the part that says if you're applying for a caregiver card, dispensary agent, and on behalf a child who is under 18 that they have to signed statement that says they do not currently hold a valid registry identification card, so these people can't be patients as well??? This is just a way for the ADHS to take a more intrusive step into our states MMJ law. I've also seen a few statements from some people, and organizations saying that the ADHS did a good job. And that really completely blows my mind. Did they really read all 47 pages of the ADHS proposed rules? They have taken a law that was just over 30 pages and turned a set of proposed rules into 47 pages of things they want. In a state that has a billion dollar deficit, does the health department really think they should help waste more taxpayer money the state doesn't have? I can already see claims being filed against the ADHS on all aspects of departments proposed rules

This 25 mile rule to obtain registered qualifying patient cultivation authorization that was obscurely incorporated into the Prop 203 language has not been specifically addressed. Aside from the fact that this legislation is discriminatory against us city dwellers, e.g. I live in Tucson and have to pay out of pocket for my medical marijuana, yet Billy Bob who lives in Klondyke will be allowed to grow his own at minimal costs, people are currently misinformed and were so before the election. The common believe is that registered qualified users will be allowed to cultivate up to twelve plants (sex undefined) for personal use. People will ultimately be arrested because of the lack of clarity (25 mile qualifying rule) when a simple, straight-forward statement could be incorporated into the rules thereby potentially avoiding arrest arising from obscure language. The best approach would be to eliminate this discrimination which I feel confident will be changed after being brought before the judiciary. But for the present, I suppose we are stuck with the intentional foolery. Let's not promulgate this misconception but make the legislation perfectly clear to all in the rules.

Not allowing the growing of any marijuana by individuals just because they live 25 miles from a dispensary. Not allowing the growing of marijuana within residential zones either by individuals or by companies or dispensing authorities. Change the time frame for inspections and investigations to immediate access while open or the dipensary is occupied by an employee or employees. Inspections to be done when the authority desires and no 5 day warning to be given. Violations of any of the rules or laws would require immediate closure of the site dispensing and the suspension of any licenses used by either individual or corporation. Means of appeal would be through the legal system in a criminal court. Force the corporationa and its owners or employees to either stand criminal trial or revoke the license forever. Not allowing federal, state or local tax money to pay for the marijuana, unless it is the medical marijuana derivative , THC, that the federal government allows prescribed now. Include a statute that states if at anytime the federal government refuses to fund any program paid for by federal taxes, grants or benefits, the law will be stricken from the books. Ensure no ACCHS or other state funded taxes are used to pay for the purchase of any marijuana. Not allow the individual growing or dispensing to do so in a residential zone.

I have a chronic disease, hepititus c. I do not have a primary, or any doctor I see on a regular basis because I can not afford the office visits nor treatment. So I self medicate with marijuana and it enables me to continue to function with the pain and other effects of my disease. I do not think that a requirement for medical marijuana should be an "established, year long relationship with a doctor" is a good rule. Simply because of the cost of health services. People need this type of pain managment now! Not a year latter after costly doctor visits! Again, people like me can not afford regular doctor visits, tests, etc. No matter how many regulations are drafted any program for pain management will have a degree of abuse associated with it, furthermore to try and tottaly contain abuse is impossible. The DHS would have to re-regulate pharmacutical prescriptions and include the same regulations for

pain management. Again, the people need the drug now, not a year down the road and $1000.00 dollars latter just to say a doctor has been seeing a patient. After all this program is state law and was designed for the people that voted it in and lets not forget the introduction of this new industry is a money maker for the state. So in conclusion, either re-regulate "all" pain management programs that are available, or make obtaining a medical marijuana prescription more doable for the sake of those seeking it! I do not know of any doctor that requires a year long x number of office visits before he will prescribe pain medication. This conception of regulation is absurd. sincerly, Joe Bradford

I think the patient Dr. Relationship is going to make it difficult to provide Medical Marijuana to many people that may need it. I spoke with an administrator in health care recently, and they said that In AZ approximately 70% of people who have a primary car physician don't know who that physician is. The way that health care is structured now makes it nearly impossible to have a personal relationship with your physician anyway. If you see a Dr. For more than 10 minutes when you go in, that is a long appointment. So many people are turning to urgent cares as a way to get seen quickly since it can be many months for some to get in to see their Dr. Since the relationship is so distant, often a quick prescription with side effects worse than the disease is given with little or no follow up. I saw someone quit taking methotrexate and enbral because they felt worse with those than they did with the rheumatoid arthritis they were treating. Medical marijuana has been shown in some studies to reduce inflammation in R.A. Also, by enforcing the patient Dr. Relationship, you will eliminate access to Medical Marijuana to people who may not have needed it last week when they were healthy and had just been going in to the Dr. for a once a year checkup, but was just diagnosed with cancer and given less than a year to live. There are many people out there, myself included,, that know the benefits of Medical Marijuana first hand, have seen it help with many health problems but will be denied access because we avoid going to the Dr. Because we don't want chemical prescriptions and their side effects, we don't want to wait for 3-6 months for an appointment, we don't want to spend the money on overpriced healthcare, and for some, have not found a Dr. That we like enough to make our way back for another appointment...My last 3 Drs have lost their practice due to financial difficulty from malpractice insurance, office expenses, and foreclosures. It's hard to maintain a relationship with them when they no longer practice in my area. I could go see another Dr, and have them look over my medical records, although I doubt those exist since the drs I have seen are no longer around. I asked my most recent dr about it, and he said many don't keep records for very long anyway. A side note. I spend a fair amount of time in many parts of CA, and I have yet to see a dispensary, or any evidence that there is a problem with the program here. I have read a lot about the problems, but have not seen them first hand. I don't think that AZ is going to have any problems adapting a solid program that is beneficial to all of the parties involved. Thank you for your work on this.

I think these rules need to be simplified , these rules are not in the spirit of prop 203 . a person can walk into a dentist and get prescriptions for extremely powerful and addictive opiates , for things as simple as a tooth abstraction .but it would take a verry long and elabrate process for a cancer patient going threw chemo to get the medicine they need and that medicine is proven to be substantially less addictive and dangerous then the opiates they will be prescribed other wise ? i understand that people are going to try to abuse this drug for recreational use but that happens with most prescription and non prescription drugs, I think ths recomendation process should be simplified for the patient and the doctor these regulations seem to be disigned to intimidate both ,treating seriusly ill patience and the doctors treating tem as criminals . The rules around the dispensarys would require much more security then is currently required for a fully functional pharmacy. this is medicine all i would suggest is treat it similiarly I understand why you would want all the security around a dispensary and grow facility but isnt it going to make them tempting targets regardless of the security by isolateing them so far from major traffic flows ?

The one year doctor patient relationship, with 4 visits before the doctor is allowed to recommend medical Cannabis is putting too great of a burden on doctors that specialize in treating medical conditions with Cannabis. It is a specialty medical field, since the majority of doctors are not willing to risk their career/reputation to help patients that can benefit from Medical Cannabis. Doctors that specialize in recommending Cannabis, won't take on patients as the primary doctor. This will let people like me, that have already quit taking narcotic pain pills, and switched to eating Cannabis, continue to risk felony arrest, even though the voters of Arizona have made it clear that the local government needs to stop arresting patients that use Cannabis to treat genuine, serious medical problems. The definition of a "secure enclosure" is going way too far. I can understand needing a fence, and lock. or even an alarm... But 12 foot tall walls? 1 inch thick steel door? 1/4 inch thick wire across the top? I call that steel rod, not wire. Can you imagine an individual that wants to try growing a couple of outdoor plants in a 4 foot, by 8 foot plot, putting a 12 foot tall wall around it?

I THINK INSTEAD OF A MEDICAL DIRECTOR AT EACH LOCATION, FIRST I THINK THAT NOT ONLY A PICTURE OF THE PERSON BUT HIS OR HER RIGHT INDEX FINGER PRINT SHOULD BE ON THE MMIC, (MEDICAL MARIJUANA IDENTIFICATION CARD) AND EACH DISPENSARY SHOULD BE EQUIPPED WITH A FINGERPRINT SCANNER ($100-$2000) AND A WEB CAM ($25-500) SO WHEN JOHN Q. PUBLIC BUYS HIS OR HER MEDICAL MARIJUANA FROM THE DISPENSARY, THE SALES PERSON CAN BE 100% SURE THAT THIS PERSON IS WHO IS ISSUED THE MMIC (MEDICAL MARIJUANA IDENTIFICATION CARD) AND AZDHS WOULD HAVE A SOLID RECORD OF THE SALES AND THIS WOULD ENSURE THAT THIS PERSON COULDN'T GO ACROSS TOWN AND GET MORE FROM ANOTHER DISPENSARY. BECAUSE WE ALL KNOW THAT IDENTIFICATION CAN BE FORGED, BUT FOR THIS TO WORK THE DISPENSARY'S WE HAVE TO BE TIED INTO A CENTRAL DATABASE (SERVER) AT THE AZDHS. AZDHS WOULD HAVE ON RECORD ALREADY A PICTURE AND A RIGHT INDEX FINGERPRINT OF THE PERSON HOLDING THAT CARD, AND A RECORD OF SALES SO IF A CARD HOLDER TRIED TO DOUBLE DIP, WE OR THEY COULD SAY SORRY BUT YOU HAVE 3DAYS UNTILL YOU CAN REFILL YOUR PRESCRIPTION, MAYBE YOU BETTER CUT BACK A LITTLE MR. JOHN Q. PUBLIC. THAT IS WHAT WE PLAN ON DOING ANYHOW IF WE ARE GRANTED TO OPEN A DISPENSARY UP. ALSO ANOTHER IDEA I HAD WAS TO HAVE A SECURITY CAMERA THAT COULD ZOOM IN ON THE PLATE OF THE VEHICLE THAT WAS USED TO TRANSFER THE MEDICAL MARIJUANA. THE PROCESS SOUNDS LIKE A LOT BUT ITS A WAY TO COVER OUR LIABILITY AND THE AZDHS! THE PROCESS ONCE A PERSON DONE IT A COUPLE OF TIMES IT WOULD TAKE 3-5 MINS EVEN QUICKER! IF A CARD HOLDER NEEDS QUESTIONS ASKED THEY CAN CALL A PHARMACISTS OR THEIR DR. LETS FACE IT MARIJUANA WHEN SMOKED YOU KNOW WHEN YOU HAD ENOUGH INSTANTLY! YES I'VE SMOKED IT BEFORE I'M NOT GOING TO LIE, I HATE IT NOW WHEN I WAS YOUNGER IT WAS OK. I SMOKED IT WITH MY MOTHER THAT DIED FROM CANCER WE WOULD SIT ON THE BACK PORCH AND LIGHT UP AND IT INSTANTLY MADE HER FEEL 1000% BETTER! SHE NEVER USED ANY KIND OF DRUG BEFORE THAT! THE HYDRO WEED WAS A LITTLE STRONG FOR HER SO JUST A COUPLE OF PUFFS AND SHE WAS GOOD, NOW MY SISTER BROUGHT OVER SOME MEXICAN WEED AND IT TOOK MORE OF THAT! WHICH BRINGS ME TO THE NEXT IDEA I HAD SOMEONE FROM AZDHS SHOULD TALK TO LAW ENFORCEMENT AGENCY AND SEE IF IT WOULD BE POSSIBLE FOR THEM THROUGH AZDHS TO SELL THE CONFISCATED MARIJUANA (AFTER THE COURT PROCESS WAS OVER OF COARSE) TO THE DISPENSARY LETS FACE IT IT WOULD BE FOOD FOR THE POLICE,AZDHS,THE DISPENSARY, AND MOST IMPORTANT OF ALL JOHN Q. PUBLIC! AZDHS COULD HAVE THE MARIJUANA TESTED TO MAKE SURE IT WAS OK. BECAUSE LIKE MY MOM THE HYDRO WEED IS GOING TO BE TOO STRONG FOR SOME! THAT"S WHY THE MAKE DIFFERENT MILLIGRAM PILLS RIGHT? I SEE YOUR POINT A LITTLE WITH THE MEDICAL DIRECTOR BUT LETS FACE HOW LONG WILL IT TAKE FOR SOME TO OFFER THEM A LITTLE MORE MONEY TO TURN THEIR BACK ONCE IN A WHILE. MY SYSTEM WOULD BE ROCK SOLID ON WHAT IS BEING SOLD OUT THE FRONT DOOR, AND AS FAR AS WHATS COMING IN THE BACK DOOR WE WOULD NEED A PERSON SUCH AS MYSELF TO GO AROUND TO THE GROWING FACILITY AND FIGURE THE CROPS TOTAL END WEIGHT! (DRIED)

NOW REMEMBER THAT THE BUD WILL BE SOLD AS BUD RIGHT BUT ALL THE SWEET LEAF STEMS ECT. CAN BE COOKED DOWN TO PRODUCTS LIKE HONEY OIL (HASH OIL) OR HASH! I'M GOING TO READ THE RULES AGAIN AND E.MAIL YOU AGAIN. I KNOW YOU PEOPLE HAVE A TUFF JOB WITH THIS NEW LAW, AND THANK YOU! IF YOU NEED ANY CONSULTANTS OR A PERSON THAT COULD OVERSEE THE DISPENSARY'S LET ME KNOW! ONE THING I'LL LET YOU KNOW THE MAJORITY OF THESE PEOPLE ARE LIKE NO OTHERS YOU'VE EVER DELT WITH THEY WILL MANIPULATE, LIE AND A FEW OTHER THINGS. LETS HOPE NOT SINCERELY [redacted] PS. YOU GUYS COULD PUT A SPELL CHECK ON THIS!

I think that they're should be a difference in the amount of cannabis a patient can have depending on how serious their medical condition is. More serious diseases such as AIDS and cancer should be able to posses up to 2.5 ounces while less serious conditions should only be able to posses 1 ounce because patients should medicate accordingly to their condition.

The regulations regarding outdoor cultivation prevent single patients from maintaining a small outdoor grow of their allowable crop. Most patients can not afford expensive indoor lighting and growing operations. The requirement of 12 feet of stone/block fencing is burdensome and prohibits any 'backyard' grows in locked chainlink enclosures. The Department should allow grows of a maximum of 12 plants with special conditions (single patient or single caregiver) to allow them to be cultivated in an enclosed chain link "box." Simply eliminating the 12 ft stone wall requirement for these people allows them to cultivate outside with an affordable chainlink enclosure that prevents theft effectively. Any grows over 12 plants can still require the large stone fence.

This is an almost impossible task givin the 99 plant rule. We need to find either a better percentage reates or more plants that are going to be able to be cultivated.

R9-17-102. Fees An applicant submitting an application to the Department shall submit the following nonrefundable fees: 1. For registration of a dispensary, $5,000; --- I don't believe that Prop 203 should be used as a money making opportunity to discourage and/or discriminate any eligible 'LEGAL ENTITY' formed by an individual and/or group of one or more persons to submit a business plan/application to the Department to request approval to operate a AZ Non-Profit Medical Marijuana Dispensary. The language of 'nonrefundable fees' is extreme in this category and takes advantage of Prop 203 in my personal opinion. --- R9-17-102. Fees An applicant submitting an application to the Department shall submit the following nonrefundable fees: 5. For a registry identification card for a: a. Qualifying patient; $150; b. Designated caregiver, $200; and --- Again, the language of 'nonrefundable fees' is extreme and takes advantage of Prop 203 in my opinion. As a Qualifying Patient myself with a desire to also be a Designated Caregiver living on SSD and tight budget. I believe these Fees to be extremely high for most individuals already dealing with health and financial issues, let alone the high cost of accessing Medical Marijuana once approved. Please keep these issues in mind in your final draft. A Qualifying Patient or Designated Caregiver shouldn't have to incur these costs if for some reason being turned down. Prop 203 should reflect affordable access to all of us individuals who choose Medical Marijuana for a personal preference healthcare alternative. --- R9-17-102. Fees An applicant submitting an application to the Department shall submit the following nonrefundable fees: 6. For renewing a registry identification card for a a. Qualifying patient, $150; b. Designated caregiver, $200; and --- The same applies to the costs of renewing a registry ID cards. ---

Making it easier for those of who truly do suffer from chronic pain to obtain the marijuana.

As a general principle, I would like to propose that no regulation affecting medical cannabis should be more burdensome to the prescribing physician, dispensary, or patient or than those currently affecting prescription of narcotic drugs. The fact is that cannabis is, at the very worst, no more addicting than opioid narcotics, has no greater potential for abuse, and is certainly less dangerous in terms of acute

adverse affects (to my knowledge, no one has ever died from an overdose of cannabis). Therefore, any regulation of medical prescribing and dispensing of cannabis that is more restrictive or burdensome than those for narcotic analgesics must be construed as needlessly obstructive of optimal medical care. Once the state has accepted that cannabis and its derivatives have a legitimate role in management of medical conditions, there can be no reasonable justification for regulations above and beyond those currently in force for narcotic analgesics. By my reading, numerous proposed regulations in the 12/17 draft go well beyond accepted, prudent regulation of narcotic drugs, suggesting that they are based on irrational prejudice against what is, after all, just another medication with potential for both benefit and harm. I therefore strongly recommend that the state dispassionately re-evaluate and streamline the proposed regulations, guided by the above-stated concept. [redacted]

The first thing and the biggest and only problem is how can you expect current physicians to just approve you for medical marijuana. first off most all the MD's wont risk their license on new drug that they know nothing about medically. And if you find a doctor you have had for more then a year just asking him he declines and now he has a different opinion of you and your family. And why would a doctor prescribe you a medication that will take the place of my sleeping pills, my pain pills, my anxiety pills and migraine pills, and my nausea for cancer treatment which i have stage 3 cancer. Why would any current established Dr even prescribe MM if it will keep you out of their office once a month because the MM has cured all my ailments. Then that Dr just lost a patient that usually sees him once a month for refills and now doesn't need the pills anymore just the MM. So why would you think theses current MD's will take a chance with a medicine they don't know about and why would they give you a recommendation so they lose you as a patient . They cant charge your ins companies if you don't need all them pills which i would if i had pot. And my oncologist already said he is not recommending MM to his patients and 90% of all doctors will do the same thing that's whats not fair. I have cancer and i get 90% relief when smoking so this you have to know your doctor a year before he can recommend has to change. The doctors that are coming in az opening up offices will be the only ones that will prescribe it. I think you should be able to go to one of the new offices and see a Dr and you have to bring medical records that prove you have been with at least one Dr a year and he did treat you for the condition your seeking MM for. Humble did say if you didn't get a recommendation from your Dr (most wont) if you have cancer and going through chemo then you should be able to go to any Dr that believes in MM and he can examine and look at medical history and be able to recommend you for MM regardless of what Dr you have been with. No doctors in Az that are established will recommend MM to their patients why would they put their practice on the line to basically lose a CUSTOMER from their practice. Just make sure the Dr that will approve you have to be held to standards of reviewing medical history and that history will prove that the patient can benefit from MM. This rule has to change if you have a medical history of chronic pain herniated disk and a long time addiction to pain pills because of it and now you get cancer, a patient should be able to go to any doctor that supports it and if you have a medical history that would prove you would get medical benefits then the law should be you can see any doctor but if its a new doctor not your pcp then you must have medical history and perscrption history to show the new doctor your medical history will support the MM use. If they come in with no records and no cancer or chronic pain that you have had say an MRI on in last year and were treated for chronic pain by a doctor then you should be able to go to another DR who will approve recommendation based on medical history. If its a new patient and no history with MRI or haven not been treated by a doctor for condition in last year then that patient should not even be examined and the Dr should be able to prove each patient with medical records with out a doubt would benefit from MM then it should be ok for anyone to go to a new Dr but they need to have a minimum amount of medical records that are serious conditions then the patient should not have to worry about what dr he goes to to get a recommendation. Just hold the Doctors responsible for collecting records and making a professional opinion, we get second opinions all the time what would be the difference in this going to a new

Dr.Meanwhile anybody can go see a new Dr tomorrow and get percocet a class 2 narcotic in 30 min with no previous medical history and they are physically addictive and Marijuana is not. I understand we don't want it to be like Cali but hold the Dr responsible for their recommendation don't make a patient in need go beg their physician all they should have to do is have their medical records sent to new Dr and based on them records any Dr can make a recommendation based on the medical history it happens everyday or put a sub section in the rules that if a patient with cancer is currently under treatment of chemo or radiation should be able to go to any Dr with medical records of course but should be fast tracked to get their cards first . something, but you have to change the patient doctor relationship they even have telemeds where u see a Dr on a tv and he can prescribe you a schedule 2 drug and narcotics just by seeing you then mailing the RX to you. So why should someone just to get a plant that causes no overdoses you want them to see a dr for a year . most dont even keep the same Dr as it is because they dont medicate them right so they leave to another so how can you expect a current Dr to approve MM for you when they are western medicine doctors not Homeopathic or alternative medication Dr so why ask a patient in need to ask a western medicine Dr that will oppose the MM .This is alternative medication its not FDA regulated Doctors wont even approve 2000 applications if you have to count on PCP of the people have that have a year relationships with their Dr. It has to be changed to see any doctor but serious medical history needs to be available to new Dr and the Dr should be held responsible for approving any form it will ruin it for someone with cancer like me. and after my chemo in April you still have up to 2 years of side affects with radiation and chemo. And herniated disk should also be at top of the list with cancer chronic back pain an MRI report doesn't lie as long as you have MRI report saying you have nerve damage and 2 herniated disk and you have gotten addicted to pain MEDS because of the pain this should be plenty of medical history after 3 years of back problems this applications should be able to be stamped by any doctor as long as the new Dr sees all medical records and reports and does own exam on patient make it hard on Dr to make sure he approves only patients with overwhelming medical evidence it should be up to that Dr make them accountable rather then making patients beg their current Dr who is against it that would not be fair to patients its not patients fault dying of cancer me that my oncologist wont recommend MM why it helps me so you mean im screwed i cant get a second opinion , you can with everything else. Look at this part of draft it wont be fare to patients and the state should no that current doctors are not in favor of changing anything in their practice so if you keep current rule you may get 5 applications. Let us see any dr we want to and hold them accountable for approving or not don't put on the patient to fail because your afraid a few might get a card that dont deserve it. The black market will still exist so should losen up the requirement a little bit on doctor patient relationship most of us haven't met the dr who will recommend our MM yet trust me, maybe in a few years other dr will start to do it but theres nothing in it for them except to them a law suit. Current Az doctors will not recommend MM
The amount the state is requesting as a fee is alot. Also i did not see anything about the amount of taxes that would need to be paid to the state and the schedule. Is the Arizona Department of Revenue going to colaborate with you on this?
The rules on a ongoing relationship with a doctor is a bit to strict. I have been going to a neurologist for chronic pain for over 11 years now, so this would not be a problem unless my doctor will not recommend medical marijuana. If my doctor will not recommend marijuana, I will have to hunt down another doctor who will. I don't know if medical marijuana will help my pain, but I am willing to try it. I have been on many different pain medications for my leg pain and nothing has helped. I am on methadone and have been on it for over 10 years now, I would love to be off it, so marijuana as I have heard will help my pain. I probably would have tried it long ago if it was available. So in closing please do not make me wait an extra year to get relief from my excruciating pain! I can not walk around a grocery store without being in so much pain, that I would have to go back home and lye in bed for the rest of the day, take all of my medication and still be in so much pain. I am 50 now, and my quality of

life would be like someone in their mid 90s I don't want to live this way, so I am praying that the medical marijuana will help me. So as I stated earlier PLEASE DON'T MAKE ME WAIT ANY LONGER!!! Thank you.
There needs to be better clarification of the food establishment requirements. It states that a licensed facility may be contracted with to produce the Infused Food Product but no additional information as to the handling of the Medical Marijuana at the licensed food establishment. Assuming that it is a restaurant, commercial kitchen etc; 1) Can it continue to serve / make / manufacture non Medical Marijuana food product? 2) If a restaurant produces this will it preclude any but a Licensed Dispensary Agent from entering the buidling? 3) What security must be in place if a licensed kitchen receives Medical Marijuana for the production of an Infused Food Product? I see no propsed amendments are clarifications to Title 9, Chapter 8, Article 1 to accommodate this activity?
Seems that the folks who make these rules just don't get the message about people who really need this product. Many people who need this medical marijuana are on medicare, retiree, and on a FIXED INCOME and really cannot afford the $150 annual fee for relief of their chronic pain. It is actually cheaper to just stay illegal and buy the product on the street than jump through all the hoops that "legal medical marijuana" laws impose on limited income folks. People are going to use it at home anyway, so risk of being arrested are negligible. What heartless police officer would drag a 65 year old man in a wheelchair off to jail for possession of a joint? Can't the powers that be come up with a reasonable fee and reasonable renewel fee? Thanks!
$150 for a card is very high. should offer some kind of lower prices for vets,disabled patients and seniors all on fixed incomes.maybe $75 for people on social security. i wish it was half this hard to get pain pills! the county is not doing anything that i read about patients who cant afford the high prices non profit dispensaries will charge. the county should not let private owners own them and keep all state ran then itll truely be non profit.
Electronic data base and back up needs to be controlled, Does the dispensary have to be HIPPA compliant, if so how is that maintained? Who at the Department of Health has access to the records of the Dispensary? Is this shared with the DEA? Assurance must be given that there are no infants or children on site where the drug will be used. There should be a HEPA filter system at the site of use if children will be visiting the site. Second hand smoke and residual should be controlled. Does this carry into real estate disclosure if a house is sold does one have to disclose that there is contamination in the building, walls, carpet etc? It should be stated that ONLY licensed physicians in this State can Rx the med, not doctors in other States, or nurses, or physician assistants. I am surprised that this isn't dispensed through a licensed pharmacy which already has controls in place. Why not eliminate the dispensary and use only a pharmacy?? I think there should be mandated malpractice insurance carried by the dispensary to protect the quality given to patients, in light of recent Ecoli and salmonella outbreaks. If this is a medication it should be handled like one and not like the produce department of the store.. Dispensary personnel should have a DEA background check, and maybe even have drug testing....
Improvement- the cost of card holder fees, they are extremely high especially for people like me who suffers from extreme dibilating pain, from various diseases and disorders. Especially on limited incomes. Also the fee levels for basic caregivers. I have approached several caregivers but when the fee is brought up they decline the help do to the amount of fees.
if the rules require that a person must have more than 6 months and or 4 visits to qualify as a relationship with the recommending doctor this would make it almost impossible for persons on social security/disability to be able to afford this even if their current doctors have no problem with the use of medical marijuana but do not want to be the doctor to give the recommendation. this will in many

circumstances make it impossible for them to afford yet another doctors costs possible and or delay the benefit of medical marijuana. with proof of disability and or treatment for at least 6 to 12 months from your current doctor or doctors and or a medical exam from the recommending doctor that should be more than enough. I am currently under the treatment of my PCP for many conditions, a pain doctor for pain medication and a clinical and health psychologist to be able to deal with my conditions and the effects of my medications. I take at least 40 pills daily and 2 injections per month. this includes 285 mg of morphine daily. I can hardly pay for my doctors fees and medications as it is. If they do not have issues with the use of medical marijuana but do not for their own reasons want to be the doctor to give the recommendation I will never be able to afford the medical marijuana for constant muscle spasms, nausea that has caused continued weight loss and not being able to sleep for more than 3 to 4 hours a day with the use of medications over the counter and RX.
A Dr. on call for a dispensary is absurd. This will only result in higher end use costs in obtaining medical marijuana for the patient. I believe this will result in patients securing marijuana through the black market as they currently do as it will be cheaper to secure illegally. please make it inexpensive for the patients who are typically poor because of the costs resulting in their illnesses.
SEE ABOVE
do not charge any money for the medical marijuana card, or have an exemption of payment for people with a disability, on a fixed income, people 55, or older, do not require said people to see thier doctor 4 times a year, because we cannot afford this, and do not charge nonprofit dispenceries any money to set up shop. etc.
I believe the fee portion of the rules is too high. I understand the purpose of the fees are to cover the administrative overhead to manage the program. Based on other states and the number of patients, it seems like a realistic estimate to say there will be 200,000-250,000 patients at least in the state. Just for the patient registrations that will be a sum of $30 - $37.5 million. That isn't including any designated caregivers. And since the registrations are valid for a year, that is how much the state will take in annually. I would like to see those fees be a much more reasonable level. A drivers license in this state costs at MOST $25. And it doesn't have to be renewed every year. I think a fee of $25 would be much more appropriate and a renewal of $10, since less work will have to be done by the state for a renewal. The fees as they are in the draft will be a burdon to ill people in this state. A lot of them already do not work or work on a limited basis. Fees being that high can really cause a financial strain on them.
seeing a dr 4x in a year is to easy , should be 2 years with the same dr 8x , and see a goverment hired dr to check you out with their own tests and compare notes with original dr , (when you tried to get disability they make you see a specialist besides your own dr) you will have to try other treatments before going on pot not smoke in public not smoke then drive since it will effect your driving not smoke while at work since it will effect your judgement not smoke in front of others , which will give them a contact high not smoke in front or near childeren which will give them the wrong message OR REJECT THIS STUPID LAW THAT WAS PASSED BY POT HEADS LIBS , IF THE FEDERAL GOVERMENT SAYS POT IS A SEQUENCE 1 DRUG THEN THATS IT , UNTIL THERE IS MORE TESTS TO SHOW THAT IT HELPS THEN OK , BUT SINCE THE FEDERAL GOVERMENT IS NOT DOING THEIR JOB IE. ILLIGAL IMMAGRATION, AND POT HEADS IN CALIFORNIA , AND NOW HERE , OUR COUNTRY IS SURELY GOING TO POT
Certified Nurse Practitioners in Arizona can function independently. In fact, many of us have our own medical clinics. As independent medical providers, we need to be able to certify our qualified patients for medicinal marijuana cards. Even if we were to have the patient seen/evaluated by a physician, there

still wouldn't be the 1 year "physician-patient" relationship as required in the draft rules. The relationship with our patients is "provider-patient', not "physician-patient". We have seen our patients many times and know them well.

I am taking classes towards Social Worker degree and it is important for me to try to get into the business of opening a dispensary and also try to offer rehabilitation to the patients that are not terminally ill and help them at the same time. I dont know if that is a good idea. What do you think?

"Enclosed" means: a. A building with four walls and a roof or an indoor room or closet; or b. An area surrounded by four solid 12-foot walls constructed of metal, concrete, or stone with a one-inch thick metal gate and a barrier covering the top of the area that is: I can understand the security issues in the city. Although A one inch thick metal gate (are you talking solid steel)? I myself do not believe you need to build fort knox with twelve foot solid walls for a rural, private property land area. A secure electric chain-link fence with a top, cameras and alarm system With siding so nothing would be visable would be sufficent.

Consider allowing a Doctor of Pharmacy to be a medical director also. A Doctor of pharmacy has more pharmacological background, and is very proficient at counseling and monitoring a patient's drug use.

As an AZ entrepreneur medically qualified to obtain a doctor recommendation + patient cardholder + caregiver registry ID cards + dispensary registration certificates. I can't find a reasonable answer to pre-invest into the location of a dispensary + cultivation site without the knowledge and/or guarantee that this investment is sound business management. The costs for me to secure these locations are substantial and makes no sense that I gamble the risk of securing these necessary investments without the knowledge of being able to proceed in directing a successful AZ Non-Profit Medical Marijuana Dispensary. --- Refer to text in (BOLD): R9-17-302. Applying for a Dispensary Registration Certificate B. To register and obtain a certificate for a dispensary, a person shall submit to the Department the following: 1. An application in a Department-provided format that includes: --- b. The physical address of the dispensary; (BOLD) --- Please disregard if the section below already addresses this concern, if so, the language above is very vague: --- R9-17-302. Applying for a Dispensary Registration Certificate k. If the dispensary and, if applicable, the dispensary's cultivation site are not ready for an inspection by the Department, the date the dispensary and, if applicable, the dispensary's cultivation site will be ready for an inspection by the Department; --- I believe the language similar to my comments below are necessary to be fair and reasonable:

There is no mention of the selection process for Dispensary Licenses. This should be spelled out very accurately and adhered to striclty in order to prevent ongoing lawsuits about preferential treatment and insider trading.

I think it is verty unreasonable that a patient needs an extensive history with a physician to get a patient card. A Dr. is plenty qualified to determine if a person will benefit whether they have been a patient for years or not. They manage to prescribe oxycontin and the likes, so what gives? Also people with sleep problems could highly benefit from medical marijauna also.It should be on the list of medical conditions. Not everyone wants to take lab created medicines with aweful side effects to sleep. Not to mention the adictive characteristics. Come on guys, if you trying this hard to keep out of recreational users hands, than do the same for the hidious man made drugs that are prescribed by thousands every day. It's easier these days to score pills on the street than pot!

There is an expectation that dispensary owners will have to provide 70% of their own Medical MJ. That places an unfair burden on persons who may not be able to cultivate SAFE medical grade marijuana. It may also create partnerships between dispensary owners and cultivators, which could lead to business problems, which in turn could create more work for your office. R9-17-302. 1. h. If

applicable, the physical address of the dispensary's cultivation site; If you are requiring people to provide 70% of the own MJ for their dispensary's, it will always be applicable. Cities are not allowing dispensary's and cultivation sites to be in the same zoning areas of a city. The ability to apply for a cultivation license would create more small business opportunities for the state of AZ, which as we know is in desparate need of more tax income. A small business which can focus on what they do best, grow safe medicinal grade marijuana.

Naturopathic physicians need to be included in the draft as medical directors of dispensaries. Naturopathic physicians are licensed in the state of Arizona and should be included in this law as medical directors for medical marijuana dispensaries.

I do not believe that a person should have to wait up to one year with their current Primary Care Physician to be eligible for a MMJ recomendation. I do believe that there should be tougher requirements than in California where they have Dr's that only work at giving recommendations, but, I do not believe it to be in the interest of the State or Governement to tell Doctors and Patients what qualifies as a patient doctor relationship. I agree with the language that the qualifying patient should be seeing that Dr periodically to assess the efficacy of MMJ to that individual patient. The reason I I do not agree with the stipulations posted here are that if someone moves here from another state and is in a horrible accident or gets a horrible disease such as cancer that, that person should have to wait up to a year before they are eligible for this treatment seems cruel and unusuall punishment. There is a big difference between making sure that patients that really need this medicine get it and keeping it unaccessable for a lot of people. Some people do not like to go to the Doctor all the time, and no Government agency should be able to tell a Doctor how long they have to see a patient before they can recommend certain treatmend protocols. I believe that keeping these provisions in the rules wil only lead to a lot of pain for a lot of people who could really benefit from MMJ treatment. I am an US Army Vetran. ASU alumni, and am married to a High School teacher. I hope you re-consider these provisons, and edit them to be realistically implemented, and find a middle ground bewtween being unaccessable and going to a in house Doctor and getting a recommendation on demand as in California. I believe that these requirments are unrealistic and will discourage a large percantage of people who need relief of their conditions and want to do it legally.

first off i just started reading the rules and will respond to more as i go, but the term "Enclosed" this rule is ludicrous. lets be real here it is a know fact the Marijuana has never killed anyone but Liquor has why would you have a fortress to secure the Grow. How many Grocery Stores or Liquor Stores have to secure the liquor to this degree? the answer NONE. are you just trying to make the cost of a grow beyond normal sense? this rule needs to be changed. the Act states Enclosed Locked Facility, means a closet, room, greenhouse or other enclosed area equipped with locks or other security devices. i own a restaurant with a full bar we have a Liquor room with a door lock , a walk-in cooler with a door lock. the whole restaurant at the end of the day is secured with a door lock just like all business. we have a camera system and a monitoring service to secure the restaurant. this rule is complete over kill and unreasonable.

(R9-17-302 subsection B. 15. a.) In the draft it speaks to having an on site or on call pharmacist. This is an area that needs better interpritation at the least. It is my understanding that a pharmacist is licensed to fill perscriptions submitted by doctors, since there are no "perscriptions" only "recomendations" what if anything is the roll of a pharmacist. It would seem to me that the medical director roll covers the education and use aspect of the operation so I am having a hard time understanding what possible roll a pharmacist could have. There is no other mention of a pharmacist in the rules other than in the initial application of a dispensary section. I feel this definately should be romved. I am all for regulation and close monitoring but I am not for adding an un-needed financial burdon on the dispensaries. The medical director should suffice. (R9-17-313 subsection 3 a) about cultivation, the dispensary is required to document the date a seed is planted and a watering schedule, in most cases the dispensary

will be using clones which have been clipped from a mother plant in a vegitative state to ensure a feminised product. there are no seeds involved. Also, what is the point of knowing the watering shedule. it seems like busy work rather than a viable meens of measuring anything.
help keep costs down...these people are poor
Allow Home delivery
I am encouraging all fellow doctors and the wider medical community to oppose your new rules. I am concerned with your definition of "physician patient relationship", forcing a patient to change their primary care doctor if their current doctor does not want to participate in the program. And also then to wait a year to receive treatment..... This redefining of PPR would set a very troubling precedent for all doctor patient relationships in the medical community. I believe that your are far exceeding your authority in this rewrite of PPR, and that these changes are in opposition to HIPPA laws and patient's rights. Patients must have the freedom to choose their doctors as they see fit..... Please drop this language altogether. You will be spending countless taxpayers' dollars to defend in court these indefensible intrusions on the Physician Patient Relationship.
At first glance, it looks like clinic medical directors must be MDs or DOs. While chiropractors and homeopaths should likely stay out of the mix, Naturopathic Physicians have an educational background, experience and professional mission well-suited to such service. While the regs seem to allow for "non-public" consumption at care facilities and private clubs, it might be helpful to further define "public area" in 18c as not including designated areas of dedicated, established 55+ communities. It would be helpful to address whether using a non-combusting vaporizer is considered smoking in public, as the initiative differentiates between "possessing and engaging in the medical use of" marijuana (e.g.-banned on school buses) and actually smoking it (banned in most places not a personal residence or care facility). A worthwhile distinction, since use of vaporizers allowed the quasi-legal "coffeeshops" in Vancouver and Amsterdam to continue to permit indoor cannabis consumption despite the recent enactment of otherwise strict No-Smoking rules. So, defining "smoking" is as important as defining "public" since the current wording would presumably allow a card-holding patient to use a battery-powered vaporizer in the park, at a bar or cafe, or while waiting for the bus (unless it was a school bus). Which is not necessarily a bad thing, but remains unaddressed in the ADHS guidelines and could lead to unnecessary confusion and/or arrest. It might also be helpful to clarify whether hotel/motel rooms and/or university dorm rooms qualify as private residences, and whether therapeutic cannabis users are restricted by blanket no-smoking rules which apply to indoor personal living spaces like those in a residence hall or hotel. For instance, if a hotel has only non-smoking rooms available, under what circumstance would management be allowed or compelled to provide alternative, "non-public" space for a guest who arrives with only the non-edible form of cannabis product. Addressing the use of vaporizers in this context (and other circumstances which might reflect the spirit of federal ADA guidelines) might again avoid later confusion. Generally, logic suggests that the use of vaporizers (like eating infused food products) should be less restricted than actual smoking, because it is not. However, routine use of vaporizers in very public places might violate the intentions of Prop 203, geared to protect the public from "in your face" consumption. Lastly, due to the overly-strict requirements for outdoor growing (the far more sustainable alternative to indoors under heavy lights and climate control, often using chemical fertilizers), the guidelines should make clear that a properly locked greenhouse qualifies as four walls and a roof.
Include medical marijuana as a part of the prescription rights of other health practitioners such as nurse practitioners and physician assistants.

More definitions on the Dispensary Medical Director requirements. Specifically whether a Naturopathic Physician qualifies for this position. The draft rules reference ARS 32-13 only as qualifying and Naturopaths are licensed in the state under ARS 32-14. They are allowed to be designated physicians to recommend marijuana to a patient, shouldn't they be able to approve them and oversee a dispensary?
**Location of dispensary~Question~La Paz County is a small population of 20,000 with about 40% FT. It is part time and resort driven. Town is surrounded by Indian Reservation and town is only 1 sq mile. Our dispensary location is 1 full block (390') away from a Learning Center owned by Arizona Western College. It is a satillite college of AWC. Is this considered a school? Due to our very small foorprint of town property available will there be any room for any type of variences on a case by case if local County Heath and/or Community Development approve? This Plaza is home to other medical facilities and would be appropriate in all other areas. **Grow areas~Does the DH "want" the grow area attached physically to the dispensaries? If not, will there be an additional location fee? Will all requirements such as security be double (for each site)? **LaPaz County is a very poor county but very much in need of the services. We have the largest senior population in Arizona. Question~What if no application for a dispensary is requested for in this County? Also who will set the price for the medicine? If one Dispensary accepts donations of $X per oz and the next dispensary in a more affluent County asks for a donation of $XX, how will that be defined? **How many plants can be grown by one grow facility? **How will the seeds, plants, etc. ONLY be from AZ if it is not yet designated?
There are some people who have been under their Doctor's care for months even years regarding health related problems, the requirement that a person needs to see their 4 times in one year before that Doctor can prescribe the marijuana seems a bit rediculous, if their Doctor feels or wants to try the person on marijuana, that should be totally up to the Doctor. I can understand if it a "new health" issue, than yes, I agree with the 4 times in 1 year before prescribing.
RD-17-303A ISSUE: In the event an applicant had built a successful dispensary over a period of years and either became incapacitated or died, his/her family would lose the dispensary's license as the rules are proposed and be forced to close. PROPOSED RESOLUTION: In very limited circumstances - death or permanent disability of the applicant (or under whatever circumstances the department deemed appropriate) - the business should be able to be transferred to another qualified applicant (upon payment of another fee). There could even be a restriction that the transferee would have to be a family member, however this would preclude anyone from ever being able to sell their business to another qualified applicant.
Patient Doctor Relationship. It seems unreasonable to require a one year relationship with a doctor and four visits for the medical condition. If a patient has cancer and is advised to take chemotherapy treatments then that patient would have to wait for a year and four doctor visits before being approved to receive medical marijuana to offset the effects of chemotherapy. In suggested time frame for approval, most chemotherapy treatments would have expired and the need no longer would justify the use of medical marijuana. As such, the drafted rule concerning doctor patient relationship is redundant in some cases. Espeicially those that need more immediate treatment. Don't make a patient that has a legitimate need wait a year. In addition, any doctor that has merit in their profession will not need four visits from a patient to determine if the medical marijuana would be beneficial to their patient. As such, I would suggest that a doctor patient time frame be variable based on the type of medical condition that is in question. In addition, patients that have been through a prior application process such as Social

Security Disability and that disability falls withing the guidelines for medical marijuana use should not have to meet new additional doctor patient timelines as proposed in the draft. Many patients that are on Social Security Disability have already gone through a long process for approval with some decisions taking as long as five years.

I like most of your recommendations except the 150 dollars for a qualifying patients and renewing patients because I like many others are on AHCCCS as well as other Federal programs like food stamps, unemployment, SSI/Disability and many other programs to help us and we have a hard time making ends meet as it is. There are no other programs intended to help the chronically ill and the dying that make you pay such high fees please reconsider this cost...and make it more reasonable like $50 dollars which still will be a hardship for many of us. Thank you Marusa Natal

1. There exists a great need for independent government regulated testing of cannabis. 70% of incoming product we do a simple visual test on in MI has contamination. According to Ca. and Co. test labs 65 to 70% of cannabis inspected has pesticides, mold, and other toxic issues. A new gas chromaticity, mass spectrometry machine can be purchased for $60,000 including operator training. A fully equiped test lab with the right personnel would run another $140,000.Mobile test labs are an option. If not mobile probably 5 sites would be needed Yuma, Flagstaff, Tucson, and 2 in Phoenix 2. Most cannabis is grown to optimize THC and getting high. Growers need to be motivated to optimize CBD,CBC CONTENT TO IMPROVE MEDICAL EFFICACY. 3.The suggested Doctor patient established one year relationship is a deal breaker - suggest requiring one year going foward relationship rather than a retroactive relationship to maintain medical patient qualification.

Requirement to have seen your doctor 4 times the PREVIOUS year.. I'm on Social Security Disability, my need is legitimate however I believe this rule is to be a stumbling stone, as well as the amount of money i'll be FORCED to pay to my doctors, and the State it has a chilling effect on my ability to seek relief and obtain medicine. I will take this to court if necessary it creates an undue burden limiting my ability to change doctors as I have recently had to due from a move from Maracopa to El-mirage. As this currently reads I automatically now will NOT qualify under the draft because with only a few days this year cannot possibly see my new doctor 4 times. So now I have to wait until 2012 to obtain a card? You can guarantee this language will go to court.

Make it legal to start non profit co-ops, or collectives that allows for people to pool resources to make medicine better, & less expensive. Also allow & outline how co-ops or collectives can produce infused edibles in non-commercial facilities so people can consume without having to smoke.

Our only concern about the draft is that it doesn't allow Nurse Practitioners and Physician Assistants to write recommendations for their patients. Living in a rural community we rely heavily on both FNP's and PA's for our primary care. My husband, a trigeminal neuralgia patient, and someone who could benefit from the use of medical marijuana, sees a wonderful FNP here in Flagstaff. In fact, our entire family goes to this Nurse Practitioner for all our primary care needs. During the last few years, Flagstaff has lost numerous Primary Care Physicians for a variety of reasons. Many PCP's, our Nurse Practitioner included, are so busy they are not able to accept any new patients. Flagstaff and other rural communities could not exist without the dedicated and compassionate care of these health care professionals. Excluding FNP's and PA's from writing recommendations will negatively impact the quality of care for many patients. Thank you in advance for your consideration, [redacted]

Requirements of a medical director (MD, DO) to participate in the licensure and operation of a dispensary does not appear to be necessary, the majority of which duplicates the scope and intent of a

Pharmacist's practice. This rule/definition appears to require a physician be paid to be on-call to provide information capable of being delivered by a Pharmacist, while at the same time is unable to create or maintain a relationship with patients to directly benefit either the dispensary, physician, or the patient. Additionally, rules appear to be unclear whether a dispensary may cultivate on site, or whether cultivation must occur away from a dispensary location. Are cultivation/dispensary sites requireing two registrations, or may be they be incorporated as under one registration?

Specify if the same "enclosed location" for growing, applies to card holders, caregivers & dispensaries. I do not see how most card holders & caregivers would have the resources to have that type of enclosed area outside. The cost would be very high & make it out of reach for most. I think the draft rules should apply to dispensaries since they will have more resources & have such bigger grows. When I read prop 203 I never imagined card holders & caregivers would have to go to such legnths to grow outside. I think a good tall fence with barbed wire or simliar on top & a good gate with lock would be enough. Make the fee less for caregivers that serve multiple card holders. Maybe charge $200 for the first application & $100 for the others, up to the 5 total. That way the cost can be very low for card holders that need caregivers which should translate into getting medicine @ a lower overall cost.

i pesronally know of several people who could maybe benifit from the medical use of marijuana. i work with vets (not in a medical capacity) a few days a week, and most are on a fixed income. it seems to me, at an estimated cost of 20$ per gram for medical marijuana, many will not be able to see if there is a use for them. in addition to that, many have no ability to drive 25 or so miles to buy marijuana. i think a medical marijuana card holder should be able to cultivate a limited number of plants for thier own use, and maybe surplus being sold or donated to dispenseries. this makes it much more affordable for fixed income people. thank you, [redacted]

This is my second comment session. After reading carefully, I now recognize that I will not likely be able to participate in the program because of your unreasonable physician-patient relationship. Although I have a qualifying and untreatable debilitating condition, a lifetime disability, my only source of health care is the Veteran's Administration. For you or me to demand that a VA physician see me four times a year is not realistic, and those who have not been involved with the veterans' programs may not understand. You see, I cannot ask to see the doctor four times a year. The doctor on the team at the time decides when I will next be seen, and then they send me a letter telling you when to schedule. They are trying to move me out to 8 month intervals. Looking forward to Obama-care? Please, sir, do not discriminate against veterans. We do not have the luxury of complying with your rules relative to physician relationship during the years to come. I ask you to reconsider on behalf of those permanently disabled veterans (seniors) who would prefer something other than government-purchased opiates! I can get narcotics easily, but I am only 63 and I don't want a life of addiction. I qualified for medical marijuana in California, where I was a health care executive. But my ailments forced early exit from the workforce and I moved here in 2006. I really want to participate in your program, but the first draft set of rules discriminates me right out. Please, help me. I want pot, not Percocet. [redacted]

I feel that the amount of plants per patient should not be twelve like in Washington but six like in Montana.If a caregiver is outside of the twentyfive miles of a dispensary and is growing for six people seventy two plants will be a sizable grow operation.The dispensary will only serve as a cover for the caregiver to profit off of his cardholders when selling his extra medicine. The same controls that are implemented for cultivation faucilitys should apply to everyone who grows for more than one patient.My experience in the past has been that most illegal grows always kept the plant total under 100 to avoid prosecution from the feds.The new law gives a green light to unsupervised grows oout of the 25 mile dispensary limit.

make it simplier, way to complicated to even read, I got lost in all the repetition. the cost is too high for

the patients, many won't be able to afford the additional cost to their current medications. don't make it so much for paperwork for drs, they have enough to do and this would discourage dr's from prescribing. describing approval for under 18 should be lower in the process.

Pertaining to R9-17-302(B)(1)(b) It would be a burdensome expense were you to require someone considering opening a dispensary to rent or buy a location until such time as they had reasonable assurance that a license would indeed be issued. Perhaps DHS could allow an applicant to supply either a physical address if they already had one, or a statement that the address will be, "an address that will comply with the provisions of DHS R9-17-318," or words to that effect.

This can be improved by listing the medical conditions that qualify for a medical card. 12 of the other states have a list of conditions that will qualify a person for a card. I was unaware of some of the conditions until reading the lists. I have diabetic nueropathy which causes a constant pain in my legs and arms due to the nerves being affected and irritated ALL the time. I have been seen by 2 doctors for this condition for well over a year. My problem is that neither believes in prescibing marijauna, due to person beliefs not medical. Both have indicated that marijauna could help me manage the pain but will not prescibe it for so that I can get a card. There should be Doctors available to review medical records of people who have been seeing a doctor, for an extended period of time, for a condtion that qualifies and then the doctor can prescibe a medical card for them. Also the fee for a card is higher that 11 other of the states that prescribe marijauna. This can be a disqualifing amount for those, such as my self, who are on SSDI and are on a very limited income and cannot afford that amount. Nowhere is the price listed for the cost of the marijauna dispensed. For those of on limited incomes we need to plan and adjust for purchases. Knowing the cost will be a great help. If the states of AZ is looking for revenue for the sale of the cards and marijauna the person who is setting these rules is going about it from the wrong end. Dr Humble should go out and talk to the patients that have disabling conditions to get a better understanding of what true pain is. The state will make MORE revenue having more people, WITH true medical conditions, utilizing this program. What I do not understand is that the people of AZ passed this law to help those of us with conditions that could be benefited by the use of marijuana but then people, politicians, get involved and try to make it so that NO ONE can benefit. I understand that the state does not want just anyone using this program who does not qualify but why make it so hard and expesensive for those who do qualify.

The section that specifies that a patient need to see the same doctor for a year before becoming eligible for a medical marijuana prescription. We do not have the same requirement for individuals who are prescribed oxycodone , so this would be a double standard and probably be defeated if challenged in court. This seems unfair. This means that if a patient has a 5 year history of chronic pain or any other qualifying condition with a doctor , but that particular doctor does not want to write a medical marijuana prescription for whatever reason, then the patient would need to see a new doctor and wait a year. At the very least this section should be amended so that any patient who can document their condition through medical records for a period over a year, should be able to immediately get a prescription from a new doctor. In addition any of the more severe conditions such as chemotherapy should be completely exempt from this requirement.

Regarding caregivers. My wife died a few years ago from a long and chronic disease, during this time I was her primary caregiver, but I had help from a number of other people over the years. It is difficult for a single person to handle a load like this long term without help. The current draft limits the number of caregivers to only one and that one cannot delegate. Additionally, for families like mine, it would have been two fees, one for my wife and one for me with the subsequent renewals. Families like mine are already strapped for money and these two additional fees would have been difficult to handle. If we sought someone outside the immediate family they certainly would have passed these costs to us as well. Please keep in mind that people with severe health problems don't have much money and the caregiver's time is already taken by the care they have to give the loved one. My suggestion is to

allow several caregivers. Perhaps the husband, hospice nurse and daughter could handle such things.
Charging $150 for a patient ID seems to be excessive and discriminatory. There are no charges to patients who use painkillers and other legal drugs for ID cards, so why are there charges for medical marijuana patients. Also, if my primary physician chooses not to sign any affadavits that their patient would benefit from medical marijuana because of their personal religious beliefs, professional pressure from the hospital or group they are working for, or from their own beliefs about marijuana their patient may be unable to use this legal medical option.
Rural homebound patients will suffer under these current suggested rules (1) Few doctors are available (2) Clinics are prohibiting their doctors from making marijuana recommendations (3) Poor people risk losing their medical care if they have AHCCS as they can't change their primary physician (4) Some caregivers will not cooperate with their immobile patients, either because they fear federal law against possessing MJ, or they don't want to go through all the paperwork hurdles (5) there are no home delivery guidelines (6) proposed zoning by some communities will prohibit home deliveries (7) poor people do not have resources to travel long distances to see other physicians, or their medical conditions make it very difficult to travel
Remove the private growing option.
A medical director? Is this an effort to make it too expensive and or too difficult to open a Medical-Marijuana dispensary? The patients doctor is already overseeing the need for medication. A physician-patient relationship for at least one year, really? Is this some kind of joke or are you just trying to make is so difficult to obtain Medical-Marijuana that no one can get the medication that they need in time, a patient could be dead before they get their medication. Come on, cancer patients may die before they achieve these outrageous goals. This waiting period should be lowered to three months or at the most six months!
don't know of any.
Having to be a patient of a doctor for a whole year, with at least 4 visits during that time is overkill. Some doctors will refuse to prescribe marijuana because of religious or other beliefs, regardless if it would help their patients. This rule could actually keep marijuana away from the people who really need it. Having the doctor sign an affidavit is also overkill. A general recommendation written on a prescription pad should be good enough, as it is for other medications.
Not everybody can afford or has the desire to see a doctor. If a person suffers from a condition they're too afraid to, embarrassed, or simply can not afford medical care, why would you turn them away from getting relief? Like photo radar, is it necessary to watch those purchase or browse the dispensaries? No, it isn't. Twenty five miles away from a dispensary is unreasonable. What will happen to those who are unable to access a vehicle, can not drive, or even walk? If it's non-profit, why are forced to purchase from a dispensary? Shorten the distance. Please not mental conditions as well as physical conditions will

benefit from medical marijuana.
16. "Ongoing" when used in connection with a physician-patient relationship means: a. The physician-patient relationship has existed for at least one year and the physician has seen or assessed the patient on at least four visits for the patient's debilitating medical condition during the course of the physician-patient relationship; or b. The physician assumes primary responsibility for providing management and routine care of the patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the patient's medical record maintained by other treating physicians that may include the patient's reaction and response to conventional medical therapies. 17. "Physician-patient relationship" means interaction between a physician and an individual in which the physician has ongoing responsibility for the assessment, care, and treatment of the patient's debilitating medical condition.
I think that felons and street hustlers should only be able to run this particuler business because then they would not be in the streets commiting illegal crimes and I bet they already know the business of marijuana.This would give them a second chance at being a law abiding citezen and do business that suits their personality.The "square" life living citezens should not be able to be involved in running this business because they are inexperienced with this business and they don't know what they're getting in to! They will be attacked by robbers and wish they weren't involved.But people who have experience in the street business already know how things are done with marijuana . Lets not put such innocent people in harms way and let the felons get involved who are built and prepared for this business and give them their second chance to become and stay legitamit! Let's stop rejecting them and let's start rehabilitating them.They probably caught cases dealing the same product that we just made legal. Not fair.Felons couldn't really get jobs way before recession,imagine their chances during recession! Let's have a heart Arizona. Thx
What about state to state reciprocity ? If I'm sick in one state and have a prescription, it should be good here as well if I travel here
Use it for lining the bird cage
I have stage 4 Cancer. I am on Social Security Disability. I get $1940.00 a month. After pay for my Medicare Medigap and Part D insurance at $371.00 a month, I have less than $1,500 a month. I don't think I can afford to buy a Card at $150 much less the marijuana.

I hope you see where I am coming from and that this wording should be with records for up to a year but even then, If you had cancer you may not live that long.
With all the fees for annual registering and the inevitable tax I think I would prefer to continue getting mine the old fashion way - illegally. Thanks, but no thanks for this implementation plan. I'd rather save the money.
Video camera's in dispensaries ? How about Patients rights to privacy ? You would think being DHS, you would know something about the laws of patient privacy. Obviously if you plan on taping either with storing devices or live feeds, maybe you people need to stop smoking whatever it is your smoking at DHS and educate yourself on the laws of HIPAA. Can't wait for the civil suits to start against the state of AZ as a result of HIPAA laws being violated.
1. Fee's are ridiculous, nothing like taking advantage of the sick. 2. 6 months to add a new disease or illness, so your going to make people suffer for 6 months of red tape and bureaucracy. 3. Time frames for licensing to long. Is it your plan to once again, see #2, make people suffer as long as you can ? 4. 1 year previous history with a doctor. So I get diagnosed with cancer today, I have to wait a year while continuing to see the same doctor before getting a license to us marijuana ?..NUTS ! You people sure are playing god with peoples suffering. What is it you don't understand about VOTERS APPROVED ?
~Improvement on the sanitation rules. They should be no less stringent than food-handling. ~Requirements for "disposal" of unusable marijuana (and proof thereof) need more attention. ~Provide more direction on "cultivation facilities" and health/safety issues therein. ~Remove the "anonymous tip" disqualification. Although tips should be viewed with suspicion, in a relatively small labor-pool, a whistleblower will jeopardize their livelihood by reporting violations.
Drasticly reduce the fees of the patient registration card. The $150.00 fee seems unfair and unreasonable. How many patients will be able to afford that type of fee each year? Or is that the hope of those opposed to prop 203?
Removing the requirement of having a medical director required on dispensary staff. I would like to be able to offer medicine at the lowest cost possible in these hard times and more staff is counter-productive to that end. In qualifying as a patient they provide proof that they have a serious medical condition, which is likely to be very costly itself in maintenance medication, doctor visits, etc. I believe that having a physician make a formal recommendation with proper discussion would have the same effect as intended and allow dispensaries to operate on smaller budgets, more the small operations I think most voters envisioned than a high volume drug store. Perhaps replacing the medical director requirement would be possible. Require dispensary agents to undergo dispensary-provided training on patient discussion of marijuana usage, side-effects, progression of symptoms, and reporting concerns to the physician whom recommended marijuana originally.
.
well i have bad form of trigeminal nuralga please make that one of the conditions that qualifies as it will be with me for the rest of my life and i dont agree with opiats thank you

In regards to "Designated Caregiver" I believe that the law will benefit from a little more specificity as to what a "Designated Caregiver" can or can not do. I would like to see designated caregivers have the same cultivation rights as dispensaries with respect to the amount of "Qualifying Patients" a "Designated Caregiver" is allowed to have; regardless of the presence of a local "Dispensary". It is the belief of most low income "Qualifying Patients" that having the option of a designated caregiver who can cultivate for their patients translates into more affordable medical marijuana. It is imperative that the state affords enough options for patients to lower the chance of diversion. That is why having cultivating patients 'donate' their excess medical marijuana to a local dispensary without any compensation is wrong. It is also wrong to expect compliant cultivating patients to stop cultivating just because someone can afford to open a dispensary within the 25 mile radius. It amounts to, at best, a form of legal extortion with the dispensaries extorting patients. I would either eliminate the 25 mile cultivating rule or introduce a "Grandfather Clause" protecting patients who were afforded the privilege to cultivate their own medical marijuana prior to a dispensary opening near them. I would also ask the dispensaries to compensate any donations of medical marijuana, from patients, in 'usable marijuana' and not in any form of monies. If we provide a state sanctioned market where cultivating patients can donate their excess marijuana and receive some form of compensation; we will greatly reduce the chances of diversion or worst illicit sale. The state has the precarious task of making a very profitable item appear to be non-profitable. By keeping the medical marijuana market competitive you make it more affordable and thus effective. Patients having a few well regulated choices will be more compliant. Designated Caregivers will help promote and maintain the affordability of medical marijuana. The Dispensaries should be the face of the whole medical marijuana market.
ONLY TIME WILL TELL.
there is nothing reguarding the limits. such as the limit of plants per house, per script? would like to know how to count cultivating plants. such as 6 flowering/12veg. what would be the limits, there?
I lost both my parents (mid 60s) in 2009. My mother died of a horrible, debilitating, rare disease. Both of my parents would have benifited from medical marijuana greatly. It would have increased the quality of their lives, which I deeply believe would have extended my mother's life, even though terminal. My father would still be alive. My parents were on a fixed income. They would not have been able to afford $150 per year, per person to register as a legal user. I don't think it is fair to make anyone pay ANY fee to legally receive a drug that increases the quality of life. That punishes those who chose that effective and natural treatment. I'm not opposed to the registration, or yearly re-registration, but the fee is outrageous and not keeping in mind the financial hardships that many of the people who have these costly diseases. Please, rethink this. It simply is not right.
16b. This provision requires that the physician prescribing the marijuana assumes primary responsibility for providing management and routine care of the patient's debilitating medical condition. Most of the debilitating conditions would require primary treatment from their specialist - oncologist, reumatologist, etc. -- not the physician who has prescribed marijuana for pain mangement. As written, it indicates that the pain management physician would be primarily responsible for the patient's care. Typically, these prescribing physicians are internists, not specialists.
R9-17-306. Inspections B. A dispensary shall provide the Department with authorized remote access to the dispensary's electronic monitoring system. This is not necessary or practical and is a great overstep of a government oversight. I recommend removing it.
It would help to have clarification on the fees for application. It makes sense that it is nonrefundable but if all the of the qualifications by the applicant are met and there simply aren't more licenses available

will the applicant still lose their application fee?
Have someone that knows the pain and anguish that many, many people are going through, write up the rules. That way they won't be obliged to kiss LaWall's backside in order to keep their job.
First; I was opposed to this move. but since it was passed, the lost card fee is too soft; it needs to be at least a $100 fee, to replace, unless the patient can provide a valid police report of theft, WITH witnesses to the theft. Otherwise it's too easy to sell a card for a fee and go get a new one. ANY request for a replacement MUST include the number of the lost card, or be considered invalid, and privilege revoked, again because it's too easy to sell and go for a replacement. ALL patients and care givers approved MUST be fingerprinted as well as photographed and prints of at least 2 digits should be on each card as well as photo, with prints on file in AFIS. IF privilege is once lost, it should NEVER be reinstated. If the individual goes off voluntarily and later needs again, must go through entire process for validation again. On qualifying conditions; this should NEVER be administered to any patient NOT terminal under any circumstances; the damaging effects of marijuana on the body would result in other medical costs which would additionally burden the state for their care eventually otherwise and that's inappropriate to burden the taxpayers with. as long as the marijuana is smoked. It's far more damaging than regular tobacco, but in the same ways. Once a person is determined to be terminal, he/she can qualify for the use. But qualification should also be reevaluated at least every 90 days, and a minimum of 2 physicians should initially certify the person has the terminal condition, then the following physician can re-certify at the intervals. Any caregiver should also be re-certified every 90 days. Set a $5-10 fee for the re-certification process. Additionally; as soon as any individual qualifies for use of this drug; his/her driver's license and vehicle registration should be immediately revoked.. This is an hallucinogen, and he/she is probably also taking other drugs that impair his/her ability to drive safely, and if he/she won't give that up voluntarily for the safety of the general driving public, the state needs to do so. There are more than enough "impaired" drivers on the roads and highways as it is. I realize this is an inconvenience; but so is killing some innocent person an inconvenience to him/her and the family of that person{-s}. This NEEDS to be STIFF to keep it from becoming abused, for the protection of the public at large.
This seems to cover most everything assoiated with other states laws.
The Fee for the applicants that are liveing at or below the FPL are exorbidant, Liveing with HIV I already have to spend 10% of my monthly Gross income on non covered medications. To have to try and come up with an aditional 150 our of my monthly income without haveing to go without food or other nescisities will create a hardship. Also it will leave me in a state where I am technically breaking the law because I am poor.
Have someone that knows the pain and anguish that many, many people are going through write up the rules. That way they won't be obliged to kiss Lawall's backside in order to keep their job.
R9-17-307 C1. The provision that mandates that 70% of the dispensary's cultivated marijuana must be provided to qualifying patients or designated caregivers and that only 30% can be sold to other dispensaries. This provision would mandate that EVERY dispensary must cultivate its own marijuana if it can't acquire more than 30% of its sales from other licensed dispensaries that cultivate. Inconsistent quality control, potential crime, unnecessary growers, limitations on location options (some areas are conducive to retail, but not to a full-fledged growing operation), inspections, etc will be unwieldly if there can be, in theory, 124 very small cultivators/dispensaries throughout the state. If a grower wants to focus on growing, where quality can be controlled, crime could be mitigated and inspections could be targeted, the grower should be permitted to do so.

See below

1: As mentioned above, I do like the idea of having a medical director. However; I would like to see the qualifications required to be inclusive of a pharmacist. I did see later in the draft a question regarding whether or not a registered pharmacist would be available on site. My reasons for this suggestion are as follows: A. I believe ADHS should emulate our current medical system whenever possible. In our system a physician is in charge of prescribing medications. It is the role of the pharmacist to dispense the medication and to discuss the benefits and/or risks associated with the use of a medication and the possible interactions with other drugs. This is exactly what we are looking for in a medical director. Also, since pharmacists cannot write recommendations, there would not be a conflict of interests in having a pharmacist as a medical director. B. Under the proposed law a medical director would have to be an MD or DO and not be in the business of writing recommendations. This presents a few problems. First, the MD/DO will be prevented from helping his/her patients with marijuana recommendations. If he/she is a supporter of medical marijuana he/she would likely not want to take marijuana out of his/her prescribing options. If he/she is against medical marijuana, he/she would then not likely want to be a medical director of a dispensary. Considering the above, I think a pharmacist would be the perfect fit as a medical director of a dispensary. 2. The draft says that an unannounced inspection is possible if a non-annonamce complaint is made. I think all inspections should be unannounced without the need for a complaint. In the pharmacy world our inspections by the Stat Board of Pharmacy are all unannounced. This should be the norm of ADHS inspections as well. A dispensary and/or cultivation site should always be in compliance with the ADHS rules and regulations. It would be nice to have the owner present, but if proper records are maintained, the ADHS should be able to conduct it's inspection without need for supervision from the owner. When the State Board of Pharmacy does an inspection they go thru the records and inventory by themselves while the Pharmacy continues to run. They only ask the Pharmacist for assistance with locating the files needed to conduct inventory. All employees of a dispensary and/or cultivation site should be able to provide the ADHS inspector with all the records they need. Surprise visits will ensure sites are compliant at all times. Owners will not have the benefit of a weeks notice to get things in line and possibly alter inventory records to be in compliance. 3. I would like to see a passport photo be acceptable for the photo requirements. They are easy to obtain and this would provide uniformity for applications and for cards issued. All registration cards would then be identical in format. 4. Inventory should be kept of all usable marijuana harvested at a cultivation site. However, to weigh and document the unusable portions might prove to be a burden and provide no benefit to inspectors. Trying to weigh an entire plant would be difficult especially if the place harvests large quantities ie; over 100 plants. I do not see any benefit of weighing plant parts that will be trashed/discarded (according to proper procedures of course). An inspector would have little use of a document that says "110 lbs" of unusable plant were discarded with a certain harvest. What really matters is how much usable plant was saved. Amount harvested minus amount sent to dispensaries, would always equal the amount of usable marijuana that is on the grounds of a cultivation site. I would require dispensaries to keep inventory of any plant waste they have on hand. For instance, if they trim off any leaves or stems from a bud they receive from a cultivation site, they should weigh this unusable portion, document and save in a waste area. When inspected a simple math equation could be used to determine exactly how much inventory a dispensary should have on site. Amount brought in minus (amount sold + waste) = amount on hand. 5. With regards to the application for a dispensary license, I would not include the requirement of DOB and a picture. I would require these to be submitted if/when a license is granted. I say this because this only opens the door for people to say they were discriminated against with regards to age, race and/or appearance. I would have a box that needs to be checked acknowledging the person applying is of legal age to run a dispensary . Again, this is a minor change that would protect ADHS from possible complaints.

As the State has decided is O.K. to go outside the Federal Law and the normal distribution of drugs through the medical channels , what now will be the State of Arizona's liability as to someone "legally"

getting high based on this law? For example, if I get high on drugs with a true prescription legitimately issued by a doctor and issued to me through a regular pharmacy, besides personal responsibility for my actions, there are many levels of responsibility and accountability by the doctor and pharmacy. Or for that matter if I get drunk at a bar, besides personal responsibility for my behavior and actions, the bar that served me can held partially responsible if I am involved in an accident. It appears to me that from what has been published that the "dispensaries" will be LLCs that I believe by Arizona statute are limited to liability of $100,000.00. If this is the case, it is only a matter of time until the State is held partially accountable (i.e. financially) since they are now regulating a drug and apparently giving it preferential l status/ treatment over other medications since it will have its own channel of distribution. I am not really against the idea of marijuana for some medical uses, but creating a whole new level of government/regulation for something that should be done through existing channels (where there are proper safeguards in place) and setting up the State for additional liabilities and expenses just does not make sense to me. Also, if this was handled by a regular Pharmacy there would likely be some type of consistency or rating as to potency/dosage, from what I have seen so far there is NO oversight as to the actual dosage. I thought the idea behind a “prescription” was a treatment plan from a doctor with a goal and measurable standards. One last thought, is the State going to properly tax the dispensaries to cover the additional expense for going outside the existing infrastructure? Just my thoughts as a citizen. Thank You, [redacted]
eliminate them.
Simplified. Too many requirements on the "patient" . We are talking about old chemo people are we not? How are they going to do all this stuff?
I saw very little language to help caregivers who live in rural Arizona. I am over 40 miles from a Wal-Mart, so if approved, I would want to raise my own on my far. If I am held to the same definitions as a dispensary, I would have to renovate one of my outbuildings just to comply. Did I miss something?
I think that one improvement to the rules would be to further clarify the role of the cultivation facilities as it relates to outside dispensaries. The requirement that a dispensary must cultivate 70% of their own medicine seemed a bit odd, as it provides a difficult situation to regulate. How would the department reliably verify what product came from that dispensaries cultivation facility, and what product came from an outside source? This also creates the need for each dispensary to have it's own cultivation facility, which means 124 dispensaries and 124 cultivation facilities. This seems like a lot of operations for the dept of health to regulate. It would seem more appropriate to either allow dispensaries to receive 100% of their product from an outside cultivation center, or at least to use another dispensaries cultivation center to grow their medicine.
I agree with most of the rules outlined and view them to be much more black and white then many other states. However, I do not think that requiring applicants for a dispensary to have lived in Arizona for two consecutive years is in the best interest of the patients. The reality is that marijuana as a medicine is much more difficult to produce then simply growing marijuana. The products used and the way it is processed is much more important then in commercial agriculture as the product is intended for severely ill people. My fear is that patients will be unable to grow their own medicine and be forced to

purchase low quality overpriced medication from an under qualified dispensary. I am by no means recommending that you focus on attracting out of state growers but allowing people who truly want to help people the opportunity to make a new life in your state is a step in the right direction. I do believe that applicants should be Arizona residents but do not view the residency time line requirements to be beneficial. Thank you for your time and consideration.
Further ensuring that the price of medical marijuana is within reach of all qualified residents. I believe the draft indicates that the herb should be priced at a non-profit level. I think greater regulation to ensure this would be a good idea. I also think the rules regarding patients growing their own need to be expanded and relaxed. Many people in the state who are qualified patients are not wealthy and many in fact are on welfare. These citizens cannot be deprived of the benefits of marijuana.
In the sections which relate to the Physicians long term relationship with the patient and the requirement for continued treatment thereafter. I am on full disability with both Social Security and the Veterans Administration and the VA supplies all my medical treatment. I was advised by them that as a Federal Agency they will not issue letters contrary to Federal Laws. The only way for me to circumvent this is to provide their Medical Records to a physician for an independent evaluation as I must continue to be treated by the VA as a matter of financial necessity.
I strongly disagree with the idea that a homeopath or a naturopath can certify a patient for medical marijuana. They do not have a strong enough knowledge base of available medications to decide if the patient is considered a treatment failure. Which brings me to my next point. Medical marijuana should be used for treatment failures or intolerance only. So I actually believe that medical marijuana should only be prescribed by a DO or MD in the area of expertise that the patient's condition requires. For example: as treatment for Crohn's disease, only a gastroenterologist who has been seeing the patient regularly should be able to prescribe marijuana. And for chronic pain: a pain specialist. Anxiety? a psychiatrist.
I understand you don't want this for recreational use. But the thing is asl this new rules are going to affect the patient. I'd you have to see your doctor for a year what happens to someone that doesn't go to the doctor and they get cancer and need medical marijuana that can't get it because of the doctor rule. It should be up to the doctors punish them if the misuse there authority. Not the patient. The doctors should decide when is a good time for someone to use marijuana.
You've frustrated the intent of Prop 203 very well.
So what exactly is the point of this law that we voted for? Did Walgreens and CVS have to jump thru this many hoops to dispense Oxy and Xanaxs? Do you need to get a card for $150 dollars in order for the pharmacies to dispense OXY and Xanax? I know two people that are going thru chemo right now, that I've already heard say "that they will not got thru the hassle and will continue getting it from whomever they're getting it from now" What is it we voted for again? You can walk into any URGENT CARE with a bad back and walk out with a script for pain pills (very addicting pills) and then go to CVS and have the pills to alleviate your pain, all with in a couple of hours. Yet to get this medication you "Have to have a RELATIONSHIP with your doctor for at least a year and he has to want to prescribe

it to you" WHAT A JOKE!!!! What other medication has all these hurdles in front of it?
Please, Please, Please Please for the sake of the children, only allow dispensing by pharmacies and pharmacists for god's sake I am begging you.
The price of a card. Come on...no other state charges this much. You cannot make up the money our state needs off of the sick and dying!!! Drop the price and the renewal price! All the cameras....how rude! And how expensive! I love my doctor but he has already told me he will not be writing recommendations....so now you want me to find a new doctor who will? How? And then, wait a year? Not right to do this to patients. So you are forcing us to procure medical from other sources and continue supporting drug cartels. And opening a door for lawsuits against the state! Already the zoning rules are not complying with Prop 203...and now all this. All you are saying is that you don't agree with the voters about this issue and you are going to make it as difficult as you can on patients. A doctor on staff....are you crazy! What doctor wants that job? They can't make enough money doing that. This part of your rules is as crazy as the price!!!!
Add draft regulations about home growing.
I believe there should be more prescription guidelines and rules; The patient should have tried the accepted therapies for at least 3 months prior to trying medical marijuana. Their doctor should have to submit a "prior authorization", if you will, for a medical marijuana prescription, submitting all records and therapies, documentation of treatments. Who would oversee (ie; make sure they are doing this) the rules outlined for the physician regarding wether they have treated the patient for 1 yr and seen them 4 times or reviewed comprehensive records from another phycisian and completes a comprehensive exam??? What about lack of documented evidence that marijuana helps the conditions listed? Who will make a ruling regarding adding new "conditions" to be added to the list?
There need to be clear limitations for caregivers based on the doctor's opinion. If a Dr. realized that he/she has a patient who requires a larger or smaller than normal amount of cannabis there should be wording to outline these limitations in a care-giving license. Without these guidelines care-givers will be unaware of plant #s and other limitations of the act of care-giving.
A physical address for the dispensary is an obvious qualifying factor in a full license approval. That being said, to have everything in place with no guarantees for an initial license lottery scenario (only 124 to be issued) will cause some to cry out that these rules have set this up for only the privileged and point to an elitist type qualification for which only the wealthy will be able to spend the type of money it will take to commit to a lease, build the space to state specification, expense set up for cultivation based on the 70% site rule all before even knowing if they will be lucky enough to receive a dispensary license that is limited to 124 locations/dispensary licenses. Even if you have money to burn, I would question why someone who be inclined to spend an estimated min. $400-500,000 on business set up with only 124 licenses being issued and hundreds if not thousands of potential application for dispensaries. Even though if may add to the time line, I believe that given their is only 124 licenses to be distributed, there needs to be some type of way for the department to provide an initial approval pending a future site/ or proposed site qualifier that allows a pending license a timeline to build out a physical address after they know they are in a pending status. Maybe something to the effect: Once the state deems a company/person a qualified candidate (initial application, background check, certified financial statement to make sure they have the capacity to set up a facility, etc..) for opening a dispensary, they a set timeline to achieve the remaining physical address requirements prior to receiving a full approved

license. This is a more practical common sense approach that at least levels the playing field a little more and can easily be implemented as it is from many other highly regulated licenses.
adding the one year with a doctor is not right. I have been extremely sick and have been turned down just to see a doctor with no explaination. I have tried every option, Pills, etc,etc,. and all have been documented. I can not find a doctor that i trust to be a primary care doctor. i think a doctor that is approved by the stste of Arizona would be sufficent. period.....
Change the fee schedule. I think the fees are "too high" no pun intended. $150.00 per annum and then another for renewal. This is an out of pocket expense for people, which many are on disability, simply cant afford. The other issue I have is the 25 mile distance away requirement from a dispensary for cultivation. If you do not have a means of transportation you must have a caregiver or "get a ride" to get your medicine. This means more fee and more expenses again! People should be able to cultivate if they live farther than walking distance from the dispensary not 25 miles, where did that number come from? I think 1.5 miles one way is plenty for a person to walk for meds. 3 miles round trip in this heat may in fact be a little extreme anyway. Dont make this a rich person's medicine. How far would you walk in 90 degrees for prescriptions.
There are many people out there that want to help but I see the current rules require a substantial amount of investment to start a dispensary. I see that cutting out the people who really want to help while allowing those who have money to jump in it just for money. This is about giving a better quality of life to those who need it and NOT about making money. I believe the rules would be better suited by having a detailed list of all salaries and benefits to the board members and a preliminary plan for funds to support local charities and communities be in place instead of the expense of building a dispensary before an application is viewed. That could cost up to 200K or more or could cause people to cut corners and have a subpar dispensary. Have a $1k non refundable application fee to include all dispensary plans, general locations, all operation manuals, accounting plan with the application. Review all the applications for completeness and fitting all the rules set forth. This would allow the department of health to review a broader range of dispensary owner, proposed locations, and how they plan to give back. Give a provisional license to those who qualify and upon full build out and passing inspection with in a period of time they would be assured full license. Just like building permits you can collect additional inspection costs as needed. This would allow for a more fair advantage for those who don't have 200K to gamble with and provide a time frame to allow the department of health to collect fee's and do full and complete inspections with out having to hire additional staff. There are some Doctors out there that will utilize having to have medical staff on the board as a way to just collect money. You should allow a Doctor to only be on 1 dispensary board instead of 3 as proposed. There are some unscrupulous doctors out there and lets not allow them to take advantage of this system.
Criminize the use of pot/marijana/mary jane/weed or what ever other name it goes by.
Approving them as is right now.
I have specific questions because I 'm a veteran with multiple sclerosis who has a history of severe nausea. My neurologist who knows my history, as it is also in my VA medical record, is a VA employee and says that because he is a federal employee he can't write the prescription even though it is legal on the state level. Will I have to pay a private doctor to look at my medical file and write the prescription or, even worse, will I be unable to go to another doctor's recommendation because they're not my normal doctor? Will I be penalized for a conflict of interest?

remove that stipulation
We need additional clarification on how the Department will measure the 500 foot separation requirement for schools. I would suggest from parcel line to parcel line, as the most verifiable form of measurement. Other ways are building wall to the lot line of a school, or building wall to building. These I would not recommend because of inaccuracies in the distance measurements. How long after can they set a date of when the dispensary site will be ready for inspection? This time period may fluctuate as the tenant improvements are reviewed with the local city's building plans review and inspections for certificate of occupancy. Under R9-17-302.B.5. Does "authorizing occupancy" mean clearance of all city permits? For example, a city may identify that the dispensary is in compliance with the separation requirements, but additional improvements to the site may be necessary before the business can actually take occupancy of the site (i.e. upgrade lighting, complete all construction, issue building permits, and have a city inspection performed to issue certificate of occupancy)
An exception needs to be made, when a patient's doctor is prevented from making a medical marijuana recommendation by the hospital or the clinic the doctor is a member of. When this occurs, a patient should be able to see a doctor as a secondary physician and still keep their primary physician (noy having to abandon their primary physician).
Considering qualified patients can grow 12 plants, this seems the production would exceed the lawful usage. 12 plants = 12 pounds. Roughly 8 pounds more than the legal usage. I think the excess should be allowed to be sold to Dispensaries in an effort to curb illegal sale. After all, do you honestly believe that any patient would sit on 8 pounds of marijuana, when they could sell it for 2-3K per pound on the street???Who's kidding who????And lets face it, there is no way it would be donated to any Dispensary. Just a thought. Good Luck.
I have a problem with the physician-patient relationships. Someone who is diagnoised with cancer see's the oncologist (for the first time) soon after being diagnoised and starts chemo immediately. The rule that you have to be seeing the Dr. for a year AND had at least four visits totally leaves out the cancer patient. I have had breast cancer, my husband had non-hodgkins lymphoma, and our 24 year old was diagnoised with testicular cancer in Oct. We know from first hand experience that marijuana is a life-saver. I believe there needs to be a provision for cancer patients that are undergoing chemotherapy.
If patients like me can't afford their medicine, this law means nothing. Most patients on disability receive around $1000 a month; these patients need to be able to grow outdoors in a fenced area. The fencing requirements need to be reasonable, 8' with security wire on top edge, a secure gate, and 24hr recorded security camera from home computer, and no cover wire. Why would you require a 12' wall if someone can grow in a glass green house, and the walled area would have to be huge, or the 12 little plants would never get any sun. Indoor grow rooms were designed to hide from law enforcement, not efficiently grow marijuana. The more you force growers indoors it increases the cost to grow by 10 times. Forcing growers indoors will increase our states energy use. As we try and get people to use 40 watt bulbs rather than 100 watt, you're asking people to plug in two 1000 watt lights. Growing indoors will cause damage to rental property from bad wiring and mold, homes were not designed to grow crops, fields were. Marijuana works better on my nerve pain than the opioids I currently take. I've started using marijuana on a regular basis now that Prop 203 has passed, and already reduced my opioids by 1/4, but black-market prices are too high to afford to reduce them any more. You're welcome

to look at my medical records, if you like. I'm tired of taking narcotics and can reduce from several hundred pills a month to a few for breakthrough pain. I can't die from marijuana, I can from opioids. [redacted]

Some clinics and some hospitals are requiring that their physicians can not recommend medical marijuana to their patients. In many rural areas they are the only health care professionals available. In effect they are a health care monopoly. Include a provision that clinics and hospitals can not restrict doctors from making medical marijuana recommendations. Some of these patients can not travel far distances to see another doctor.

Will the "fee" for the Dispensary applicant be due upon submitting the application or paid upon approval of the application? If the "fee" is required up front will it be refunded if the application is not approved?

1. R9-17-202 (F) 1 e This reads: "The name, address and telephone number of the physician recommending medical marijuana for the qualifying patient." The words "recommending medical marijuana for the qualifying patient" should be deleted and substitute therefore: " providing the written certification that in the physicians professional opinion, the qualifying patient may receive therapeutic or palliative benefit from medical marijuana." The Act uses the "written certification" language not "recommendation". Reason: Under the Model City Tax Code a drug prescribed or recommended by a physician makes it exempt from sales tax. Using the written certification of an opinion may allow sales tax to be applied to these sales. See, R9-17-304(A) in the same regard. 2. R9-17-302 (B) 6 This subsection has the Applicant certifying that the Dispensary is in compliance with local zoning restrictions. This is from the Medical Marijuana Act. We think that you should add "and as verified in writing by the local jurisdiction." 3. R9-17-302 (B) 5 This subsection has as part of the initial Application process a certificate of occupancy issued by the local jurisdiction authorizing occupancy for a medical marijuana dispensary and, if applicable, as the dispensary's cultivation site. This doesn't happen that way. A certificate of occupancy is the last stage in local building and zoning approval. It is usually issued when everything is done, all the punch lists are fulfilled and the business is ready to open. Cities won't be able to issue a C of O for a Dispensary unless and until all of the requirements, both state and local are met. Cities can't issue a C of O for a Dispensary until all of your requirements are met and all of the city's are met. Cities probably won't issue the C of O until ADHS approves it for a Dispensary or cultivation site. I would suggest that you provide instead, somewhere, that prior to opening or growing, a C of O from the local jurisdiction must be filed with ADHS. This way, the cart is not before the horse, and local jurisdictions can help ADHS enforce it's requirements.

Protect caregivers. Include a provision that cities can not zone against medical marijuana delivery. Some medical marijuana patients will not be able to travel to get their prescription. Do not let cities zone to prevent deliveries. A patient's caregiver should not have to be put in the position of buying marijuana for their patients since it is a crime in the eyes of the US Government. As a caregiver I do not want to do an illegal activity. I don't want to get a marijuana card for myself.But, I don't want to deny my patient marijuana. I want my patient to get a marijuana card and some delivery person or dispensary operator deliver the medical marijuana to my patient.

The defining the security of the building. It does address the structural nature of the building, but really not enough detail about panic systems and security cameras, and what resolution they should offer; we would want 100% coverage. I just think it is too vague, and leaves many opportunities for discretionary

approval. There should be some consulting with security providers to ask them what is needed. I know our facility system works well at night, it is in color and has tracking capabilities. It is not good enough for us, we are also not distributing such a product. We can be certain the dispensaries are likely to be a target of some criminal activity. The ability to only record 5 minutes worth of video is not a long time.
Instead of 2 year residency you should make it 5 years to make it harder for out of state guys trying to get into Arizona and doing it.
Would it be within the scope of the rules to discuss enforcement?
Problem 1: Why is a dispensary required to grow 70% of dispensaries own medical marijuana? This is really a bad idea. While we may understand the initial thinking behind this statute, which is to possibly contain any growing to a few locations, the amount needed to be grown for one dispensary is staggering. Most Dispensaries will dispense nearly 30 pounds of medical marijuana each month. This means that on average a single dispensary will need to grow 320 plants at a time. That is a direct conflict with the federal government and the 100-plant limit. There is a five-year mandatory minimum prison sentence for cultivation of 100 plants or greater. Solution 1: The solution may be to allow outside growers to obtain permission from qualified patients to grow their medical marijuana and sell it to a dispensary where they could obtain their medication? This would create smaller more manageable cultivation facilities, but still produce enough medical marijuana to supply all patients and dispensaries. Problem 2: If a dispensary is only allowed to purchase marijuana from a licensed patient, caregiver or other dispensary, how will a start-up dispensary get marijuana legally in the beginning? The way the statute is written someone will need to purchase seeds or clones illegally the way we see it? Solution2: Possible allow licensed dispensaries and cultivation facilities to obtain their starting medical marijuana from legal sources in surrounding states such as California or Colorado. Problem 3: Why is a full time medical director necessary? The way we read the statute they are only consulting on labeling and educational material issues? Once the safety disclosures and educational material are written we don't see a need? Then to make things worse the medical director can only work with 3 dispensaries? Solution 3: If this statute was developed to ensure proper labeling and education then either eliminate this rule and set specific standards, guidelines and education requirements through the AZDHS statutes without a medical doctor requirement OR let a doctor that wishes to specialize in this area help ALL dispensaries.
My doctor is with a large health care system. As it stands now, he cannot prescribe medical marijuana. So am I to start Dr. shopping? Plus the one year rule is discriminates against people who do not have a regular doctor. Too many restrictions. And why $150.00 to renew? If so then $150.00 to register your automobile. I note something about a clinic having a supervising doctor. Does the WalMart pharmacy have a supervising doctor?
The draft rules can be improved by providing a set of rules for patients/caregivers and a separate set of rules for the dispensary. The draft as is stands is too lengthy.
Proposed Rule R9-17-202(G)(13)(e)(i)(1) States that the physician must have a relationship with the patient that has existed for at least one year or the physician must assume responsibility for the patients use. I have several clients diagnosed with pancreatic or other soft-tissue cancers that pass within 6 months of the first diagnoses. In fact my most recent client, passed with 4 months of the first symptoms. There should be some sort of provisional recommend that would allow for access to medical marijuana without this requirement in those scenarios where the patient has a need and making them wait a year (or scour the state for a doctor who will assume the responsibility) is simply unfair. I propose allowing clients who have certain conditions (undefined here) to apply and receive a provisional recommend good for 90 days immediate use, executed in the same manner as the rules provide and allow a one-time renewal and then force the patient to find a doctor to assume primary responsibility or

wait the year.
less restrictive for patient/doctor rules.
The section (5.e.i.) where it states: [the physician] Has a professional relationship with the qualifying patient that has existed for at least one year and the physician has seen or assessed the qualifying patient on at least four visits for the patient's debilitating medical condition during the course of the professional relationship; continuing to section 5.e.ii. & iii. (et al.) where the physician "has assumed primary care" and will monitor the patients progress, assumes that there is such a thing as a 'primary' physician for a patient. Unfortunately, since there will be no change in the Health Care system here in Arizona, the ability to have a physician that one visits regularly lies neither with the physician, nor the patient. Those decisions are made by insurance companies. How can a physician, or patient, be asked to make such a claim? I myself have no insurance. Any physician I visit has no guarantee that I will ever visit them again for various reasons: 1) I must shop around for cost effective visits 2) I may get insurance and be forced to visit another physician 3) Insurance companies might, at any time, change the physician that I am required to go to. This requirement would work well if there was universal health care and all of us were able to regularly visit a physician and the physician actually knew who their patients were...however that is not the world we live in. The one we live is one where we are forced to be medical transients by the insurance companies that lord over the health of this great state of Arizona. Please take that into account.
(There is no part of the comment form designated to raise concerns, so forgive me for doing so in this space.) Do these rules create difficulty in acquiring medical marijuana disproportionate to the difficulty of acquiring alternate therapies? The most useful standard seems to be that it should be, on average, no more or less difficult for doctors and patients to arrange this legal treatment option than other legal treatment options. If this standard was attained, then we could be confident the prescriptions were based on real medical need rather than on addiction or on frustration with legal hurdles. The Arizona Republic article makes it sound like there are significantly more obstacles to the use of legal medical marijuana than to alternatives. If this is the case, I urge the rule writers to aim for a balance based on benefit to the patients rather than on political struggles. If this is not the case, then I commend the rule writers for their fairness.
Because I work with Middle School students in Flagstaff and because many times they tell me they know someone who already smokes; I would like to see the distance increase from 500 feet to at least 1,000 from a school.
Marijuana prevents Alzheimer's. It should be available to anyone who wants it!

Most sick people can not afford $150 per year fee. Should have a low income program.
?
Make them more user friendly. Make getting and using a recommendation less burdensome. Not ALL in need will be lawyers. The # of hoops to jump through is mind boggeling, for both patient and dispensaries. Requireing a $5,000 non-refundable deposit is beyond stupid and arrogant. $10,000 refundable makes way more sense. Security requirements are overkill. Look at other states . Requireing a physical location before approval is putting the cart before the horse. Approve the applicants and then approve their eventual location. Growers and distributors should be separate fields as they are COMPLETELY different skillsets.
They need to be less restrictive. I see the method for requesting that other conditions be included, but annually is not often enough. Rather than listing conditions, it should simply read that it must be recommended by your care giver. It does not list chronic pain, insomnia or depression. Ambian is a popular insomnia medicine, that can be very dangerous. More and more we're learning about the myriad of dangers from lack of sleep, not the least of which is heart problems and the many annual fatalities from drowsy drivers. So if a doctor determines that it could help their patient, they should be able to make that call and not be hampered by a list of only the most common uses.
they are putting an Unreasonable barrier in the way for someone with a disability to be able to afford the FEE for the card. Most patients are dying to be able to quaify for the card in the 1st place so the fee is way out of line. People on disability don't have a lot of money left after they pay their bills do how are they supposed to have enough money to get regsitered. they should be giving people on Disability a waiver of fees like in N.M. and Colorado.. As for Growing your own plants should be allowed for people who have no transpration to the and as long as they have a registered for the card. if thisis going to be the cost of the card people will still keep getting it off the streets because it is cheaper so this has to be a compramize here. help the people that are dieing and give them an easier life for them to live.. this cost is way out of reach and unreasonable, you just don't want this to work in this state.
Non-refundabe $5000 fee? I believe it should be large... but non-refundable?
Price &/or profit oversight. Using California as an example, the "legal" retail prices are so high they are driving the consumer to revert to the illegal supplier. These retail prices are inflated in spite of the substantially lower costs of the drugs, preuming these drugs are provided by "legal" sources. Can you honestly define where the Arizona enforcement personnel for this new industry are coming from. Currently AZ can't adequately oversee, much less enforce, traffic , the medical industry or the legal industry just to name a few "regulated" activities.
Just continue to get public input and be fair and just for those who will benefit from the treatment. Making it tough but not so bureaucratic and difficult to hinder efforts of those truly trying to run a legit dispensary and cultivation center.
I know this is all new 4 AZ, U can Grow, Marijuana, 3 or 4 times a Year did takes, 3 to 4 months, 2 grow, Hydro, outdoors, greenhouse, But Hydro is the Fastest way, very safe, Hydrophonic, i hope i spelled that Right But it means { water works} so please TELL ME, How is a Dispensary when it first opens up, How can they have Product ?? when u want the dispensary, 2 grow 70 % of the Product, they will have 2 get, some product from somebody, Most Dispensarys, in my Opinon,

should be close to a Hospital, thanks [redacted]

I would like to see clarification on 2 points. 1) What makes a dispensary owner a qualified Arizona resident for 2 years? Is an applicant a resident who has paid Arizona State Income tax for 2 years? Does the applicant have to have a valid Arizona drivers license for 2 years? Resgistered to vote in Arizona for 2 years? I would prefer for the qualifications to be that an individual has paid income tax in Arizona for 2 years. 2) I am concerned about making a very large investment in my dispensary and then not getting one of the 125 licenses that will be issued. There will definitely be more than 125 dispensary applications. In order to get a dispensary license, will I have to make my entire investment in the operation before I even apply? This would be incredibly risky if I could not get my license based on a lottery system. How will the AZ Department of Health determine who gets licenses for dispensaries? On a competitive basis? If it is a competitive basis, what will the criteria be to obtain a license?

There needs to be a clear distinction in care giver rules. Also there need to be rules for co-op grows. I thought in the first draft on 203 that 25 miles from a dispensary is a double standard.

I believe the 8am-5pm hours could be improved by allowing them to stay open later. You will already have lines in AZ because there will be so few dispensaries per patient (i.e., 1 dispensary for every 7 in CO, with the same or more number of patients). I see the point, you don't want these stores turning into late night hang out spots, but more than half of the patients will have full time jobs, right? You don't want to limit patients' access to their medicine. A good example of this is dispensaries in CA and CO that don't have handicap access to their stores. I feel this should be a requirement as well. The requirement to see a physician four times is unreasonable in my opinion, unless you were to change laws across the state for obtaining more dangerous drugs such as oxycodin, zanex, etc. --of course, this is opinion but worth considering. Also, how are businesses in this industry to make enough cash flow to get through their first year if their patients are just now starting their 1st of 4 visits in a yr requirement to see a doctor? What about a current patient in CA or CO who is considering moving to AZ? Do you make them wait a year to have access to their medicine again? Also, what about doctors who want to move to your state for work? Do you not allow them the opportunity to have existing patients, but make them start seeing potential patients from scratch? Seems like a hard way to start a successful practice. The 2 yr residency requirement is understandable to "keep the mofia out," which is how it's been put in CO. I think that there should be a way to determine through the dispensary applications who is "mafia" and who has a good heart and is trying to serve patients and humanity. I think it is a mistake not to take applications from people all over the country, or at the least, in one of the other 14 states that allow medical marijuana, because you will end up with a much lower quality pool of applicants to choose from.

There should not be a requirement for a debilitating disease causing chronic pain or problems. I am a veteran who suffered many injuries in many areas in Iraq. I endured eight surgeries, most of which left chronic pain, arthritic pain, and strong pain associated with activity. The worst injury I received was a back injury, I received surgery for it but the pain has not subsided and is with me every day. That pain prevents me from running, sitting too long, standing too long and just causes general grief. I also suffer from a traumatic brain injury and PTSD, caused from the same HUMVEE rollover. Those illnesses and

problems are not addressed in the draft rules but could be. Another issue is that I will continue to be unlikely to receive medicinal marijuana treatment because my medical care is issued through the VA hospital system. I would have to acquire secondary insurance with a secondary provider for another year under the draft rules as I've read them to be considered for medicinal marijuana treatment. This poses a problem for me, I could use narcotics and aspirins to try to get the pain to subside or go without treatment and endure the pain. I recently stopped using narcotics and use only aspirin for pain relief but it is not enough and I have only one kidney so I'm prevented from using some of the more effective types. I don't want to take narcotics because of their proven addictive tendencies and would prefer medicinal marijuana. I've found that narcotics not only have addictive characteristics but also hinder my ability to work effectively. They make me irritable and affect my judgment. I am aware of similar effects in marijuana but consider it a safer, less damaging alternative to narcotics which provides the same benefits. Under the existing draft rules, I would be denied a right to a medicinal product that could enhance my quality of life. There are many soldiers with similar problems who may benefit from medicinal marijuana. Please change the rules to allow them access, as they will receive none under VA guidelines and will actually be further left out under the existing draft rules.
Clarify if the "enclosed" location for growing includes for card holders & caregivers, or only for dispensaries. I do not think the same security as far as type of fence & having a covering etc. would be needed for card holders or caregivers. I think it would only need to be in a locked/fenced area. If card holders & care givers had to follow the same guidelines I think it would cost to much & be unrealistic for most. Can a Card holder also be a designated caregiver? If so could he grow for himself & the card holders he is a caregiver for? Give a place for questions to be answered via email once the final rules come out. I think most want to fully abide by the laws set by you but would need some clarification.
Less restrictive rules on the dispensary. I understand the video cameras and inventory control but it sounds like a draftsman and engineering group must put together the floorplan and design the store. How about if they move into another business and use the plans previously provided by building inpsection?
See above....
I believe that a dispensary should be able to aquire more than 30% of their medical marijauna from caregivers or patients. I don't believe that they should have to cultivate 70% of their medicine. I believe they should be able to aquire as much as they need from outside sources, as long as those sources are following the rules. I think you should add some sleep problems to the list of qualifying medical conditions, like slep apnea and just trouble sleeping or falling asleep and staying asleep through the night. A lot of people hve sleep issues and would rather injest marijauna than taking prescription drugs that can become highly addictive and have side effects. It definatly does work, and other states have sleep issues in there list of conditions.
R9-17-310 Medical director A marijuana patient already has his own medical doctor who can be contacted by telephone or pager for inquiry or emergency. In paragraph B-2, you are asking that a medical director be "Able to be contacted by any means possible, such as by telephone or pager." I fail to see the necessity of duplication of services in this matter. The physician may not at the exact moment be able to return a call or page and it is difficult to know when he or she may return a call or page. If it is an emergency the patient should be instructed to call 911. The patient's own doctor should determine the medical use of the marijuana, because he has seen and evaluated the patient and knows better the patient's medical condition. I believe that the medical director's oversight of the dissemination of 1. Educational materials ...etc. is fine and should be maintained.

I have a qualifying condition, but my doctor does not believe in the use of Marijuana. Do I really have to wait a year while being treated by another doctor before the doctor can make a recommendation? I do not believe enough doctors will support the patient population, and thus many folks will either not get the treatment they need, or they will go black market.. these regulations are cumbersome for doctors. believe me, I have to struggle to get my doctors to do anything. I have to bug them multiple time just to get my current scripts renewed. All this procedure for a marijuana script will make it hard on patients and doctors will just become annoyed. If there are so many obstacles (which I believe) for a patient to get a marijuana recommendation, then I believe the supply chain (dispensary) will not be there to produce the medicine. It seems very risky to ask for such a large investment on behalf of the dispensary applicant, without really knowing weather there will be a market for the product. You very well know large drug companies do not have their patient population regulated like this. I've been given Medications for pain over the years like its candy. Easy for my condition. The application process for patients and fees are discriminatory against me. You have drafted rules that seem to protect those not in favor of this law, rather than those patients that need the drug. Are you not opening yourself up to legal challenges from patients...

The Arizona Medical Marijuana Act recognizes out of state card holders (mine is from Oregon) but goes on to say that visitor card holders can't use Arizona dispensaries. I for one do not want to deal with the black market, I also do not want to transport marijuana across different states. When dealing with the black market there is no way to tell what is in the medication or of medical quality. It would be great if the department would allow visiting card holders to purchase a dispensary card.

I thought the idea was to offer safe access to medicine for needy patients? I know you need rules and regulations, but it seems like you have set things up for big bussiness. I have a high level spinal cord injury and money doents come easy. With these fees, it will force me to get meds off the streat still or grow it myself...It sounds like these are rules made bye good people that dont know anything about the cultivation and use of this medicine. Do you know how much time and space and money it takes to produce this medicine? from your space and location restrictions, i thinks not.You couldnt possibly serve these patients with these restrictions without the price going sky high.It sounds backwards, but a looser framework will bring the patients out of the shadows and clean up the back alley, black market trade. you always see in the news that these shops raise crime. that is ridiculous.thats just politicians talking out the wroung end. ive lived in california and know that those shops have cleaned up the black market trade done in the back allies.I know ruled and guidelines need to be set, but i think we need to figure out what arizona is trying toget done.Are you trying to raise money for the state?Are you trying to stop grime? or are you really trying to serve a community that doesnt want to feel guilty about managing their medical needs? we are not bad people, if you really think this is a viable medicine, why do i have to register and pay a large fee to get my meds? if you need any other medicine, you dont need to do any of this. I want to be equal, not different!!! Please think about these points, im sure im not the only one that has pointed these things out... thank you for your time

Limit the amount of involvement the recommending Doctor has in the application process for a qualifying patient. Just the reading of what Doctors must provide in order to get his/her patient the medication they need will make these Doctors skeptical on wanting to get involved and put their name on such recommendations. Under R9-17-202 Part F Section 5 items e and h are too much and should be removed. The Doctors should not be responsible for patients who just see them enough to get the recommendation and then stop going to the doctor. As it is there are only to be a limited number of Doctors willing to recommend marijuana at all, thus the majority will not be the primary doctors of these patients. Its unfair to expect the Doctors to be so responsible for the patients and its unfair to make

these patients wait any longer in order to establish a year long relationship with a new Doctor that is willing to recommend marijuana.
I believe the cost of Qualifiying patient, Caregiver and Dispensary Agent cards are a little high. Patient cards should be no more than $50-$100 so as not to be a fiscal hardship on patients. Caregiver and Agent cards also seem a bit high but I understsand you need to make this a self-sustaining program.
"Medical Directors" should be defined as: Physician, DO, Nurse Practitioner, Physician Assistant, or Pharmacist. There is no reason these health care practitioners do not qualify for inclusion in this business.
It is unfair and exclusionary, if not downright corrupt to enforce a residency requirement. What you are effectively saying is the same as "No Blacks Allowed". It is downright riduculous to have these rules in place when the Gap, Starbucks, or Wings Plus have no residency requirements to do business. Do Doctors have to be 2 year residents to practice as well?? It smacks of corruption and I will post until Im blue in the face to expose this type of liberal nepotism. It effectively excludes businesses that have good plans and missions from competing with local drug dealers. It is after all the local drug dealers that forced that rule in Denver and the same group is now forcing it on AZ. To ensure that their tainted mass produced garbage marijuna is not threatened by a REAL company or business that is 100% Medical oriented for the benefit of patients. This is not fair to cancer patients who are running to the legal states to get involved in some way to help the others out there who need it. You preclude people like my wife, who has the best business plan n the world for a MMJ Dispensary by and for Cancer patients. I guess that will have to give way to Mom and Pops chemicalized weed shoppe. Because they are residents but have no desire to run a business, their only desire is to mass produce chemically tainted marijuana. Where is the section that imposes penalties on producers of tainted or unsafe product?? Where is the rule saying black market growersCANNOT be vendors?? So far it smells of nepotc corruption.
All the medical marijuana should also be over looked by professional staff like nurses and medical assistants that have been screened and drug tested yearly for the medical part of it. Narcotic sheets or log books and signatures after each day, similar to nursing homes and hospital regulations of all narcotics. Charting and evaluating vital signs, ie, blood pressures, pain scale evaluations, 0-10 pain scales, with every visit dispensary exchanges.
Has anyone in your office done the math on growing marijuana? You almost require growing indoors where plants produce 2-4 ounces, rather than 1-2 pounds or more outdoors. With the federal 99 plant limit, you're forcing dispensaries to violate federal law to produce enough to supply patients. [redacted]
I am a 75 yo living on mostly social security. The Veterans Administration will not be issuing scrip for medical marijuana. The proposal that I have to be under another doctors care for a year is discriminatory and financially impossible. How will I be able to participate? (I am eligible, live in a small northern AZ town)
The list of conditions needs to be expanded to include more autoimmune diseases such as polymyositis, etc.

I see they can be improved by fixing the cultivation rule. You want every plant tracked from seed to harvest. Many large scale growers don't use seeds. They use clones from mother plants. Many large scale growers use hydroponics for growing instead of soil. What possible reason would you need a water schedule for? Seems to be an unreasonable request for no apparent reason.
Ensure the innocence of medically determined conditions and use.
"Each principal officer or board member of a dispensary is an Arizona resident and has been an Arizona resident for the two years immediately preceding the date the dispensary submits a dispensary certificate application." This is going to be a discrimination issue. Other companies are not required to do this. Denver is currently re-writing their law after trying the same thing.
The more difficult and expensive you make the process, the more you force patients to the black market. At $20 a pound, it's just herbal medicine, at $2000 a pound, it's the main source of income for Mexican drug cartels. Want to bring the drug violence to Arizona, make a worthless weed worth it's weight in gold.
The law should also include provisions for card carrying patients who are allowed to cultivate MJ living outside the 24 mile area to also be able to purchase from a dispensary. The reason is because they may not be able to grow enough, or have bad plants, or need the medicine before the plants are mature.
I think the " One year rule", with the physician/patient relationship is too much to ask. I understand making restrictions to deter unworthy individuals easy access after one doctor's visit but in a situation that your long time physician no longer practices or moves his/her practice away and you are than prompted to see another physican in which you would have to have to wait atleast a year regardless of what your medical history or prior doctor says. What about the individuals that don't have health insurance and can no longer see their primary care doctor? You state that you want the doctors to be responsible and the "gate keepers" of the program, yet you are requiring a year and atleast 4 visits about your debilitating condition before you can even start talking about it. It just seems to me that you are making a special concession to the crowd who opposed this initiative in the first place to flex your muscles about how strict this is going to be for supposed "recreational users". I understand that stance but this is going to deter "eligible patients" who might already obtain their marijuana illegally through the black market and see these procedures as not worth it. So many other addicting narcotic pain meds don't have these time restrictions and again it seems like you guys are making a special concession to please the anti-MM crowd.
To much process. 99.8 percent of the AZ population should be able to have access to this medicine if THEY think its benificial. Free country.
First part that could be problematic is the 70% rule. Shall cultivate at least 70% of the medical marijuana the dispensary provides to qualifying patients or designated caregivers; I foresee multiple issues with this portion or the rules. A crop can go bad for multiple reasons essentially crippling the dispensary. Mold, bugs, and deficiency can render a crop useless. If this happens to a crop, a dispensary could be down as much as 3 months not allowing a patient to receive his medicine. With this rule, a dispensary would be forced to sell its own product regardless if it is ready or usable and could damage the patient. Leaving this portion in does not help the medical/recreational issue. It will just hinder a

patient and make us more like New Mexico which consistently has product shortages. Also, without some sort of free trade between dispensaries and caregivers, we will never be able to produce "medical" strains. It has taken California years to develop high CBD (Cannabidiol), low THC (Tetrahydrocannabinol) strains which are truly medical. This free trade idea will allow more dispensaries to have these strains available and further the legitimacy of Cannabidiol, the true medicine.
I think, perhaps, some clarity in regard to the surety bond referred to within the draft, perhaps in the "definitions". Is posting a bond a requirement for all dispensaries? If so, what amount? If not, what conditions and what amount? More information regarding the role of the Medical Director: routine involvement in education and operational oversight vs. rubber stamping P&Ps and patient education materials.
For adding a new condition, the time-line is entirely to long. 30 days just to let someone know azdhs has received the application. We the people decided we need this. 7-10 days max to approve or decline.
See minor typo: R 9 -17-101 19. "Registry identification number" means the random 20-digit alphanumeric identifier generated by the Department containing at least four number and four letters. Should read "...containing at least four NUMBERS and four letters..."
eligibility. Many people suffer from debilitating migraines which are classified the same as being a parapalegic. Many people suffer depression,bipolar, etc that are on deadlier pharmaceuticals that don't work. Cannabis would be perfect for them or anyone on anti-depressants. If we truly want to improve the way people feel, this should be included.
The patient fees should be reduced to a point where the poor can afford it.
When a patient is in pain and would benefit from Marijuana waiting one year and four Doctor visits is punitive and shows deliberence indifference by the State. It appears policies are being set up to block the public's vote and will. Mental health issues need to be added to the approved illness list. Please do not discriminate agian them. They are protected by The 1964 Civial rights Act-Title VII.
I think that a pharmacist would be appropriate in place of an MD or DO for dispensaries to have on staff. Their profession is centered around medication information. I think that a prescription for each quantity dispensed would be appropriate. Refills would allow for the pharmacist to maintain regulation and avoid abuse.
Your time periods and first to your doctor are way out of line.. I was diagnosed with glaucoma this last summer and my eye doctor only see's me every six months. I already have alot of pain with my eyes and extreme headaches. So according to your required medical visits in one year and way out of line. So I would never qualify because I am not seeing my doctor often enough for you, even though I live in a remote area and it takes months to get in to see him and I would be wasting his time and my money to see him more often (4x a year) because all he can do is tell me how my disease is getting worse and write my script for eyes drops. Not enough in regards to myselfm. My father in law's cancer was found by a new doctor he was referred to and has started treatment very quickly. Excuse my bluntness however he could pass away before he would qualify for your program that is suppose to help people.
making sure there isn't any loop holes for errors
You only mention profit 3 times in your draft. Removing the profit is the only way to keep criminals and cartels out of the medical marijuana business, and preventing patients from turning to the black market.

I'm a former narcotics investigator, and you need to understand that the harder you make it to grow medical marijuana, the more the price goes up. Unless we remove the profit from medical marijuana in Arizona, we will have criminals and cartels involved, if not in sales, then through extortion. Indoor grow rooms were designed to hide from law enforcement, not efficiently grow marijuana. The more you force growers indoors it increases the cost to grow by 10 times, increases our states energy use, and will cause damage to rental property. Homes were not designed to grow crops, fields were.
loosen the felony restrictions- a non-violent offense of 5 years prior is more than sufficient to prove non-criminality. do not let growth for those under 18 years old
Fees will always be too high, please rethink this. There actually should be no fee at all. This is a medical product used for the treatment of numerous ailments just like many other pharmacuetical products, please treat it as such, or require anyone who is seeking medical care and medications to pay the same fee. If you require dispensaries to be non profit, please extend this to all businesses engaged in providing medications or re classify to at the very least NOT for profit. It is the marketplace that should determine those businesses that are best suited for this industry, not a government agency and I would argue that you will have more problems over seeing a non profit and even not for profit that you would a for profit corporation and the ensuing taxes and fees they may generate. The 4 visit rule is draconian at best. Imagine that you had cancer and were told you had to come back three more times before they would treat you. The 1 year rule also precludes many who are under and non insured who for financial or other reasons simply cannot get adequate and ongoing care, these persons should not be precluded from the benefits of mmj for financial or other reasons. Either you trust the medical industry or you do not. They should be able to assess and recommend mmj just as they would any other medication for any other patient. You do not require doctors to have relationships with pharmacies and I think having to establish a doctor/dispensary relationship is improper and problematic. The dispensary is simply a conduit to provide a product and should not be relied on for medical advice. The rules for a physician recommending mmj should mirror those for any other medical recommendation. You unduly burden the physician and thereby unecessarily burden the patient by expecting a higher level of accountability for mmj than any other medication of medical care. Rather than go point by point, I think I am making the statement that the passage of the law was not a mandate for the state to get in between a patient and a caregiver and I think that you should work very hard toward treating mmj like any other medication or care dispensed by the medical profession. I believe the citizens of Arizona would benefit most from a system similar to California. I think it ought to be the goal of AZ dept of health to oversee the process at the lowest cost, quickest methods and least invasive of personal privacy and the physician patient interaction. I commend you for the work you have done, but look forward to a lot of improvement and very very happy to have you taking public comment and being open to comments, criticism and finding a working model that we can all live with.
I am concerned about the plans for dispensaries requiring the location of the panic button. Wouldn't that information then be available through a public information request which would then possibly endanger the employees?
Add a contingent approval process where a dispensary application can be approved and recieve a license contingent upon the final site inspection. This would lessen the financial burden/risk of the proposed dispensary. The application can be approved as per the information submitted by the potential dispensary. This would allow a potential dispensary to secure a location per zoning guidlines and plan for the grow/dispensary location without actually spending the money to have the site ready to go only to be denied a dispesary license. There is already a substantial burden placed on organizations trying to setup a dispensary with the requirements to have a physical address for the property where the dispensary and grow will take place along with the license fees. In the contingent plan would be the

business plan outlining the capital required to be "operational" within x amount of days upon a "contingent" license being approved by the state. This would allow for organizations with "more to risk/loose" to have a chance at owning and operating a dispensary per the state requirements. The way it is written now requires a large initial investment that is unrealistic for some organizations to have a chance to even apply.
At this point I think it is a good starting point for the process.
I believe the Fees for Registry Identification and Dispensary to be inappropriately low in nature. Considering the cost of "marijuana" to the user, the fact that it is not covered by Insurance, and the cost to society in the consequence of drug cartel violence, and Arizona Border Violence which is a direct result of the drug trade and affects Arizona directly, the fees are woefully low. Insurance carriers and drug programs pay for medical pain killers and medicine to alleviate debilitating conditions. Medical "marijuana" is an option which the patient selects through his own desire to use an "Alternative" medication. When a person elects to use Alternative medicine, it is well known that it is not covered by insurance, and must be paid for out of pocket, and the availability is determined by the patients financial wherewithal. Obviously, those who chose to use marijuana as an Alternative drug, are willing to pay the exorbitant cost of same. Therefore, the cost of $200 for a Registry ID card is woefully low and should be raised to a minimum of $500.00. The cost of the dispensary is too low at $5000.00, as well, considering the cost to society of same, via affects upon the general population and school aged children as well. It should be treated in a similar manner as a liquor store, or an adult pornography outlet, and the fees for Registering the dispensary should be no less than $20,000.00, considering the sizeable profit the outlet will sustain over a long period of time, as well as the consequences to society and community by the presence of same. I believe that the State of Arizona and the Health Department should have much more profit in the endeavor than that intended. This profit will help aid some of the public health programs, as well as fight some of the drug cartels on our very own border. Thank you for allowing input.
I really like the safeguards that are being put in to deter people from a 5 min meeting with a doctor and handed a card. As a HIV patient myself one thing I did think about are people who are recently diagnosed that have to be placed on HIV medication immediately. These medications are often very strong and can cause severe nausea and dizziness. There is a absence of history developed or perhaps the primary physician is not a specialist in the field of HIV treatment. This is important since the treatment and understand is constantly evolving, perhaps some separation of the length background or ongoing 4 visits/ 1 year for patients diagnosed with severe condition like mine that need specialist care.
As an assisted living operator, I think it is ludicrous to charge such a nominal fee, compared to licensing an assisted living center, to open and operate a dispensary. At the price that has been suggested,

everyone "pot-smoker" who wants to make a living will be submitting for an application. Will there be any special training required? Pharmacists must be licensed to dispense medication? Should there not be licensing process that proves someone able to own and operate this type of business?
i did not see any definition of 'physician' --- what physicians will be able to certify? MD, DO, what about NMD? ND ? DC? homeopaths? the first seven diagnosis labels are too broadbased without up front qualification of need to be at debilitating state [which the certification by a physician qualifies]--however, a public citizen may simply read it as diagnosis of 'cancer' and have had a simple superficial skin cancer removed years ago >> now demand that it is debilitating.
any conviction of driving while under the influence of marijuana, shall result in the offender's license to use marijuana to be revoked, and shall prevent that offender from ever obtaining a license to smoke marijuana again.
Need to specify that home delivery is allowed by any dispensary with proper recordkeeping, proper identification. Many medical marijuana patients are homebound either with or without a caregiver. They are not able to travel and require home delivery. Also many caregivers will not want to get involved getting medical marijuana for their patients since it is still a federal crime.
If this draft is appoved by ADHS the ACLU will file suit the next day. Do not waste the taxpayers monie with this. Make Medial Marijuana the same as all other Drugs. Keep the goverment out of peoples medical condition.
In Section R9-17-202. of the RULES it states :"Department-provided format". Will the AZDHS supply the format for the physicians certification or as long as the physician covers all of the points necessary in their own formatted certificate, will this be acceptable to the AZDHS?
More information about cultivation (locations, guidelines, amounts) and designated caregivers (where they must live/grow and amounts, etc.)
Dedicating a section to "This is what you need before you can apply for a card," and then "This is what you need to do when applying for a card." Because that whole part seemed a little confusing.
A Pharm.D. should be able to provide the services of medical director.
the cost of the card is high most people that needs marijuana is in a fixed income and 150.00 could be a burden to some in ss or ssi should be some form of discount for people on s.s.or s.s.i.this is to inprove life not take away for it
Include certified nurse practitioners as part of the medical community allowed to prescribe medical marijuana.
You need to clarify the informaton on fingerprinting. A fingerprint card is issued for 6 years and at great expense by the person applying for one (they run over $65.00). In your informal draft rules you do not acknowledge that a person possessing a valid Fingerprint card does not have to go through the fingerprint process again because that's the point of having a 6 year fingerprint card. Sort of like a driver's license you require everyone to provide ID to show they possess one and not make them go take the driver's license test again just because they are applying to be a caregiver or dispensary agent.

Also the "transporting" of marijuana is now the new word for delivery? Why don't you use the word delivery which is mentioned 6 times in the Arizona Medical Marijuana Act. Pima County and Tucson, Marana and other municipalities have banned off-site delivery and you are giving them credence now because of the word "transport". Clear this up please so cities can revisit their zoning on this. Finally you are violating the whole Arizona Medical Marijuana Act and inviting a slew of lawsuits by the demands for video cameras to be in the dispensaries. What don't you understand about the confidentiality of patients rights to go pick up their medicine without having their face put on camera and beamed directly to your offices. This is not part of the AMMA which clearly states "minimum security requirements", you are putting in maximum and unreasonable security requirements and this has to go.
Allow more medical coditions then proposed....seems very limited to all conditions.
There is almost no mention of quality assurance or product safety. Other than basic sanitation and restaurant like regulations, there are no guidelines to ensure that growing conditions, product manufacturing practices, inventory control, storage, distribution, packaging, infusion activities, and shipping meet even the most minimum of FDA standards and procedures. The legal and public safety exposure is considerable and almost inevitable, given the lack of regulatory oversight. I suggest you have a QA expert from the FDA suggest some basic guidelines on product safety.
1. This is a little confusing....Do we need to provide all or some? Same for Patient, Dispensary. A copy the designated caregiver's: i Arizona driver's license issued after October 1, 1996; ii. Arizona identification card issued after October 1, 1996; iii. Arizona registry identification card; iv. Photograph page in the qualifying patient's U.S. passport; or v. An Arizona driver's license or identification card issued before October 1, 1996 and one of the following: 2. Cultivation sites were not addressed. As I read this we can ONLY recieve medical marijuana from another dispensary, caregiver or grow our own in the dispensary? The Site Inspection part is alittle confusing because a. we don't have the seeds or clones till we have been approved so nothing can be set up b. we have a contigency lease based on if we recieve a dispensary license or not c. we have to already have a business up and running before applying for a dispensary license?
"Has a professional relationship with the qualifying patient that has existed for at least one year and the physician has seen or assessed the qualifying patient on at least four visits for the qualifying patient's debilitating medical condition during the course of the professional" This creates an unnecessary burden on the patient. As an example, North Country Health Care clinic does not allow it's doctors to make medical marijuana recommendations even if the doctor believes the patient needs medical marijuana. For someone who is poor or homebound, they will have to see a new doctor with 4 vists probably costing $400, transportatation probably costing $200 plus they'll have to get their license for $150. A poor patient will have to pay close to $750 just to be considered. In addition the patient will have to wait a year to get their medical marijuana
I think that anybody can say that they have neck pain or back pain or trouble sleeping etc... So according to the rules all that a person has to do is walk into a doctors office and say they can not sleep and then they are given a recommendation for medical marijuana. So this is going to be just like California (which we were all led to believe that rules would be stricter) and everyone is going to be running around smoking a controlled substance... I think that what I read in the "rules" is nothing like what I voted for. I was led to believe that only terminally ill patients were going to be able to use the medicine. There is a guy that lives 5 houses down from me who already has a recommendation for a medical card and his illness is sighted as insomnia... This is NOT what I voted for! Now every drug addict with $150 dollars can become a LEGAL drug addict. Another misleading bill believed by me and hundreds of thousands of other misled voters.

Coming up with the money needed to rent build-out and operate is a little more than most people have the ability to throw away on the chance that they will get a certificate. I think their should be a contingency plan similar to how a nursing home gets it certification and preliminary certification and then be given at least 30 days to comply and be ready for inspection at which time the applicant is either ready with all their ducks in a row so to say or they loose their certificate.
How about some protection for home care nurses who enter the home of up to 10 patients a day. will they have to spend 200.00 if a single patient is smoking or the nurse may become exposed from entering a smoky home. They could enter a few homes or 1 home have a car accident and be tested that would be rutine for a drug test. now is that nurse subject to license lost.
The rule mandating physician patient relationship should be revised to put the medicine in the patient's hands as quickly yet appropiatley as possible.
Chuck it in the garbage and start over. This is the worst rules I've seen and shame on ADHS. What do you think we are New Jersey with their worthless rules? Look at Michigan or Oregon and see how they provide compassionate care at the government level for their citizens.
Many technical requirements (especially related to security and physical plant) appear to be unnecessarily specific, and such specific requirements serve little useful purpose. In fact, it is detrimental to require an essentially uniform approach to security and access control at these facilities - any entity wishing to breach security knows exactly what measures are in place at any dispensary. It almost appears that some requirements, such as the extremely specific technical requirements for video recording and monitoring, may have been incorporated to benefit the few commercial providers of such specific technical solutions.
I am hoping it has a clearly defined way to become a dispensary and what the laws for advertising/marketing will be.
Dispensary agents will ALL be using Marijuana. I believe it should be absolutely illegal to do so. Mandatory random drug testing should be required.
This is test content and can be deleted.

How can the draft rules be improved?
Open-Ended Response
If you pay special attention to Section 36-2803 "rulemaking," you will notice that the AzMMA does NOT give authority to the Arizona Department of Health Services to define-or redefine-the patient-physician relationship and does NOT give the authority to amend the AzMMA language, e.g., adding "ongoing" to "patient-physician relationship." The Arizona Voter Protection Act specifically DENIES authority for such usurpations.
When a pharmacutical company introduces a drugs to a formulary it lists most of the illnesses or conitions the the drug is indicated for. MOST of them. Sometimes a specific drug may be used for a condition that is not listed on the original "indications for use" form. One example is the use of antidepressants for pain relief. What provisions are in place so that should a patient require medical marijuana for a use not originally listed or intended,-per the draft- that patient may aquire the medicine for the prescribing doctor?
Delete the requirement that a patient have a 1 year relationship with the recommending doctor. The requirement of a 1 year relationship is unrealistic. It discriminates against all veterans. Any V.A. cancer patient or V.A. chronic pain patient would not be able to get a marijuana recommendation because their doctor works for the federal government! Any V.A. patient would not have a civilian doctor that had seen him for their diagnosis for a year, so they would not be able to get a recommendation. I believe that we owe our U.S. War Heroes the right to pain relief, especially if they are dying from cancer! Any civilian patient, newly diagnosed with a fast moving cancer (such as pancreatic or lymphatic cancer) would not be able to gain pain and nausea relief in time, before the disease killed them. The voters did not approve of this provision, and the reason it was not on the ballot this way is because of the argument that I have just presented. It never would have been allowed to go to ballot written that way, because Veterans organizations and cancer patient advocates would have recognized the discrimination right away and had the language changed. Do not add fundamental stuff that wasn't approved by the voters! You are the implementers of the peoples will, not the writers of the law! By adding such things as the "1 year doctor-patient relationship" requirement, you are inviting law suits that can not be won by the state. Law suits that would be expensive, and would be lost anyway. Money would be spent defending the indefensible. Lets use that money as a state to do something else such as give music, art, Shop class and extracurricular activities back to our schools!
Delete: R9-17-101(15) Medical Director, there are no need for medical marijuana dispensaries to have a medical director we are not performing any medical treatments that need their supervision as in the need for pre-hospital providers aka EMTâ€™s and paramedics. Also if any counseling is needed it need to be done between the patient and their doctor before they are recommended medical marijuana.

Change: R9-17-101(16)(a) two visits instead of four if this is the primary care doctor it should take four visits to determine if medical marijuana will be beneficial Change:R9-17-102 from non refundable to refundable this isnâ€™t a chance for DHS to get rich and take advantage of people seriously if need be add a processing fee $50 Change:R9-17-102(3) Change of location to $1000 if a dispensary feels it is necessary to relocate due to a safer location for it patients which I feel this will be an issue due to the unreasonable restriction the municipalities are looking to enforce Add:R9-17-102(3)(a)Fee for adding a cultivation site $1000 so that expanding dispensaries can add a cultivation site if one wasnâ€™t in place on the original application. Change:R9-17-102(4)Change to $1000 this is a reasonable fee Change:R9-17-102(5)(a)Fee should be reasonable to patients similar to other states like Colorado which is $90 so change to $90 Change:R9-17-102(5)(b)There are no fees in other states like Colorado for a care giver and there shouldnâ€™t be one in Arizona if there is to be a fee it should be reasonable like $50 no more than what a patient should pay which I feel should be $90 Change:R9-17-102(5)(c) Change Dispensary agent fee to $100 there should be no fee at all as in other states but since the law requires background check for violent felonies and drug felonies a reasonable fee for this would be $100 anymore may be a burden on the dispensary Add: R9-17-102(5)(d)Fee for board members and principal officers $100 Change:R9-17-102(6)(a)Fee should be reasonable to patients similar to other states like Colorado which is $90 so change to $90 Change:R9-17-102(6)(b)There are no fees in other states like Colorado for a care giver and there shouldnâ€™t be one in Arizona if there is to be a fee it should be reasonable like $50 no more than what a patient should pay which I feel should be $90 Change:R9-17-102(6)(c) Change Dispensary agent fee to $100 there should be no fee at all as in other states but since the law requires background check for violent felonies and drug felonies a reasonable fee for this would be $100 anymore may be a burden on the dispensary Change:R9-17-105(4) Is this an error should it be in reference to R9-17-102(8) Change:R9-17-106(A)(2)change to â€œif applicableâ€ on telephone number Clearify:R9-17-106(B)(3)(a) What is the exact reference for (B)(2) is it R9-17-106(B)(2)? Clearify:R9-17-106(B)(3)(b) What is the exact reference for (B)(2) is it R9-17-106(B)(2)? Delete:R9-17-106(C) a terminal or debilitating condition should have to wait til Janruary or July to be added it should be at anytime. Change:R9-17-107(E)(2) should have 30 calender days to provide necessary paperwork Add:R9-17-107(F)(2)(c) should add a chance to correct paperwork if it is just an issue with paperwork before it is just denied Change:R9-17-107(G)(2)(b) Change to 30 calendar day to provide additional paperwork Change: Table 1.1 Changing a dispensary or cultivation location to reflect 30,30,10,20 if a dispensary is changing location it shouldnâ€™t take as long as a new application and should be similar to a renewal Delete:R9-17-108 Delete medical director Add:R9-17-108 Add employee into the list not just board members and principal officers Change:R9-17-202(F)(1)(h) Change to if applicable Change:R9-17-202(F)(5)(e)(i) Change to two visits Change:R9-17-202(F)(5)(k) Have it be required that the doctors document has to be notarized Change:R9-17-202(G)(1)(i) change to if applicable for email address Change:R9-17-202(G)(3) Not sure if this is possible due to how the law is written but it shouldnâ€™t matter if a care giver for a minor has a felony or not a minor canâ€™t get their own medication so the legal guardian should be able to no matter of a felony or not Change:R9-17-202(G)(9) Should have the felony restrictions removed as stated in the argument stated above if the law allow for that Change:R9-17-202(G)(13)(e)(i)(1) Change to two visits Change:R9-17-202(G)(13)(i) Doctors document should be notorized Change:R9-17-204(A)(1)(i) Change to if applicable on email address Change:R9-17-204(A)(4)(e)(i)Change to two visits Change:R9-17-204(A)(4)(k) Doctors paperwork should be notorized Change:R9-17-204(B)(4)(f)(i)(1) Change to two visits Change:R9-17-302(A) Change to 5 year resident prior to applying for a dispensary I think Arizona should take care of Arizona residents and not allow out of state investors to try to make a profit off of us here in Arizona and take away opportunities for us to employ Arizona resident that could use a job in these trying times Delete:R9-17-302(B)(1)(g) There is

no need for a medical director a pharmacy does not require one neither shall a dispensary Change:R9-17-302(B)(3)(b)Change to five years immediately Delete:R9-17-302(B)(8) There is no reason why a site plan should be a part of the required materials this has no bearing on security or safety and is just another expense and unnecessary hurdle for a prospective dispensary owner Delete:R9-17-302(B)(10) There is no reason why a site plan should be a part of the required materials this has no bearing on security or safety and is just another expense and unnecessary hurdle for a prospective dispensary owner Delete:R9-17-302(B)(13) It is not a concern on if or how a prospective dispensary owner plans to make a viable not for profit dispensary just that it is a not for profit entity and that is covered in the yearly financial report Change:R9-17-302(B)(14) There should be set hours of operation on the dispensary side (not cultivation) that limits the hours to reasonable operating time no earlier than 7am and no later than 10pm to limit criminal activity that may endanger patients and dispensary agents working in a dispensary Delete:R9-17-302(B)(15) All of this section (a) thru (d) has nothing to do with what a dispensary should be responsible for and should be deleted what training does a pharmacist has in dealing with medical marijuana? Exactly none and the nutrition and physical activity information is something apatients doctor shall be providing a pharmacy doesnâ€™t provide any of this why should a dispensary again another unnecessary cost for a dispensary Delete:R9-17-304(A)(5)(a) There is no reason why a site plan should be a part of the required materials this has no bearing on security or safety and is just another expense and unnecessary hurdle for a prospective dispensary owner Delete:R9-17-304(A)(6)(a) There is no reason why a site plan should be a part of the required materials this has no bearing on security or safety and is just another expense and unnecessary hurdle for a prospective dispensary owner Add:R9-17-304(E) the time frame for a change in location should be 30 calendar days similar to a renewal with time frame reflecting 30,30,10,20 and also change table 1.1 to reflect this as well Change:R9-17-305(1)(h) Change to five years Delete:R9-17-305(1)(i) No need for medical director Clarify:R9-17-305(1)(j) What does this pertain to Delete:R9-17-305(3) This is another added expense that is unnecessary this is not a concern of the DHS office other than it holding up to a not for profit business the state and federal entity in charge of taxes will know if there are any discrepancies Change:R9-17-306(C) change to 10 working days Change/Add:R9-17-306(E) the dispensary will be provided a copy of the complaint and person reporting Change:R9-17-306(F)The department can only inspect for specified violations made in complaint and not take it as a free for all to try and find another infraction during their investigation Change:R9-17-306(G) Change to 10 working days Delete:R9-17-307(A)(3) No need for a medical director Delete:R9-17-307(A)(4)(b) No need for a medical director Delete:R9-17-307(A)(5)(b) No need for a medical director Add:R9-17-307(C)(5)Should consider adding that a dispensary can in their first year be responsible for 50% of their own product but must receive the other 50% from patients, caregivers and other dispensaries due to the newness of this business and to get use to supply and demand and what to expect from their crops ie. Turn around on product and actual harvests size Delete: R9-17-310 There is no need for a medical director all of this is items a pt and doctor should be going over in the visits prior to the recommendation to use medical marijuana and on the ongoing care of the pt Delete R9-17-310 (A) thru (D) Change/Add:R9-17-311(1) Add a list of approved identifications for a dispensary agent to verify a patients identity Delete:R9-17-311(2)This is for a doctor to provide his patient before recommending medical marijuana Delete:R9-17-312 There is no need for a dispensary to maintain any pt records other than medicines dispensed and verifying that they are not receiving more than 2.5 ounces in a fourteen day period all other logs and records are for a doctor and patient to go over Delete R9-17-312 (A) thru (D) Change:R9-17-313(B)(3)(b)(ii) This needs to be change due to the fact that marijuana losses up to 80% of its weight when it is dried and cured so there needs to be a change to this Delete:R9-17-313(B)(6)(e) This is not something a dispensary should be liable for once the medical marijuana has transferred custody to the food

establishment Change/Comment:R9-17-313(C) This needs to be change due to the fact that marijuana losses up to 80% of its weight when it is dried and cured so there needs to be a change to this Change:R9-17-313(D)(1) Change to two years not five there is no reason to keep records longer than necessary Delete:R9-17-314(A)(3) Should be on record with the dispensary but not nessesary for patient labeling requirements Delete:R9-17-314(A)(5) Should be on record with the dispensary but not nessesary for patient labeling requirements Change:R9-17-314(C) Change to one gram of medical marijuana Delete:R9-17-315(C) (1)(c)(i) not necessary Delete:R9-17-315(C) (1)(c)(ii) not necessary Change:R9-17-315(C) (1)(c)(ix) delete the recorded video Change:R9-17-315(C)(1)(d) Define the number of panic buttons and where they need to be located Delete:R9-17-316(B) Delete this is not the dispensaries responsibility but rather the food company preparing this edible item Delete:R9-17-317(B)(4)no medical director needed Delete:R9-17-317(B)(5)no medical director needed Change:R9-17-319(A)(2)(a) Change to five years ADD:R9-17-319(F) A dispensary can re apply for certification after a certain time frame as long as it is a serious offense for revoked

The draft rules could be improved by not being so restrictive in regards to how a patient may get access to medical marijuana. A.R.S. Title 32 Chapter 14 licenses naturopathic doctors and A.R.S. Title 32 Chapter 29 licenses Homeopathic doctors in the state of Arizona. Proposition 203 never gives any authority to the AZ DHS to determine which specific type of doctors may recommend marijuana. Patients that want a choice in health care should not be forced to see a specific type of doctor. Is it not discrimination to allow one time of doctor to recommend marijuana but not another? Additionally, the requirement that a patient doctor relationship having to have existed for at least 4 visits and one year is overbearing. What if someone does not have health insurance and then is forced to go to unnecessary doctor appointments? And what if someone looses their health insurances or has to change their health insurance? The patient might have to see another doctor and then loose their year long relationship and visit count. R9-17-101.16b would be the patient's only alternative; however, circumstances related to this rule or the comfort of the physician may prevent a patient from getting a recommendation in this manner. A patient should be allowed to combine their visit time with different doctors to satisfy the one year and 4 visit rule.

Delete: R9-17-101(15) Medical Director, there are no need for medical marijuana dispensaries to have a medical director we are not performing any medical treatments that need their supervision as in the need for pre-hospital providers aka EMTâ€™s and paramedics. Also if any counseling is needed it need to be done between the patient and their doctor before they are recommended medical marijuana. Change: R9-17-101(16)(a) two visits instead of four if this is the primary care doctor it should take four visits to determine if medical marijuana will be beneficial Change:R9-17-102 from non refundable to refundable this isnâ€™t a chance for DHS to get rich and take advantage of people seriously if need be add a processing fee $50 Change:R9-17-102(3) Change of location to $1000 if a dispensary feels it is necessary to relocate due to a safer location for it patients which I feel this will be an issue due to the unreasonable restriction the municipalities are looking to enforce Add:R9-17-102(3)(a)Fee for adding a cultivation site $1000 so that expanding dispensaries can add a cultivation site if one wasnâ€™t in place on the original application. Change:R9-17-102(4)Change to $1000 this is a reasonable fee Change:R9-17-102(5)(a)Fee should be reasonable to patients similar to other states like Colorado which is $90 so change to $90 Change:R9-17-102(5)(b)There are no fees in other states like Colorado for a care giver and there shouldnâ€™t be one in Arizona if there is to be a fee it should be reasonable like $50 no more than what a patient should pay which I feel should be $90 Change:R9-17-102(5)(c) Change Dispensary agent fee to $100 there should be no fee at all as in other states but since the law requires background check for violent felonies and drug felonies a reasonable fee for this would be

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"5. For a registry identification card for a: a. Qualifying patient; $150; b. Designated caregiver, $200; and c. Dispensary agent, $200;" These fees are very high. While it is true that some states charge more for their application fees, most charge significantly less. Oregon state law allows for a $20 fee for Qualifying Patients who provide proof of either State Health Plan eligibility or receipt of Supplemental Security Income (SSI) monthly benefits. California's initial application fee is $66 for patients without state medical aid and $33 for those with state medical aid. Lowering this fee to $75 for patients without state medical aid is the recommendation here "6. For renewing a registry identification card for a a. Qualifying patient, $150; b. Designated caregiver, $200; and c. Dispensary agent, $200;" These renewal fees are too high. The rules allow a dispensary to renew for 1/5 of the original application fee. Qualifying Patients, Designated Caregivers, and Dispensary Agents should have the same consideration. They will have already gone through the initial, rigorous application process and will not be as difficult or time consuming to process as new applicants will be. The two year residency requirement for dispensary owners is somewhat extreme. Many people have had to move "back home" and need to start over. There are people with college degrees wanting to start new businesses in Arizona but are shut out of this opportunity due to the two year residency requirement. The recommendation here is to lower the requirement to 12 months.

Delete: R9-17-101(15) Medical Director, there are no need for medical marijuana dispensaries to have a medical director we are not performing any medical treatments that need their supervision as in the need for pre-hospital providers aka EMTâ€™s and paramedics. Also if any counseling is needed it need to be done between the patient and their doctor before they are recommended medical marijuana. Change: R9-17-101(16)(a) two visits instead of four if this is the primary care doctor it should take four visits to determine if medical marijuana will be beneficial Change:R9-17-102 from non refundable to refundable this isnâ€™t a chance for DHS to get rich and take advantage of people seriously if need be add a processing fee $50 Change:R9-17-102(3) Change of location to $1000 if a dispensary feels it is necessary to relocate due to a safer location for it patients which I feel this will be an issue due to the unreasonable restriction the municipalities are looking to enforce Add:R9-17-102(3)(a)Fee for adding a cultivation site $1000 so that expanding dispensaries can add a cultivation site if one wasnâ€™t in place on the original application. Change:R9-17-102(4)Change to $1000 this is a reasonable fee

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and that is covered in the yearly financial report Change:R9-17-302(B)(14) There should be set hours of operation on the dispensary side (not cultivation) that limits the hours to reasonable operating time no earlier than 7am and no later than 10pm to limit criminal activity that may endanger patients and dispensary agents working in a dispensary Delete:R9-17-302(B)(15) All of this section (a) thru (d) has nothing to do with what a dispensary should be responsible for and should be deleted what training does a pharmacist has in dealing with medical marijuana? Exactly none and the nutrition and physical activity information is something apatients doctor shall be providing a pharmacy doesnâ€™t provide any of this why should a dispensary again another unnecessary cost for a dispensary Delete:R9-17-304(A)(5)(a) There is no reason why a site plan should be a part of the required materials this has no bearing on security or safety and is just another expense and unnecessary hurdle for a prospective dispensary owner Delete:R9-17-304(A)(6)(a) There is no reason why a site plan should be a part of the required materials this has no bearing on security or safety and is just another expense and unnecessary hurdle for a prospective dispensary owner Add:R9-17-304(E) the time frame for a change in location should be 30 calendar days similar to a renewal with time frame reflecting 30,30,10,20 and also change table 1.1 to reflect this as well Change:R9-17-305(1)(h) Change to five years Delete:R9-17-305(1)(i) No need for medical director Clarify:R9-17-305(1)(j) What does this pertain to Delete:R9-17-305(3) This is another added expense that is unnecessary this is not a concern of the DHS office other than it holding up to a not for profit business the state and federal entity in charge of taxes will know if there are any discrepancies Change:R9-17-306(C) change to 10 working days Change/Add:R9-17-306(E) the dispensary will be provided a copy of the complaint and person reporting Change:R9-17-306(F)The department can only inspect for specified violations made in complaint and not take it as a free for all to try and find another infraction during their investigation Change:R9-17-306(G) Change to 10 working days Delete:R9-17-307(A)(3) No need for a medical director Delete:R9-17-307(A)(4)(b) No need for a medical director Delete:R9-17-307(A)(5)(b) No need for a medical director Add:R9-17-307(C)(5)Should consider adding that a dispensary can in their first year be responsible for 50% of their own product but must receive the other 50% from patients, caregivers and other dispensaries due to the newness of this business and to get use to supply and demand and what to expect from their crops ie. Turn around on product and actual harvests size Delete: R9-17-310 There is no need for a medical director all of this is items a pt and doctor should be going over in the visits prior to the recommendation to use medical marijuana and on the ongoing care of the pt Delete R9-17-310 (A) thru (D) Change/Add:R9-17-311(1) Add a list of approved identifications for a dispensary agent to verify a patients identity Delete:R9-17-311(2)This is for a doctor to provide his patient before recommending medical marijuana Delete:R9-17-312 There is no need for a dispensary to maintain any pt records other than medicines dispensed and verifying that they are not receiving more than 2.5 ounces in a fourteen day period all other logs and records are for a doctor and patient to go over Delete R9-17-312 (A) thru (D) Change:R9-17-313(B)(3)(b)(ii) This needs to be change due to the fact that marijuana losses up to 80% of its weight when it is dried and cured so there needs to be a change to this Delete:R9-17-313(B)(6)(e) This is not something a dispensary should be liable for once the medical marijuana has transferred custody to the food establishment Change/Comment:R9-17-313(C) This needs to be change due to the fact that marijuana losses up to 80% of its weight when it is dried and cured so there needs to be a change to this Change:R9-17-313(D)(1) Change to two years not five there is no reason to keep records longer than necessary Delete:R9-17-314(A)(3) Should be on record with the dispensary but not nessesary for patient labeling requirements Delete:R9-17-314(A)(5) Should be on record with the dispensary but not nessesary for patient labeling requirements Change:R9-17-314(C) Change to one gram of medical marijuana Delete:R9-17-315(C) (1)(c)(i) not necessary Delete:R9-17-315(C) (1)(c)(ii) not necessary Change:R9-17-315(C) (1)(c)(ix) delete the recorded video Change:R9-17-315(C)(1)(d) Define the

number of panic buttons and where they need to be located Delete:R9-17-316(B) Delete this is not the dispensaries responsibility but rather the food company preparing this edible item Delete:R9-17-317(B)(4)no medical director needed Delete:R9-17-317(B)(5)no medical director needed Change:R9-17-319(A)(2)(a) Change to five years ADD:R9-17-319(F) A dispensary can re apply for certification after a certain time frame as long as it is a serious offense for revoked

Take the 47 pages and cut it down to the bare bones. The patients need 2 pages of forms, the caregiver 1 page, the dispensaries need some rules about how to use the database, keep simple inventory control and follow Pima County Health Department rules when it comes to hand washing. You are still keeping it a state secret on how the dispensary licenses will be granted and you should grant to every single dispensary that applies and spends $5,000 a provisional permit to be up and running on conditional status. At the end of the year you'll have lots that have failed and many that will succeed and the final licensing will be granted to the top 124 dispensaries in the state with the ones that don't make it given the inside track to transition to a licensed kitchen facility affliate of a now fully licensed dispensary. That way the program treats everyone fairly and gives small businesses and our economy a huge jump start. Colorado is in a moratorium right now why they do this very thing and if you look at their unemployment (especially Denver) you will see how Medical Marijuana has saved their state from going down the tubes. Arizona is hurting financially and growing a natural herb that has so many uses besides medical will help us get out of the ditch.

Drop the requirement that a patient be treated by a doctor for a year before the doctor can recommend MMJ. That is not what the voters voted upon, it is an illegal and unconstitutional addition by those that want to control something that they disagree with fundamentally. Drop the requirement that a patient continue to see the physician that recommended MMJ for the patient. That is not what the voters voted upon, it is an illegal unconstitutional addition by those that want to control something that they disagree with fundamentally. HERE IS AN EXAMPLE OF WHY THE ABOVE IS NOT FAIR TO PATIENTS: I am a perfect example. I have "Multiple Endocrine Neoplasia type 1" I have thyroid cancer in my lungs. I have massive pain and take large doses of morphine (another flower extract) to control the pain, and to keep coughing to a minimum. I have wasting syndrome and no appetite. Also as a result of the thyroid cancer, I have no parathyroid glands. This causes massive muscle cramps and uncontrollable spasms. MMJ is perfect for treating most of my conditions that no other medication could do, at least until they kill me. There is only one problem; I am a former U.S. Marine, injured in the line of duty by and explosion during the first Gulf War. I am a Veteran. My primary, and my cancer doctors are all V.A. doctors. V.A. doctors are Federal Employees and cannot recommend MMJ as a treatment. So how am I to get a doctor that has treated me for a year prior for cancer to recommend MMJ? How can I have a doctor continue to treat me after the recomendation when I have V.A. doctors as my primary and oncology doctors? By attempting to add to the bill something that was not voted upon by the voters, I.E. the one year doctor clause; you are EXCLUDING every Veteran that has given so much to our country. That is why your job is not to add anything to the bill that the voters did not intend. Make rules that make sure the the patient has cancer, or massive pain, give them an ID card, and leave them alone. The $150 fee for an ID card is exorbitant. A person that has never had to deal with cancer may have a hard time understanding this. Cancer is expensive. A person with cancer usually can't work. A person with cancer needs to pay for medications, transportation to doctors hundreds of miles away, hotel bills and food for traveling to the doctors, not to mention the doctor bills not covered by insurance! Why add unnecessary burdens to the very people that this bill is designed to help? $150 per patient can be easily carried by the dispensaries. The huge retail prices paid to the dispensaries for the Cannabis is bad enough, the extra

fees should be paid by those making the money, not those dying to get their product (literally!) $50 is a more reasonable figure for a fee for patients. The amount of a patient's fee should also be adjusted by their income, taking into account the money they spend on doctor bills, medicine, travel, and room and board for treatment. An additional flaw in the proposed rules is the requirement that a Dispensary agent not owe child support, have outstanding student loans, or be a police officer. First it is not the business of the government weather any of these things exist, second, it is overly intrusive by BIG BROTHER, and thirdly, do you want the child support and the Student Loan paid? Being a dispensary agent, even with a non profit, can be very lucrative, and it is the perfect means for the person to earn the money to pay the very thing back that you are trying to discriminate against them with. If a person owes child support, why keep them from making money to pay it with? Likewise with Student Loans! A police officer is the perfect person to be running a dispensary! Who else can we trust better than a police officer to keep everything legal? Be logical and stop trying to be intrusive and ORWELLIAN! Another unreasonable requirement of the proposed rules is the requirement of the Dispensary to furnish scale drawings of each room of the dispensary, and the names of the rooms, that is ridiculous and burdensome for a start-up business. Other than the obvious need for security and the requirements involved to insure it, there should be no additional requirements placed upon a dispensary business that would not be required of any other business licensed in that county. Any additional requirements would be an obvious case of discrimination and would show a definite bias on the part of the rule-makers to make it as difficult as possible for dispensaries to open. Stop thinking like BIG BROTHER and start thinking about the people in pain that need help, after all, most of the people that will be visiting these dispensaries are in the last years of their lives, like me.

Director Will Humble Arizona Department of Health Services 150 N. 18th Avenue, Suite 500 Phoenix, AZ 85007 Dear Director Humble, To begin, I thank you and and the Department of Health for your hard work on the proposed draft rules to implement Proposition 203, the Arizona Medical Marijuana Act. Though many of the draft rules are excellent, some provisions frustrate the Department's goal of safeguarding the health of the people of Arizona. To aid in improving these rules, I offer the following comments and suggestions, drawing upon my experience as a medical cannabis attorney whose law firm represents over 150 collectives in states that currently allow medical marijuana. Physician Requirements: Though the Department's goal of having a medical director be affiliated with licensed dispensaries is laudable, many applicants will not be able to comply with this requirement. In states that have allowed medical marijuana, many medical doctors and osteopathic physicians fear losing they will be investigated by the Drug Enforcement Administration, other law enforcement agencies, or the state medical board if they discuss medical cannabis with their patents, let alone issue a recommendation or certification to their patients. Most likely, Arizona medical doctors and osteopathic physicians will have similar fears, not only about recommending medical cannabis to patients, but also about serving as the medical director of a collective. Consequently, many dispensaries will be hard-pressed to find a medical doctor or osteopath to serve as their medical director. Accordingly, the Department should not require that licensed dispensaries have a medical director on staff. Because of the difficulty dispensaries will have in finding a physician to serve as medical director, this requirement will only frustrate ensuring the health of medical cannabis patients. To help promote good health among medical cannabis patients, the Department should consider requiring dispensaries provide other services to promote good health, such as classes in nutrition, cooking with medical cannabis, counseling services, or support groups. Alternatively, if the Department continues to require that licensed dispensaries have a medical director, the Department should consider allowing not only medical doctors and osteopathic physicians to serve as medical directors, but also nurse practitioners, physician assistants, homeopathic physicians, naturopathic

physicians, and registered nurses to serve as medical directors. By allowing other medical professionals to serve as medical directors, DHS will help achieve its laudable goal of ensuring that all dispensaries offer services beyond providing medical cannabis to help promote the good health of patients. Another obstacle to safeguarding the health of medical cannabis patients in the draft rules is how the rules currently define an ongoing relationship with a physician. The current draft requires that a patient have an ongoing relationship with a physician, defined as a relationship of at least one year, during which the patient visited the physician at least four separate times for treatment of the patient's debilitating condition. Alternatively, a patient can have an ongoing relationship with a physician if the physician reviews a patient's medical history in depth and then agrees to assume "primary responsibility for providing management and routine care of the patient's debilitating medical condition." Presumably, by requiring that patients have a far more extensive relationship with a physician to receive a written certification for the use of medical cannabis than DHS requires a patient to have with a physician before receiving a recommendation or prescription for any other drug, including Vicodin, Oxycontin, or Codeine, DHS intends to safeguard the health of medical cannabis patients. However, this rule will only frustrate safeguarding the health of Arizonans who would benefit from the use of medical cannabis. As discussed above, many physicians in Arizona will refuse to issue a written certification for the use of medical cannabis -- regardless of whether the physician believes that the patient would benefit from using medical cannabis -- because many physicians will fear being investigated or losing their license to practice medicine. As a result, a small number of physicians will be willing to issue written certifications. Patients may be forced to choose between receiving a written certification for the use of medical cannabis and seeing the physician of their choice to treat their debilitating medical condition, if DHS imposes the proposed definition of an ongoing physician-patient relationship. For example, a patient with cancer may have to choose between visiting the best oncologist possible -- who out of fear refuses to issue written certifications for the use of medical cannabis to any patient, regardless of whether the patient would benefit from medical cannabis -- or granting a less-qualified physician -- who believes that the patient would benefit from the use of medical cannabis and will issue a written certification -- primary responsibility for their medical care in order to benefit from using medical cannabis. DHS does not impose this dilemma upon Arizonans who benefit from the use of any other legal medical treatment or drug. DHS should not impose this burden on medical cannabis patients either, and may violate the Equal Protection rights of medical cannabis patients, if it adopts the proposed definition of an angling physician-patient relationship. Rather, DHS should impose the same requirements upon medical cannabis patients as they do upon patients who receive any other legal medicine or treatment: require that the patient visit the physician, that the physician assess the client's symptoms and medical history, and that the physician issue a written certification for the use of medical cannabis only to those patients whose debilitating medical condition or treattment thereof will benefit from using medical cannabis. This approach treats medical cannabis patients and patents using other medicines equally, and it helps ensure that patients can find a physician who is willing to issue written certifications for the use of medical cannabis to evaluate them to determine whether they would benefit from the use of medical cannabis. Also, by allowing medical cannabis patients to see a physician regarding the use of medical cannabis, without requiring that the patient put the physician in charge of the patient's care, DHS would ensure that patients can choose the best physician for each aspect of their treatment. Very few people, particularly those who suffer from debilitating medical conditions such as cancer, HIV or AIDS, ALS, or multiple schlerosis, have only one doctor, or even designate one doctor to be in charge of their care. Rather, people receive treatment from a team of doctors for serious conditions, thereby ensuring that they receive the best care for their condition and the treatment thereof. Arizonans who suffer from debilitating medical conditions as defined in

Proposition 203 should be allowed to add a physician who can evaluate them for the use of medical cannabis and monitor the effects of this medicine to their team of doctors, rather than having to risk choosing between using medical cannabis or putting the best physician in charge of their care. Another issue regarding the physician-patient relationship is the requirement that on the stathement that the patient submits to the Department as part of the patient's application for a registry identification card, the physician identify which debilitating medical condition from which the patient suffers. R9-17-202(F)(5)(d) This disclosure may violate the patient's right to privacy and the patient's right to physician-patient confidentiality. Dispensary Application Process: While the Arizona Medical Marijuana Act calls for careful regulation of licensed dispensaries, certain aspects of the application process proposed in the draft rules impose too heavy of a burden upon potential applicants and local jurisdictions. For example, by requiring that applicants for dispensary certificates obtain a certificate of occupancy or other land use approval from the local government in the jurisdiction where the applicant seeks to locate, the Department will make it very difficult for many applicants to submit their application in a timely manner. Indeed, it may not be possible for even the most organized applicant to go through the entire local land use approval process before the beginning of April 2011. As for local governments, many of which are still determining the proper land use requirements for licensed dispensaries, they will be forced to expend valuable time and resources evaluating applications from many more possible dispensary applicants than is necessary. To ensure that licensed dispensaries comply with local land use rules, while also imposing less of a burden upon applicants and local governments, the Department should delay requiring potential applicants to demonstrate compliance with local land use laws. Instead, the Department should evaluate applications on other criterion in an initial stage. Then, those applicants with the best applications should then have to prove that they can comply with local land use requirements. Another aspect of the dispensary certificate application process that the Department should revise is contained in R9-17-107, Section B: "A registration packet for a dispensary is not complete until the applicant provides the Department with written notice that the dispensary is ready for an inspection by the Department." Similar inspections are required in R9-17-302(B)(1)(j) and (k). While requiring an inspection makes sense if applied to a dispensary that seeks a renewal of its certificate, it is unclear how the Department intends to impose this requirement upon an applicant for a dispensary certificate. Does the Department intend to inspect a proposed dispensing site and the additional cultivation location? What would the Department look for, since the dispensary is not yet operating? In short, what is the Department's criterion for evaluating applicants with such inspections? How can applicants prepare for the inspection? R9-17-302(B)(15) also requires revision. This section requires that the dispensary applicant state whether a registered pharmacist will be onsite or on-call during the operating hours of the dispensary, and whether the dispensary applicant has a surety bond. Given that neither the Arizona Medical Marijuana Act nor the draft rules require that a licensed dispensary have a relationship with a pharmacist or maintain a surety bond, potential applicants cannot understand why the Department asks them to provide this information in their application. In the next version of the rules, the Department should remove this requirement, or explain why the Department seeks this information. As for R9-17-302(A), which requires that potential board members and officers of licensed dispensaries have resided in Arizona for two years, this requirement may violate the Due Process and Equal Protection rights of Arizonans. The Department has not offered any rational basis for this two-year residency requirement. While the Department can justify requiring that potential board members and officers be residents of Arizona, the Department cannot justify excluding residents of Arizona who have moved to the state in the past two years from applying for a dispensary certificate. Lastly, the Department must specify what criterion the Department will use to determine which applicants will receive a dispensary certificate. Does the Department intend

to hold a lottery? Rank applicants according to as-yet unspecified standards? A combination of these methods? The potential applicants needs to understand the criterion that the Department will apply, so that they can decide whether they wish to apply, and best prepare their applications. Promoting the Health and Safeguarding the Privacy of Qualifying Patients: Licensed dispensaries will be charged with promoting the health and safeguarding the privacy of qualifying patients. While many aspects of the Arizona Medical Marijuana Act and the draft rules serve these goals, the Department must revise some sections to ensure that qualifying patients have access to a sufficient supply of affordable medical cannabis. If the Department imposes the propsed restrictions on the cultivation of medical cannabis by licensed dispensaries contained in R9-17-307, licensed dispensaries may not be able to supply sufficient medical cannabis to the qualfying patients of Arizona, without running great risks of prosecution under federal law. Under federal law, marijuana remains a Schedule I substance, and possession or cultivation of marijuana, even for medical purposes, remains a crime. To minimize their exposure under federal law, many medical cannabis collectives and cooperatives in states such as California and Colorade cultivate a maximum of 99 plants. The reason for this is that under federal law, a person convicted of possession 100 or more cannabis plants receives a five year minimum mandatory sentence. By cultivating fewer than 100 plants at any time, the collectives and cooperatives minimize the risk that if they are prosecuted under federal law, they will be sentenced to a mandatory minimum of five years in federal prison. Licensed dispensaries in Arizona will also want to cultivate fewer than 100 plants at any time to minimize the risk of federal prosecution. However, by cultivating relatively few cannabis plants, licensed dispensaries will not be able to supply the qualifying patients of Arizona with sufficient cannabis. To ensure that licensed dispensaries can supply the qualfying patients of Arizona with sufficient medical cannabis, the Department should license individuals or groups that are not affiliated with licensed dispensaries to cultivate medical cannabis to sell to licensed dispensaries. The Department could regulate these cultivators with rules similar to those ultimately imposed upon licensed dispensarires. By allowing both licensed dispensaries and licensed cultivators to grow medical cannabis, the Department can regulate the cultivation of medical cannabis, while still ensuring an adequate supply for qualifying patients and allowing those who cultivate medical cannabis in compliance with Arizona state law to minimize the risk of federal prosecution. By licensing cultivators and requiring that they not be affiliated with a licensed dispensary, the Department will help ensure that licensed dispensaries can provide sufficient cannabis. The Department must alter R9-17-312(D), which requires that dispensaries turn over patient files when the Department requests. In its next draft rules, the Department must state the circumstances under which the Department would seek access to a patient file. Further, the Department should be required to obtain a court order before having access to a patient file. Unless Arizonans feel confident that their patient files are truly private, some Arizonans who would benefit from the use of medical cannabis will not use medical cannabis, because they will fear that using medical cannabis will compromise their right to privacy. Another group of qualifying patients whom the draft rules fail to protect are certain qualifying patents who are under eighteen years of age. R9-17-107(G)(3) requires that the parent or legal guardian of a minor qualifying patient sign a statement that the parent or guardian has not been convicted of an excluded felony offense. Subdivision (G)(5) of this section strongly implies minor patient's primary caregiver must be their parent or legal guardian. By requiring that a minor patient's parent or guardian serve as the patient's primary caregiver, and that the parent or guardian not be convicted of an excluded felony offense, the Department may discriminate against those minors who are patiients and both of whose parents have been convicted of an excluded offense. These minors will not be able to benefit from medical cannabis, because if the draft rules are imposed, no one will be eligible to serve as their primary caregiver. If I can be of further assistance, please do not hestitate to contact me. Thank you.

Sincerely, [redacted]

Director Will Humble Arizona Department of Health Services 150 N. 18th Avenue, Suite 500 Phoenix, AZ 85007 Dear Director Humble, To begin, I thank you and and the Department of Health for your hard work on the proposed draft rules to implement Proposition 203, the Arizona Medical Marijuana Act. Though many of the draft rules are excellent, some provisions frustrate the Department's goal of safeguarding the health of the people of Arizona. To aid in improving these rules, I offer the following comments and suggestions, drawing upon my experience as a medical cannabis attorney whose law firm represents over 150 collectives in states that currently allow medical marijuana. Physician Requirements: Though the Department's goal of having a medical director be affiliated with licensed dispensaries is laudable, many applicants will not be able to comply with this requirement. In states that have allowed medical marijuana, many medical doctors and osteopathic physicians fear losing they will be investigated by the Drug Enforcement Administration, other law enforcement agencies, or the state medical board if they discuss medical cannabis with their patents, let alone issue a recommendation or certification to their patients. Most likely, Arizona medical doctors and osteopathic physicians will have similar fears, not only about recommending medical cannabis to patients, but also about serving as the medical director of a collective. Consequently, many dispensaries will be hard-pressed to find a medical doctor or osteopath to serve as their medical director. Accordingly, the Department should not require that licensed dispensaries have a medical director on staff. Because of the difficulty dispensaries will have in finding a physician to serve as medical director, this requirement will only frustrate ensuring the health of medical cannabis patients. To help promote good health among medical cannabis patients, the Department should consider requiring dispensaries provide other services to promote good health, such as classes in nutrition, cooking with medical cannabis, counseling services, or support groups. Alternatively, if the Department continues to require that licensed dispensaries have a medical director, the Department should consider allowing not only medical doctors and osteopathic physicians to serve as medical directors, but also nurse practitioners, physician assistants, homeopathic physicians, naturopathic physicians, and registered nurses to serve as medical directors. By allowing other medical professionals to serve as medical directors, DHS will help achieve its laudable goal of ensuring that all dispensaries offer services beyond providing medical cannabis to help promote the good health of patients. Another obstacle to safeguarding the health of medical cannabis patients in the draft rules is how the rules currently define an ongoing relationship with a physician. The current draft requires that a patient have an ongoing relationship with a physician, defined as a relationship of at least one year, during which the patient visited the physician at least four separate times for treatment of the patient's debilitating condition. Alternatively, a patient can have an ongoing relationship with a physician if the physician reviews a patient's medical history in depth and then agrees to assume "primary responsibility for providing management and routine care of the patient's debilitating medical condition." Presumably, by requiring that patients have a far more extensive relationship with a physician to receive a written certification for the use of medical cannabis than DHS requires a patient to have with a physician before receiving a recommendation or prescription for any other drug, including Vicodin, Oxycontin, or Codeine, DHS intends to safeguard the health of medical cannabis patients. However, this rule will only frustrate safeguarding the health of Arizonans who would benefit from the use of medical cannabis. As discussed above, many physicians in Arizona will refuse to issue a written certification for the use of medical cannabis -- regardless of whether the physician believes that the patient would benefit from using medical cannabis -- because many physicians will fear being investigated or losing their license to practice medicine. As a result, a small

number of physicians will be willing to issue written certifications. Patients may be forced to choose between receiving a written certification for the use of medical cannabis and seeing the physician of their choice to treat their debilitating medical condition, if DHS imposes the proposed definition of an ongoing physician-patient relationship. For example, a patient with cancer may have to choose between visiting the best oncologist possible -- who out of fear refuses to issue written certifications for the use of medical cannabis to any patient, regardless of whether the patient would benefit from medical cannabis -- or granting a less-qualified physician -- who believes that the patient would benefit from the use of medical cannabis and will issue a written certification -- primary responsibility for their medical care in order to benefit from using medical cannabis. DHS does not impose this dilemma upon Arizonans who benefit from the use of any other legal medical treatment or drug. DHS should not impose this burden on medical cannabis patients either, and may violate the Equal Protection rights of medical cannabis patients, if it adopts the proposed definition of an angling physician-patient relationship. Rather, DHS should impose the same requirements upon medical cannabis patients as they do upon patients who receive any other legal medicine or treatment: require that the patient visit the physician, that the physician assess the client's symptoms and medical history, and that the physician issue a written certification for the use of medical cannabis only to those patients whose debilitating medical condition or treattment thereof will benefit from using medical cannabis. This approach treats medical cannabis patients and patents using other medicines equally, and it helps ensure that patients can find a physician who is willing to issue written certifications for the use of medical cannabis to evaluate them to determine whether they would benefit from the use of medical cannabis. Also, by allowing medical cannabis patients to see a physician regarding the use of medical cannabis, without requiring that the patient put the physician in charge of the patient's care, DHS would ensure that patients can choose the best physician for each aspect of their treatment. Very few people, particularly those who suffer from debilitating medical conditions such as cancer, HIV or AIDS, ALS, or multiple schlerosis, have only one doctor, or even designate one doctor to be in charge of their care. Rather, people receive treatment from a team of doctors for serious conditions, thereby ensuring that they receive the best care for their condition and the treatment thereof. Arizonans who suffer from debilitating medical conditions as defined in Proposition 203 should be allowed to add a physician who can evaluate them for the use of medical cannabis and monitor the effects of this medicine to their team of doctors, rather than having to risk choosing between using medical cannabis or putting the best physician in charge of their care. Another issue regarding the physician-patient relationship is the requirement that on the stathement that the patient submits to the Department as part of the patient's application for a registry identification card, the physician identify which debilitating medical condition from which the patient suffers. R9-17-202(F)(5)(d) This disclosure may violate the patient's right to privacy and the patient's right to physician-patient confidentiality. Dispensary Application Process: While the Arizona Medical Marijuana Act calls for careful regulation of licensed dispensaries, certain aspects of the application process proposed in the draft rules impose too heavy of a burden upon potential applicants and local jurisdictions. For example, by requiring that applicants for dispensary certificates obtain a certificate of occupancy or other land use approval from the local government in the jurisdiction where the applicant seeks to locate, the Department will make it very difficult for many applicants to submit their application in a timely manner. Indeed, it may not be possible for even the most organized applicant to go through the entire local land use approval process before the beginning of April 2011. As for local governments, many of which are still determining the proper land use requirements for licensed dispensaries, they will be forced to expend valuable time and resources evaluating applications from many more possible dispensary applicants than is necessary. To ensure that licensed dispensaries comply with local land use rules, while also imposing less of a

burden upon applicants and local governments, the Department should delay requiring potential applicants to demonstrate compliance with local land use laws. Instead, the Department should evaluate applications on other criterion in an initial stage. Then, those applicants with the best applications should then have to prove that they can comply with local land use requirements. Another aspect of the dispensary certificate application process that the Department should revise is contained in R9-17-107, Section B: "A registration packet for a dispensary is not complete until the applicant provides the Department with written notice that the dispensary is ready for an inspection by the Department." Similar inspections are required in R9-17-302(B)(1)(j) and (k). While requiring an inspection makes sense if applied to a dispensary that seeks a renewal of its certificate, it is unclear how the Department intends to impose this requirement upon an applicant for a dispensary certificate. Does the Department intend to inspect a proposed dispensing site and the additional cultivation location? What would the Department look for, since the dispensary is not yet operating? In short, what is the Department's criterion for evaluating applicants with such inspections? How can applicants prepare for the inspection? R9-17-302(B)(15) also requires revision. This section requires that the dispensary applicant state whether a registered pharmacist will be onsite or on-call during the operating hours of the dispensary, and whether the dispensary applicant has a surety bond. Given that neither the Arizona Medical Marijuana Act nor the draft rules require that a licensed dispensary have a relationship with a pharmacist or maintain a surety bond, potential applicants cannot understand why the Department asks them to provide this information in their application. In the next version of the rules, the Department should remove this requirement, or explain why the Department seeks this information. As for R9-17-302(A), which requires that potential board members and officers of licensed dispensaries have resided in Arizona for two years, this requirement may violate the Due Process and Equal Protection rights of Arizonans. The Department has not offered any rational basis for this two-year residency requirement. While the Department can justify requiring that potential board members and officers be residents of Arizona, the Department cannot justify excluding residents of Arizona who have moved to the state in the past two years from applying for a dispensary certificate. Lastly, the Department must specify what criterion the Department will use to determine which applicants will receive a dispensary certificate. Does the Department intend to hold a lottery? Rank applicants according to as-yet unspecified standards? A combination of these methods? The potential applicants needs to understand the criterion that the Department will apply, so that they can decide whether they wish to apply, and best prepare their applications. Promoting the Health and Safeguarding the Privacy of Qualifying Patients: Licensed dispensaries will be charged with promoting the health and safeguarding the privacy of qualifying patients. While many aspects of the Arizona Medical Marijuana Act and the draft rules serve these goals, the Department must revise some sections to ensure that qualifying patients have access to a sufficient supply of affordable medical cannabis. If the Department imposes the propsed restrictions on the cultivation of medical cannabis by licensed dispensaries contained in R9-17-307, licensed dispensaries may not be able to supply sufficient medical cannabis to the qualfying patients of Arizona, without running great risks of prosecution under federal law. Under federal law, marijuana remains a Schedule I substance, and possession or cultivation of marijuana, even for medical purposes, remains a crime. To minimize their exposure under federal law, many medical cannabis collectives and cooperatives in states such as California and Colorade cultivate a maximum of 99 plants. The reason for this is that under federal law, a person convicted of possession 100 or more cannabis plants receives a five year minimum mandatory sentence. By cultivating fewer than 100 plants at any time, the collectives and cooperatives minimize the risk that if they are prosecuted under federal law, they will be sentenced to a mandatory minimum of five years in federal prison. Licensed dispensaries in Arizona will also want to cultivate fewer than 100 plants at any time to minimize the risk of federal prosecution.

However, by cultivating relatively few cannabis plants, licensed dispensaries will not be able to supply the qualifying patients of Arizona with sufficient cannabis. To ensure that licensed dispensaries can supply the qualfying patients of Arizona with sufficient medical cannabis, the Department should license individuals or groups that are not affiliated with licensed dispensaries to cultivate medical cannabis to sell to licensed dispensaries. The Department could regulate these cultivators with rules similar to those ultimately imposed upon licensed dispensarires. By allowing both licensed dispensaries and licensed cultivators to grow medical cannabis, the Department can regulate the cultivation of medical cannabis, while still ensuring an adequate supply for qualifying patients and allowing those who cultivate medical cannabis in compliance with Arizona state law to minimize the risk of federal prosecution. By licensing cultivators and requiring that they not be affiliated with a licensed dispensary, the Department will help ensure that licensed dispensaries can provide sufficient cannabis. The Department must alter R9-17-312(D), which requires that dispensaries turn over patient files when the Department requests. In its next draft rules, the Department must state the circumstances under which the Department would seek access to a patient file. Further, the Department should be required to obtain a court order before having access to a patient file. Unless Arizonans feel confident that their patient files are truly private, some Arizonans who would benefit from the use of medical cannabis will not use medical cannabis, because they will fear that using medical cannabis will compromise their right to privacy. Another group of qualifying patients whom the draft rules fail to protect are certain qualifying patents who are under eighteen years of age. R9-17-107(G)(3) requires that the parent or legal guardian of a minor qualifying patient sign a statement that the parent or guardian has not been convicted of an excluded felony offense. Subdivision (G)(5) of this section strongly implies minor patient's primary caregiver must be their parent or legal guardian. By requiring that a minor patient's parent or guardian serve as the patient's primary caregiver, and that the parent or guardian not be convicted of an excluded felony offense, the Department may discriminate against those minors who are patiients and both of whose parents have been convicted of an excluded offense. These minors will not be able to benefit from medical cannabis, because if the draft rules are imposed, no one will be eligible to serve as their primary caregiver. If I can be of further assistance, please do not hestitate to contact me. Thank you.
Sincerely, [redacted]

1. R9-17-307 Section C # 1-5 This rule appears to have no basis nor justifies the origination of the percentage base (70%). If the medical marijuana business (a business is an organization designed to provide goods, services, or both to consumers or businesses in exchange for money) is to survive and thrive for the participants, meaning the dispensaries, the patients, care givers, cultivators etc., there will need to be a sharing and bartering of products, supplies and inventory. For the longevity as well as the ability to produce revenue for the state you will want to ensure the life of the medical marijuana industry. By putting limitations on the ability for dispensaries to diversify their products and variety of growers is putting a strangle hold on the Arizona medical marijuana industry. If patients have a variety of medical conditions or desire multiple strands and products of marijuana then they will want a variety of products. You run the risk of dispensaries being limited in what they can offer if they have to grow 70% of their own products. Patients will want to take advantage of the best products at convenient locations, this concept goes for any business. The variety will suffer at each location given the current rules set out in this section of the draft. You also have to take into consideration the time it takes to cultivate marijuana. A harvest of new plants and products can take months to come up with a finalized product. This is different then your current medical supplements as you create pills, medicines, and liquids in warehouses in assembly lines that produce new batches

at a rapid pace. Crops can go be bad, infested or not grow properly. If this happens the whole inventory can be in jeopardy. For this reason locations need to have the availability to purchase inventory from suppliers to ensure enough product is available to the consumer.

Drop the 70% self cultivation requirement for dispensaries! This will save so much I really can't imagine why it was added & badly need someone to explain to me the thinking behind it. What possible good effect can this have? I can tell you a couple of the bad effects. First & foremost it will unnecessarily inflate prices patients pay for this medication by not allowing the industry to take full advantage of the economies of scale & the economies of specialization for no reason other than keeping the price artificially inflated. It will also unnecessarily inflate the number of manhours spent by the state on inspecting, documenting, etc. redundant facilities that wouldn't otherwise exist, again driving up costs for no reason. Granted, we want to gain all the legitimate jobs we can from this as a state, but can jobs created by unnecessarily driving up costs to patients be considered legitimate? It's also very foreseeable that different areas in the state won't have the medication available for patients due to no other reason than compliance with this rule. Maybe what's needed is one more level, wholesalers, to be added to the 3 currently licensable entities, patients, caregivers, & dispensaries. It seems so obvious fewer growing facilities would be more productive & less problematic I have to ask, why was this rule added? I was planning on dealing solely with dispensaries & having my business be an invaluable source of manufacturers support as well as product for them. R & D is an extremely important activity in this field that will be severely limited without the existence of a wholesale level. There's no way a dispensary in a less populated area can afford extended trips to Amsterdam & California to collaborate with those most knowledgeable in growing, so in effect the rule forces 70% of the inventories of dispensaries in rural areas to be less effective and/or more expensive than their urban counterparts, again, completely unnecessarily & due solely to compliance with this rule which exists for no reason.

1. Concerning R9-17-302.5 A certificate of occupancy required before a license is issued is an onerous and unnecessary requirement. A C of O shortly after a license is issued and before it can open should be enough. The current draft rule will only insure that "deep pockets" such as cartel money will be able to afford the gamble for one of the 124 dispensaries. 2. Concerning R9-17-302.15.a. A dispensary is not a pharmacy! A registered pharmacist should not be required. Again, you are setting this up so only the wealthy or the cartel money can afford to have a pharmacy. b. Requiring a surety bond is not even required for a pharmacy! A Medical Doctor does'nt even have to have a surety bond! The result of this is again not in line with what we the voters voted for. 3. Concerning R9-17-307.A.3 Requiring each dispensary to employ a Medical Director is again not in line with the way Prop 203 was presented to us. Pharmacies don't have an M.D. on staff. 4. Concerning R-9-17-310.A. , R-9-17-310.B. , R-9-17-310.C. These rules concerning the M.D. on staff are again sure to create problems with the drug cartel money playing a dominant role. A doctor friend of ours told us that a low estimate for the cost of a Medical Director as defined would be $20,000.00 annually. With that expense added to the overhead of a new business, only the aforementioned "deep pockets" or cartel money will be able to afford to be in the dispensary business, and the true healer motivated people who actually care about helping sick and dying patients will never be able to afford to open a dispensary.

Re-wording of patient/doctor requirements in order to perscribe medical cannabis, patients with cronic conditions should not have to wait to appreciate the benefits of medical cannabis,

Require â€œwarningâ€ language on marijuana packaging that addresses the addictive nature of the drug and its impact on motor skills (e.g. do no operate a vehicle or machinery while using); Cancer causing agent: also require dispensary representative to verbally discuss the side effects of the drug and impact on others.

Obviously, you didnâ€™t understand the will of the people. We voted and clearly you lost, and now you want to change the rules because you are a sore loser, LOSER!!!

There is still potential for abuse, and loopholes in the proposed Rules that could be tightened. The main concerns are centered on food establishments that will be allowed to produce marijuana-infused food and products, physician requirements, and patient education. It seems that there is much potential for theft and loss of marijuana after it is sent to the food establishment for marijuana-infused food products. There is also likelihood of marijuana being infused into electronic cigarettes, which should be addressed. The regulations need to be greatly tightened in this area and more closely aligned with the regulations for dispensaries. Alternatively and more simply, the food and other marijuana-infused products need to be produced and distributed only in the Dispensary. In order to prevent abuses, the physican medical visit should be in-person, and the physican should be licensed in Arizona. This could prevent on-line and videoconference medical visits that occur in some other states. I understand that there has been some concern about veterans not being able to access medical marijuana through the V.A. medical system. However, they can be prescribed marinol by their physican, and they can also choose another physican who is not within the V.A. medical system. The physician should not have any financial or other affiliatin with the Dispensary in order to prevent conflict of interest or benefiting from the recommendations for medical marijuana. More defiinition of what "on-going physican patient relationship" means is needed by including the projected medical visits in the next year. There are extensive requirements for patient educaitn regarding the marijuana product, health side effects, interaction with other drugs, etc.. However, it needs to be clear that these materials need to be in writing and given to the client. Pharmacists are required to give similar information on prescribed medication in writing to their clients. It would be most accurate for the materials to be approved or provided by ADHS. Other concerns include definitions of public places, inspection advance notice, allowing anonymous complaints, disposal of unusable marijuana dn product dispensing tracking. There should be language reaffirming the right of a multi-unit housing provider to prohibit smoking of marijuana inside units or on property to protect tenants and property. This is a right thatis increasingly used by owners concerning smoking of tobacco products, and should extend to marijuana smoke. Foster care homes should also be included in the list of public places. Despite the fact that these are private homes, secondhand smoke should be regulated in order to protect the health of the children. Date and time of inspection of dispensaries does not have to be specific. Original Initative language states in 36-2806, H that "The Department shall give reasonable notice of an inspection under this notice". It does not say that the dispensaries have to be forewarned with the exact date and time. Advance notice is not given for environmental health inspections, smokefree air inspections, or any other inspections. A general notice within a month period rather than an exact notice helps to protect the integrity of the inspection. Anonymous complaints about dispensary non-compliance should be allowed to protect the safety of the person lodging the complaint. The number of complaints will be very minimal if complainants need to identify themselves, and the amount of non-compliance by dispensaries will increase. Disposal of marijuana needs more definition and regulation to avoid potential abuse. Tracking of the source of marijuana may be necessary for health reasons, and the product should be labeled with an ID number.

Clear abuse of power here. You just can't make up your own laws; we have a legislature for that.
There needs to be a fundamental reconsideration of the objective of the Department. Some key questions for you to ask yourselves: whom do you serve? If the answer is "conservative skeptics opposed to this Act," or "those with the deepest pockets," or "my own personal agenda/values" which all appear to be the case, then your premise and perspective would well be re-examined and abruptly changed to one which EMBRACES and ENACTS a WORKABLE AND REASONABLE PROGRAM whose intent and SOLE OBJECTIVE IS TO MAKE MEDICAL MARIJUANA CONVENIENTLY AVAILABLE TO QUALIFIED PATIENTS. Mind you, the term "qualified" implies ligitimate and there should be little if any further hinderances in the market to procure this naturally occuring herb for said persons. Another major point of contention is the extreme security interest the Department has charged itself with taking. The security of the inventory is rightfully of more concern to the proprietors, prospective dispensary owners, than to an overly vigilent, self aggrandized Department of peeping Toms (or Wills) who wish to look in on businesses who are, again, qualified and ligitimate until found otherwise, NOT TREATED AS SHADY, SUSPECT OPERATIONS, as appears to be the disposition of the Department. Such surveilance by the State is a gross and flagrant infringement on personal privacy of individuals and an unnecessary and offensive way of treating proprietors with whom you should be extending intentions of earnest cooperation, IF THIS IS TO BE AN EFFECTIVE PROGRAM, that is. In the same vein, prescribing build-outs of these facilities is presumptuous and even laughable; how about offering suggestions or recommendations for achieving an effective level of security, which may take many shapes, and not tread where YOU HAVE NO BUSINESS?! Leave such specifics to the enterprises, they know better than you, who are certainly NON-EXPERTS, and reluctant implementors of a program you admit to not support. Now Will, I challenge you to keep your cool (er, INTEGRITY) and not get in the sack with Big Joe or DEA or whoever might have the weapons/money to help you feel bigger than you are by "making examples of some" or "setting up" or planting evidence, or anything SHADY yourself; DO THE RIGHT THING WITH THOSE WHO ARE DOING THE RIGHT THING, AND DON'T EMBELLISH CHARGES OR EVIDENCE OR ALLEGATIONS FOR UNSCRUPULOUS AGENDAS. If you can abide by this, there will still be enough heads to roll, don't worry, it's not so different than many other businesses at its core; PLEASE DON'T TREAT WOULD-BE PROPRIETORS, SO MANY WHO ARE TRULY COMPASSIONATE AND INTEGROUS, AS SECOND-CLASS BUSINESSPEOPLE, OR SET THEM UP TO FAIL BY ANY NUMBER OF MEANS!! You'll be surprised at the level of cooperation you'll get when you meet this industry where its heart is; leave profiteering and unscrupulous dealings to cartels and DON'T CONFUSE THE TWO! By now you've heard from me a few times, and, although my only means of passion is use of ALL CAPS, and my responses don't always address the questions above the given text boxes, this is the vehicle by which you've invited response. I have participated in good faith and with sincerity in the interest of helping shape an effective program with ample, not undue regulation. My well wishes go out to you, and if I've hurt any feelings, it was only to shake some sense and effect abrupt reconsideration of your first attempt; I hope I've been reasonably effective. Be well, and do a great job. Thank you much.
There are several areas that are of concern after a thorough review of the initial draft rules. 1.-R9-17-

302 B-9-F,G (Detailed Security plans) f. Location of each video camera g. Location of each panic button Including detailed security plans of video camera locations including panic button is not a good security policy due to the eventual publication of said materials. Such information could be obtained and render a well implemented security plan useless. 2.-R9-17-102. Fees Setting the initial application fee at $5,000.00 and requiring each person employed by the dispensary to pay a $200 fee for a registration card will place an undue financial burden on non-profits that are working to help sick people. 3.-R9-17-310. Medical Director "During hours of operation, a medical director is: 1. On-site, or 2. Able to be contacted by any means possible, such as by telephone or pager." This is one of the most unrealistic parts of the draft rules. The cost to a non-profit would be unsustainable and undermine the foundation of an organization. Pharmacies like Wallgreens and CVS are not required to have a Medical Director available during hours of operation, on-site, or able to be contacted by any means possible, such as by telephone or pager. This is an excessive requirement for a non-profit to comply with; furthermore the doctor that writes the prescription should be available if there are any questions that need to be addressed in a urgent manor. 4.-R9-17-315. Security C. To prevent unauthorized access to medical marijuana at the dispensary and, if applicable, the dispensary's cultivation site, the dispensary shall have the following: 1. Security equipment to deter and prevent unauthorized entrance into limited access areas that include: c. Electronic monitoring including: ii. A video printer capable of immediately producing a clear still photo from any video camera image; iii. Video cameras: (1) Providing coverage of all entrances to and exits from limited access areas and all entrances to and exits from the building, capable of identifying any activity occurring in or adjacent to the building; and (2) Have a recording resolution of least at 704 x 480 or the equivalent; v. A video camera in each grow room capable of identifying any activity occurring within the grow room in low light conditions; vii. A failure notification system that provides an audible and visual notification of any failure in the electronic monitoring system; ix. The capability of providing authorized remote viewing of live and recorded video with: (1) Internet connectivity of at least 384 kbps upstream; and (2) A static IP address to allow for remote connection; The draft rules on electronic monitoring R9-17-315 -C-1.-C are requiring technology that is currently not required in most government buildings. It seems excessive to have this requirement for a non-profit dispensary. The current availability of the required communications infrastructure in the state of Arizona is not available in most rural counties. This is a major hang-up with compliance. The total cost of the internal infrastructure for a dispensary to comply with these draft rules would be more than twenty thousand dollars based off of initial estimates. The section that requires " ix. The capability of providing authorized remote viewing of live and recorded video with: (1) Internet connectivity of at least 384 kbps upstream; and (2) A static IP address to allow for remote connection;" Would appear in its current wording to not even be legal under current State and federal telecom laws. The term "authorized remote viewing" is not defined and would be legally questionable as well. Thank you for this opportunity to offer comments and suggestions.

Desist with or amend the one year prior relationship and four visit patient qualification. R9-17-202 F 5 e subsection i. I understand the intent, but this causes both medication and patient to be treated differently than other prescriptions. This requirement delays treatment, causes expense to the patient and generates multiple pays to the provider before ever arriving at the first administration.

I see at least two areas where the ADHS is over reaching its authority and will likely be challenged in court if not removed from the rules. I do not believe that ADHS has authority to create zoning restrictions and I also believe that by limiting how much medicine a dispensary can acquire from

another dispensary and forcing dispensaries to produce specific percentages of the medicine they sell is clearly government over reaching and is not in line with the merchants right to free enterprise, as well, this could be viewed as overly burdensome on the dispensaries.
A couple of the draft provisions appear to be in direct conflict with Article IV(1)(6)(C) of the Arizona Constitution which prohibits actions which do not "further(s) the purposes of such measure." In particular the requirement for a 'medical director' could easily be categorized as an attempt to thwart the initiative. Every doctor we interviewed indicated that they believe that any 'affiliation' with a dispensary would be grounds for the DEA to revoke their authorization to write prescriptions. Furthermore the duties set forth in R9-17-310(C) do not require the expertise of a doctor and in many cases are outside their education, training, or are in direct conflict with their malpractice coverage. These are normally administrative actions. If they need to be reviewed by a qualified professional, it can easily be accomplished without the affiliation. The requirement that 70% of the marijuana sold by a dispensary must be to patients defies logic. It would seem from a public safety perspective that it would be much better for patients, law enforcement, and the DHS if natural selection concentrated the growing of marijuana to a few dispensaries with excellent results and safeguards rather than having numerous growers doing thier own thing. Allowing for concentration would have several benefits which include: 1. Excellent quality control. 2. Ease of audit. 3. Economies of scale resulting in cost savings to the patient. 4. Consistent policies designed to focus on quality patient experiences within the boundaries of the law. Limiting outside acquisitions to 30% of the marijuana sold only burdens the patient by unnecessarily increasing the cost of the medical marijuana as well as dramatically increasing the probability and therefore risk to the patient of financial hardship to the dispensary and resulting chance that the lack of resources will result in contaminated or adulterated product, unverified quantities, or financial loss. Furthermore, the administrative overhead burden has the strong potential of creating a broad network of non-compliant 'cottage industries' among patients and caregivers. In all reality, there is no way to effectively police anyone outside the dispensary chain. The dispensaries are the best place to make this work by developing a mechanism that produces a clean, consistent, and affordable product. Costly and unnecessary impediments will only increase your administrative burden and result in costly and protracted litigation. In addition, they will significantly reduce the funds available for education. Please keep in mind that just because a business is 'non-profit' does not mean that it is not a business. It still needs to generate sufficient income to pay its bills as well as set aside reserves for unexpected expenses. The requirements on patient doctor relationship is troubling. As I stated before, as a non-user I believe that if this is going to be like any other prescription, it should be handled the same way. Putting these restrictions could well mean that someone who would otherwise qualify would be denied the benefits because their primary care physician was unwilling or precluded from recommending marijuana. If this is truly medically related, the relationship restricitions could also be a constitutional violation. It is our goal to see that this works. Establishing rules that are counter productive, no matter how well intentioned, runs the risk that some judge will issue an injunction against them until this is resolved leading to no regulation at all. We trust this is not your goal.
The draft Rules can be improved by making sure that this program follows along the Arizona's Constitutional laws that take precedence over the laws that were enacted. A state run program can not be set up with rules that violate the Citizens Rights. as in PREAMBLE 2 SEC 32. Constitutional provisions mandatory Section 32. The provisions of this Constitution are mandatory, unless by

express words they are declared to be otherwise.

Remove the restiction of having a MD or DO on the board. I understand the pharmisist on-call which can help with the drug interactions, but the patient has a doctor, and that is who the patient should be contacting.

Remove the restictions on the amounts of marijuana a dispensary can grow and must sell. If there are dispensaries that can not afford or want to purchase instead of grow the product they shold be able to. The language should be removed.

I have read the rules about having a medical doctor on call at dispensaries. This should not be the way it is handled. A trusted doctor has already recommended the marijuana for treatment and submitted all of the necessary paperwork in their review of why the patient needs marijuana. Why should a patient physician relationship start again with a new doctor that is not there? If something was really wrong a patient would contact their own doctor or go to a hospital. No established doctor that we have spoke with is going to make house calls, and if they did it would be only at extremely high rates as they have their primary practices to run. Plus a lot of doctors will not risk their achievements and schooling as this still goes against Federal Law and a doctor runs the risk of losing their practice. If the patient is not feeling well, they are not going to be told to drive in and see a new doctor. If they drove anywhere it would be to their own physician that they have an existing physician-patient relationship. We must assume that they have no other person to drive them, as there are many sick people without friend and family which makes it even harder to go through an illness. Patients are already told about the effects and not mixing drugs by their own doctors. And that information can also be reiterated to the patient at the time of pickup at the dispensary or by their caregiver about possible effects exactly how prescription drugs have warning labels about not mixing with alcohol. Having to pay large salaries to less competent doctors or paying enormous salaries to already highly paid doctors is going to increase the cost for the patient. Lets remember that this law is for people that are very sick. It is not right to raise the cost of the product for them. If you call a Pharmacy and you feel sick, they will tell you go see your doctor, go to a hospital, or call 911. What doctor with a successful practice is going to want to be at a dispensary all day? Only ones that you will have to pay high salaries too accommodate them. And if you go lower, then you get a lesser of a doctor and run into problems with ethics. Either way it is a slippery slope. Perhaps you should make it read a â€œA medical doctor or nurseâ€. That way their can be a nurse there, and they can dispense the marijuana in the dispensary to the patients and talk with them and take down the information of which strains are helping them and identifying results on a pain scale of 1-10, nausea, and other effects. Then the data can be given to the Department Of Health which will achieve the goal of finding out the best way to treat patients with marijuana. If anything, the doctors should be educated by dispensaries as they will not be the ones talking with the patients, dispensary agents will be. Therefore, dispensary agents should have to take a course or pass a test to become agents so we know there are knowledgeable people around the valley (state) giving proper information at the educational facilities within the dispensaries. These agents will also be developing regular relationships as the draft rules state the exact record keeping of

use data on different strains of marijuana and their effect on the patient. That data can be requested by their primary physician that recommended marijuana so they can be in tune with what is going on. Much like how a transplant team works with a NP, doctor, surgeon, altogether to make sure the patient is getting the ultimate care possible. It is extremely difficult to find a doctor to be on call and also have their license at risk by the Federal Government for a few extra bucks a week. Most doctors do not want to get involved and those that do are mostly in it for the money. As the draft rules state that if you are a doctor, you can own 3 dispensaries and be on call for them. Then they could just pay themselves. Also, how can 1 doctor be on call for so many patients? If something were to happen to multiple people, the doctor would be overtaxed and still recommend they go see their primary physician or go to the emergency room. The medical factor is already taken care of by the physician-patient relationship. Also for caregivers, which medical person is overseeing them? Who does the patient contact when they have questions or concerns with medical help? The dispensary that the caregiver bought the marijuana from? The Department of Health should have the power to police the caregivers.

The draft Rules can be improved by making sure that this program follows along the Arizona's Constitutional laws that take precedence over the laws that were enacted. A state run program can not be set up with rules that violate the Citizens Rights. as in PREAMBLE 2 SEC 32. Constitutional provisions mandatory Section 32. The provisions of this Constitution are mandatory, unless by express words they are declared to be otherwise.

Only used for those with TERMINAL ILLNESS or those who are denied organ transplants An effective caregiver would only have 5 patients maximum. Those under 18 do not need medical marijuana as it could be misused by a parent for the wrong purposes. I am unhappy with medical marijuana being allowed in Arizona, my father has had glaucoma for 45 years & takes eye drops-he has never complained or wished that he could take "medical marijuana" It is a big trick to get illegal drugs in the front door, opening up a pandora's box. Arizona is too broke and this further burdens our government. The draft still leaves too many loopholes...I have a migraine.

I don't think a person should be required to pay a five thousand dollar dispensary application fee but rather a more modest one thousand dollar application fee which should be refunded if the person is not granted a medical marijuana dispensary license. I don't think a medical director is necessary at all as this will simply make marijuana seem dangerous when in fact it is less dangerous than many prescription pills. I think its only fair to allow anyone that meets the final requirements established by your board, the opportunity to own and operate a medical dispensary if they choose to do so and not determine this by how deep the individuals pockets.

â€¢ R9-17-102 The Liquor Licensing model would be a better choice in regards to the application process The license fee is similar cost but there is a non refundable $100 application fee and the license fee due upon the granting of license Perhaps a $100 application fee and a refundable license fee posted with application â€¢ R9-17-101.20 Work Day hours are too limited, need longer days and at least Saturdays with same hours â€¢ R9-17-202.B This removes a patient's freedom of choice of health care. If their Designated Caregiver is unavailable for unexpected reasons, the patient would suffer needlessly â€¢ R9-17-302.G No need for a Medical director, customers already have a relationship and a recommendation from a licensed medical doctor No other business is required to attempt to educate their customers â€¢ R9-17-302.B.4.c Normal Business Practices in providing a high value product have inherent interest in providing a safe and secure environment for their staff

and inventory â€¢ R9-17-302.B.d No other business is required to attempt to educate their customers â€¢ R9-17-307.C State has no business defining where inventory comes from beyond a licensed producer nor what percentage from whom â€¢ R9-17-310.A No Medical Director needed This requirement provides no value to state or patient - implies their primary health care provider is providing inadequate medical advice â€¢ R9-17-315 This category needs to be deleted in whole Normal business practices will control inventory and staff security not necessary to define excessive controls The requirement for a Surety Bond serves no purpose to vet an applicants worthiness of qualifying for a Dispensary License Surety Bonds are enormously expensive and difficult for any entity that is not extremely wealthy, to acquire - This requirement must be eliminated not modified
The rule could be improved by requiring the doctors to have patients submit a extensive medical history, at least two office visits prior to recieving the drug, and at least two follow-ups appointments. This relationship between the doctor can only occur by monitoring of the drug in each individual. This occurs in conventional methods easier because samples of drugs are generally available from doctors.
ELIMINATE THE SURETY BOND. ALLOW PRESCRIPTIONS LIKE ANY OTHER DRUG ELIMINATE REPRTS ON HOW CROP IS GROWN DO NOT INVOLVE PHARMACISTS DO NOT REQUIRE MORE OF A DOCTOR RELATIONSHIP THAN FOR ANY OTHER DRUG DO NOT REQUIRE A LOCATION BEFORE GETTING A LICENSE MAKE THE RULES MORE CONDUCIVE TO SMALL OPERATORS ELIMINATE VIDEO 24/7 SINCE IT IS NOT REQUIRED OF ALLL PHARMACIES
PLease include more information as to baked infused medicine. You have to purchase and secure goods from start to finish.There are no clear guidelines other than it can be a baker in a health dept ok place
Make sure that one entity cannot get more than one license so we do not create a "Corporate" chain environment.
The $150 fee for patients and $200 fee for designated caregivers for initial and renewal cards should be changed to a sliding fee scale. For example, patients whose income is under the poverty line should pay nothing (and their caregivers, if they use one, should pay nothing as well), patients whose income is 200% of the poverty line should pay $75 (and their caregivers should pay $100), and only those whose income is greater than 200% of the poverty line would be charged the full $150 ($200 for their caregivers). The way the fees are currently set up, a patient with low income and high medical expenses would face the added burden of having to pay an additional $150 (or $200 for their caregiver), an amount which could be a severe burden to an already ill person.
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I believe the 25 mile rule will make it very hard for poor patients. They can not afford to purchase $2000.00 worth of medicine a month. But you can authorize them to grow a 5X5 garden. It is very cheap for them to grow there own medicine.
*More clarification is needed regarding the Surety Bond for a medical marijuana dispensary license? A dollar amount is needed as well as a party to be named. Information is also needed as to when and where the bond form can be obtained. *More clarification is needed regarding the Certificate of Occupancy? Does this require potential dispensaries to build out a dispensary and cultivation site without preliminary approval from the AZDHS? If so, this significantly hinders the ability of small entrepreneurs to enter the industry by the shear fact of money. Does a potential cultivation site have the ability use a "staged growth" model? *More clarification is needed regarding the medical director or pharmacist on staff or as consultants? I am concerned this requirement significantly favors the larger and possible out of state investment groups by the simple fact of money.
Work the sections little more
I am not sure why there must be a physician on call or on the premisis during opperation or at any time. The patient is seeing a physician for his condition and is being reffered to use medicinal marijuana for his or her ailment. I think as long as you provide them with a information of what indica and sativa's are to be used for, what their affect are, when to use them and to let them know that if they are having any adverse affects to contact their physician or call 911 if they feel it is a life threatening condition. Also provide them with the rules and regulations of using the medical marijuana and the laws backing them. 2. I am not sure if I read it right but I am confused if a person owning or working in a dispensary can or cannot be a qualifing patient with the right to use marijuana for their own illness. If so I don't understand why I think they would be the best people to own or run a dispensary: one they believe in the usage 2 it would not be someone just in it to make money. That

would be like saying only people who don't drink can own a brewery they wouldn't understand the difference between quality medical marijuana and mediocore and we want the patients who qualify for this medical ussage to get the very best product. Only those who use know the difference. Those of you making all the rules and regulations may not agree with this new law but we all need to put the patients best interest first and make sure people with experience are doing the cultivation and running the dispensaries. It doesn't make sence to disquallify them.
1. This draft has illegally redefined the pt-dr relationship. This action would prevent patients whose primary care doctors won't recommended Medical marijuana (MMJ) and prevent patients from access to this medicine. VA doctors in particular, are not allowed to recommend MMJ. Please decline from unfair redefinition of the MD patient relationship. Consider the blind, patient who cannot tolerate conventional pain meds. He is blind and has multiple sclerosis and unable to get out of the house. He wants to try MMJ but has no access. His VA doctor is not allowed to recommend it even though he thinks it would help him. How will this patient be served? Multiple visits, changing physicians are not options and should not be considered such.
can the cultivating site and retail site be in the same location with wall and doors separating the two areas?
R9-17-307. Administration I believe the 70/30 split in this rule will first of all be very hard to track and second does not have much to do with the running the dispensaries. If one has a shortage and another has a surplus, they should be able to sell between themselves freely on the wholesale market as long as it is accounted for audit purposes. There can only be approved growers that are attached to the dispensaries so it isn't leaving any openings for wholesale growers.
With the current financial situation, how is DHS ever going to be able to keep up with all these rules effectively? Shouldn't the dispensaries be farther than walking distance from our schools? How is it possible that DHS would be able to monitor patients growing their own marijuana? What will happen to a person who uses marijuana legally then drives? Is he/she considered impaired? Would it be like drunk driving?
I would recommend that the dispensary fee of $5,000 at least be doubled or tripled as this will hold the dispensaries financially more accountable to follow the rules and this will keep out the ones who will be more likely to break rules and less to lose. In raising the dispensary fees, i would offset this by lowering the cost to the patients in the system...These dispensaries are the ones who will have a lot to gain and therefore the ones who should be financially more liable.
can the cultivating site be located in a residential area?
I think the number of dispensers shouldn't be so limited for the state, but have limitations within city limits.
Though I understand the purpose of the 1 year Dr./patient relationship requirement and the subsequent requirement to have four visits within the year, I do strongly believe that Cancer, Aids/HIV

patients, and any other patient who has a prognosis that is terminal, particularly those less than 1 year, should have expedited processing of all valid documentation (Medical Records, to include X-Rays, CT Scans, and all other pertinent records relating to the patients medical care) This is to say that, provided all documentation and or physical examinations validate such conditions, a patient should not have to wait the 1 year to obtain an ID, Recommendation, or any access and or protection provided by proposition 203. Depending on the case by case submissions, each potential patient should be granted a recommendation based upon careful examination of the patients physical, mental, emotional status. Some patients do not have the time to wait for relief, such as sufferers of Aids/HIV/Wasting syndrome, or Cancer, and they should not have to if doing so would present more hardship and or loss of life.

LAW OFFICE OF [redacted] I am an attorney in Flagstaff, Arizona who is consulting with twenty-five groups or individuals who hope to apply for dispensary licenses from ADHS, many others who hope to become patients or caregivers and three doctors who have concerns about the December 17, 2010 proposed regulations (â€œPRâ€). DISPENSARIESâ€™ CONCERNS All of the groups that I have been consulting with consist of 2-6 individuals who hope to operate relatively smaller dispensaries in the smaller rural communities of northern Arizona. Their biggest concerns are that the PR appear to be written so as to favor the few wealthy individuals and entities that can afford to comply and who will then control the new medical marijuana industry in Arizona while making the application process and regulations so expensive and burdensome that no â€œmom and popâ€ or boutique type of dispensary owners will be able to obtain a license. Specifically, the requirement that the applicant obtain a physical location that is fully in compliance with all of the PR and local zoning requirements prior to knowing if they will receive a license effectively eliminates all but the wealthiest individuals and entities. The PR especially discriminates against the small groups and individuals in the rural areas and reservations who cannot afford to buy or lease property in the smaller communities and bring those properties into full compliance with the PR with no assurance that a license will be available. The medical director requirement is equally unfair and unworkable for the small guy in the rural communities. No one but the most wealthy can afford to have a medical doctor on staff or on call. The three doctors I have spoken with in Flagstaff all tell me that no reputable doctor would leave their practice to act as a monitor for a dispensary, especially if they could not treat the patients, nor would any doctor want to assume the responsibility and liability which the PR create for a medical director. The medical director requirement is especially unfair for those in the small communities, rural areas, and reservations, where medical doctors are already scarce and overworked. If ADHS is going to require medical doctors to serve as monitors at all dispensaries, it should first confirm that there are any doctors who would be foolish or desperate enough to accept such a position. At a minimum the requirement should be modified to allow other types of doctors and nurse practitioners to serve as medical directors. The current requirement has to be changed in a way that will be feasible for all of the small communities and rural areas of Arizona. Otherwise, we will end up with dispensaries only in Tucson and Phoenix and everyone else in the State left on their own to grow their own medicine. The State will be creating an administrative nightmare if it has to regulate and inspect the thousands of patients throughout rural Arizona who will be denied access to an urban dispensary. Other concerns include the apparent requirement that dispensaries will need to obtain a security bond and maintain inventory controls, security and patient information in a way that no other business in Arizona is required to do. It seems apparent that the purpose of the PR is to strangle the infant medical marijuana industry to death before it even has a chance to breathe or grow into what

the voters in Arizona envisioned it would be when they passed Proposition 203. Clearly, much of the PR are contrary to the intent of the voters and must violate the Voter Protection Act. Another clear example of this is residency requirement which is not required of any other corporation or its officers or members and which prevents several of the small family groups that I have been working with from even applying because one or more family members currently lives out of state. In one case a family with two members who are doctors in Florida had intended to retire in Sedona and to operate an alternative medicine wellness center. Neither of the doctors, who represent the medical knowledge and financial backing for the project, are able to apply or act as officers or members because of the residency requirement. Another client has successfully operated a dispensary in another state and he and his family are denied the opportunity to bring his knowledge and experience back to Arizona so that his family can open a dispensary here in rural northern Arizona. PATIENTSâ€™ CONCERNS The single largest concern is the PR definition of the doctor-patient relationship. Most low income people who rely on urgent care facilities and public health clinics do not see the same doctor each time they seek medical assistance. The turnover in Indian Health Services hospitals is also very high which results in patients seeking several different doctors over the time they receive treatment and care. In speaking with the three doctors here in Flagstaff, they again all agree that few low income patients are treated 4 or more times by the same doctor in a year especially with serious conditions that often involve seeking general practitioners and several different specialists. They also agreed that no reputable doctor would feel comfortable committing to provide all future care for a patient with a serious and complex medical condition in order to be able to recommend that the patient try medical marijuana to see if it will benefit them. Finally, the doctors expressed concern that few, if any, doctors in the smaller towns and rural communities have the knowledge about serious medical conditions listed in Prop 203 or about marijuana as medicine to be able to recommend marijuana or be a medical director. Again, this extremely burdensome requirement seems clearly to be designed to prevent all but the weathiest patients and the most unethical doctors from being able to comply with the PR. And, again, this requirement is clearly contrary to the votersâ€™ intent and violates the Voter Protection Act. I strongly urge you to reconsider the PR and re-draft them in a way that is true to the intent of the voters rather than desires of the state politicians and law enforcement officials who oppose any use of marijuana. -
[redacted]

need clarification on whether or not an LOI for the space for the dispensary and cultivation site is sufficient for the application process. It seems difficult to have a site up and running and ready for inspection prior to having been approved - need better clarification here. does the Medical Director have to be an MD or have any specific credentials other than performing the tasks listed on pages 38 & 39? I suggest a less expensive registration fee for low-income patients A dispensary may provide only 30% of its cultivated marijuana to other registered dispensaries and may acquire only 30% of its own marijuana supply from other registered dispensaries. This is very problematic and not in the best interests of patients, as it will likely create acute shortages in rural areas and drive costs up. Those patients within 25 miles of a rural dispensary unable to meet demand will have no secondary option for safe access to their medicine. We propose an open wholesale relationship between dispensaries. This will assure consistent supply to rural Arizona, easy access for all qualifying patients, and lower costs due to increased competition of organizations trying to meet demand. Additionally, we are looking into offering a Dispensary only facility and purchasing all medicine from other growers/ Dispensaries. This model works very well for Harborside Health Center in Oakland CA. From what we understand, it is one of the premier facilities in the United States. A patientâ€™s Arizona physician must either 1) have been treating that patient for the debilitating medical condition for at least a year

that included at least four visits, or 2) have taken primary responsibility for the care of the debilitating medical condition after compiling a medical history, conducting a comprehensive exam, and reviewing medical records. This provision is stricter than in most of the medical marijuana states, but does not appear designed to prevent a seriously ill patient with a demonstrable debilitating medical condition from getting a written certification. It may make it impossible for some veterans to qualify, because Veterans Administration Hospital doctors do not issue recommendations. Is there a square footage requirement of the maximum allowable size of a Dispensary, or is this up to each Licensee?

Costs will significantly increase if a medical doctor must be present at the dispensary. I would suggest that this requirement be omitted. Suggest clarification on what non-profit means for both the state and IRS. Specifically, does a dispensary need a 501(c)3 status with the IRS before submitting for a license?

The intent and purpose of the law is being undermined by excessive and unwarranted restrictions in the draft rules. Too costly for the patient, doctors will not want to give recommendations and the rules will effectively once again maintain the illegal status of medical marijuana. total intrusion into the doctor patient relationship. Legislation by the bureaucrat.

There are a couple items that did not seem to have a reasonable basis to establishing a professional and healthy market. The major items include: The definition of "enclosed" does not seem to include any flexibility in allowing growers to use secure greenhouses. I am worried about the electrical requirements (particularly during the summer months in Arizona) of these cultivation centers. Growing medicinal marijuana indoors requires a tremendous amount of electrical energy, which is expensive, unsafe, and harmful for the environment. One negative event, such as a fire, could force the entire industry and regulations into the public spotlight. With such a nascent industry, this 70% / 30% rule seems counter to encouraging a healthy market. Different patients will require different strains depending on their condition, and an artificial rule, such as this one, does not allow for dispensaries to offer sufficient variety. Compounded with this, some highly-qualified potential dispensary agents may be discouraged from applying for a license without the expertise on the grow side. As a long-time Arizona resident, the two-year requirement seems unnecessary and borderline legal. Finally, there didn't appear to be any clarity on how this process will work (first-come first-serve, competitive, etc), so added transparency on that front would be greatly appreciated.

I disagree with the state determining what a doctor patient relationship is. I have issues with chronic pain and when my primary doctor sends me for treatment itâ€™s usually just for that one visit and then I go back to him for my primary care. He has been my doctor for over 20 years and I want to keep him as my primary doctor. He has counseled me on the issue of using cannabis as a treatment but will not recommend it for me because he sayâ€™s there isnâ€™t enough scientific data that proves it helps with chronic pain I told him I disagree because I have been using it for my pain for many, many years so he suggested I go to a doctor who knows more about cannabis and pain. I will be taking his advice but I still want him as my primary physician for everything but this one issue. Sir for any other treatment besides cannabis I can go to a specialist my doctor has recommended and then I go back to him. Stop this foolishness of you changing the definition of my doctor patient relationship. I already have a doctor I just need to go to a specialist for this one issue. Thank you for your time [redacted]

R9-17-02 A sliding scale of fees for card holders. Low income patients (ie elderly on fixed income)

need to benefit from this new law as well. R9-17-101 Ability to be diagnosed needs to be less formal and as drafted, could be prohibitive for some patients such as veterans or those treated at a goverment hospital. R9-17-202(F)(5) Physicians already have verifiable relationships with their patients. The wording of this seems cumbersome and extremely restrictive. R9-17-307 This could be detrimental to patients and sellers if there was a traumatic event that lead to crop failure. There is no ability for free market with this provision. R9-17-310 This is more restrictive than current pharmacy oversight. A trade organization will eventually be formed and should be responsible for these items. Or the recommending physician could provide said oversight.

Outdoor cultivation needs to be allowed with proper security in agricultural areas of the state which are in heavy decline. The state should encourage dispensaries to locate grow facilities and even indoor cultivation in depressed agricultural areas. This will provide tremendous economic boost in those depressed economies and the tax benefits to rural counties will be tremendous. There are obvious and clear differences in outdoor and indoor grown marijuana and both have their place in therapeutic care situations.

Draft Rule R9-17-311 should be expanded to include a requirement that when verifying the qualifying patient's identity, dispensaries must employ a biometric identity verification system, such as a thumb print scan. DHS is mandated by the Initiative to ensure that dispensaries are only releasing medical marijuana to qualifying patients who hold a validly issued registration card. If DHS required biometric verification in the rules, it would ensure that counterfeiting, identity theft, or other forgeries resulting in medical marijuana falling into the wrong hands would be prevented. This requirement will have the best chance of preventing the type of abuse we see, for example, with underage persons purchasing alcohol using fake identification. By requiring biometric identity verification, it would be nearly impossible for a dispensary employee to dispense marijuana illegally. While it is certainly expected that dispensaries will self-police their agents, under the current Rules it would be very easy for a disreputable agent to collude with a non-patient to dispense MM under somebody else's registry number. In this scenario it would be extremely difficult for a dispensary owner to discover illegal transactions as the record would appear legitimate. However if that transaction must be accompanied by a cardholder's thumbprint illegal transactions would be impossible. The proposed rules require a dispensary agent to verify information from the State's medical marijuana electronic verification system and enter additional information into the system relating to the transaction. The technology is available to allow this process to be automated so that the dispensary computer directly communicates with the medical marijuana electronic verification system without a human user being required to enter the information. This automatic communication from computer-to-computer would reduce the chances of human error while reviewing or inputting information, and thus better prevent fraud and improper dispensing of medical marijuana. It would also mean that human users could not alter or enter fraudulent information, again reducing the chances for fraud or abuse of the medical marijuana system. The rules should explicitly allow such electronic transactions by making the existing R9-17-311 part A and adding as part B:

Will & Staff....keep up the good work! I think I have a way you can let patients not abuse the system, but not hurt the patient who needs it. A new patient must have 2 visits each year unless it is obvious, like a paraplegic, advanced cancer, etc. A patient who has a year's history can keep their doctor and can see a marijuana doctor once each year providing the original doctor provides the marijuana doctor the necessary documentation.

The criteria that a location must be secured before, and possibly built out before, we know if we have been selected for a license. That is undo cost not only upfront but ongoing as most landlords will require a long term lease be signed.
I would ask that the 25 mile distance requirement for self cultivation be cut in half if possible. I implore you to maintain the 2 year AZ residency requirement for those whom wish to run a dispensary. People that are opposing this will most likely be from California and they seek to dominate the dispensary locations. They are most likely already established in their state and therefore capable of putting up the money, immediately, that it will take to start a "Non-Profit" establishment. Arizona residents should have first rights to serve Arizona patients!
Include criteria for placement of dispensaries in communities such as Bulhead City.
Section R9-17-106 is far too restrictive. In particular, section A7, requiring papers in peer reviewed journals, is not appropriate for many conditions which are rare (and thus unlikely to be specifically researched), but widely researched to be chronically debilitating and painful which would potentially be a good candidate for medical marijuana. For example, Ulcerative Colitus is very similar to Crohn's Disease (a specifically allowed condition in Prop 203), and would similarly enjoy the help for nausea, pain, digestion, and lack of appetite, but happens to have less research in this area. There are a great number of rare conditions for which it is not realistic to expect specific peer reviewed studies. The strictness of this requirement goes far beyond the physician's usual ability to prescribe medications as needed (for example, not every painful condition has a peer reviewed study suggesting that conventional pain killer will help. Furthermore, generating a peer-reviewed study will be beyond the means of most suffererers of chronic, disabling conditions. As the requirements for the recommending physician are quite thorough, it should suffice to determine that the condition in question is in fact chronic and debilitating (per the Proposition) to be added to the qualified list, and thus allow Medical Marijuana provided the qualified physician. Or, at the very least, to make the requirements to add the condition less onerous. Similarly, the requirements in section R9-17-106 B are too restrictive. Also, it is not clear when a public hearing would be needed. There should not need to be any public hearing for these requests. Section R9-17-106-C appears to be completely unnecessary and could potentially cause undue suffering to victims of chronic, debilitating diseases. Petitions should be allowed at any time
Re: The fee structure (especially for patients with limited income) This absolutely needs to be addressed! These prices are far too high! (pun) Re: The processes for approving dispensary registration certificate You need to allow people to have a location secured, but NOT built! Secured via a contingency lease and then providing a blueprint of how security/patients/sales/growing/preparation/ storage/etc. will all be provided for. Approve a tentative license that will be fully granted once a dispensary has complied with their agreement to build the location that is virtually identical to their plan. Simple solution and this will eliminate hundreds if not thousands of unnecessary medical marijuana dispensaries popping up and then most promptly going out of business, what a mess that would be! Re: The requirement that dispensaries have a medical director ADHS' intentions for this were in the right place, however this position is superfluous and will

be complete overkill. Require the dispensaries to adhere to a policy implementing educational materials and advisement of dangers and responsibilities. Qualified Patients already have consulted with their own Doctor and have access to that Doctor for any technical questions. According to our business attorney the unnecessary expense of this position would legally be deemed an undue and unreasonable burden. By all means when you evaluate and consider business entities consider the addition of medical professionals an obvious benefit! Along with Horticultural, botany, law enforcement, clerical, and business experience.
I disagree with patients being filmed; grant them anonymity. Charging $150/year, every year is prohibitive. Establishing a year-long relationship with your doctor, including 4 visits a year, is also cost prohibitive and some patients do not have more than a year to live. Or military personnel aren't around long enough to establish the required relationship. Some patients who have established relationships with their doctors have doctors who will not prescribe medical marijuana.
No mention herein makes mention of sourcing genetic material from within the state. Early news stories reported such material must originate from within the state. There are portions of the proposed draft rules that are not entirely clear but may be implied; R9-17-302 B. 9. f. location of cameras but no mention on number of cameras needed/required R9-17-302 B. 3. d. vi- as it pertains to utility bill dated within 60 days before the date of dispensary application. The wording of this section has led to some confusion. However, I believe, it is only one of other potential proof of residency by the principal applying for the application; not a requirement on the proposed site of the dispensary prior to being awarded a license as many alarmist are claiming. R9-17-102 6. a.b.c. Qualifying patients with chronic illness, at least the more severe cases, should have a lower annual renewal fee.
pricing! from cards to product. smoking areas
The draft rules state that only debilitating medical conditions can be added at a future date. There are numerous scientifically-reviewed non-debilitating medical conditions to which marijuana can have theraputic value. Debilitating means a condition that causes a disability. Those patients with disabilities are generally eligible to receive some form of Social Security. Based on what I can make of the draft rules I have read.patients eligible to receive marijuana are most likely to be on Social Security. How can you expect someone living below the poverty line to pay $150 for a registry identification card let alone for the marijuana?
Please clarify the language that deals with the principal officer and Arizona residency requirements. Does each principal officer have to be a resident or at least one officer? I believe that perhaps the requirement of Arizona residency could effectively be relaxed. Perhaps it would be adequate to allow individuals who do not currently reside in Arizona but show intent to take up permanent residence in Arizona. For those non-Arizona residents, each case could be considered on an individual basis.
I just thought of a fabulous idea for adding to the definition of an ongoing physician patient relationship. You should make it absolutely clear on the physician recommendation and attestations that the physician is required to have and maintain medical records to back up his or her recommendation for Cannabis. These definitions are already in state law in ARS Title 32. Make it clear that if a physician doesn't have and maintain a medical record to back up the recommendation that it's considered unprofessional conduct. It would help if the form actually lists the language in

Title 32 so that the physician knows they are held accountable to the record retention requirement. Since the Initiative language states that the physician needed to be in an ongoing physician relationship as well as have done a medical history- these should be evident in the medical record. 32-1501. Definitions 3. "Adequate medical records" means legible medical records containing, at a minimum, sufficient information to identify the patient, support the diagnosis, describe the treatment, accurately document the results, indicate advice and cautionary warning provided to the patient and provide sufficient information for a similarly qualified practitioner to assume continuity of the patient's care at any point in the course of treatment. 32-2936. Patient records A licensee must keep a patient's medical records as follows: 1. If the patient is an adult, for at least seven years after the last date the licensee provided the patient with medical or health care services. 2. If the patient is a child, either for at least three years after the child's eighteenth birthday or for at least seven years after the last date the licensee provided that patient with medical or health care services, whichever date occurs first. 3. If the patient dies before the expiration of the dates prescribed in paragraph 1 or 2, for at least three years after the patient's death. 32-3211. Medical records; protocol; unprofessional conduct; corrective action; exemptions A. A health professional must prepare a written protocol for the secure storage, transfer and access of the medical records of the health professional's patients. At a minimum the protocol must specify: 1. If the health professional terminates or sells the health professional's practice and the patient's medical records will not remain in the same physical location, the procedure by which the health professional shall notify each patient in a timely manner before the health professional terminates or sells the health professional's practice in order to inform the patient regarding the future location of the patient's medical records and how the patient can access those records. 2. The procedure by which the health professional may dispose of unclaimed medical records after a specified period of time and after the health professional has made good faith efforts to contact the patient. 3. How the health professional shall timely respond to requests from patients for copies of their medical records or to access their medical records. B. The protocol prescribed in subsection A of this section must comply with the relevant requirements of title 12, chapter 13, article 7.1 regarding medical records. C. A health professional shall indicate compliance with the requirements of this section on the health professional's application for relicensure in a manner prescribed by the health professional's regulatory board. D. A health professional who does not comply with this section commits an act of unprofessional conduct. E. In addition to taking disciplinary action against a health professional who does not comply with this section, the health professional's regulatory board may take corrective action regarding the proper storage, transfer and access of the medical records of the health professional's patients. For the purposes of this subsection, corrective action does not include taking possession or management of the medical records. [redacted]

Allow physicians other than patients primary care provider to write recommendations. They may not have an established physician, they may not have a home. No insurance etc.. Allow for a fefund of fees, if for some reason a dispensary is denied. It is unreasonable to keep the entire $5,000.00 It should be a portion of the fee submitted

Change the fencing requirements to less restricitive ones. The current draft puts to many limits on making it in peoples reach.

The 2 year residency requirement is onerous and really not constitutional, plus will lead to a weak industry with poor quality and quantity of medical marijuana The patient-doctor relationship needs to be toned down. Only the chronically ill with good insurance see the same doctor 4 times a year. If

you don't have insurance you only go to a doctor in emergencies. This also discriminates against the under-insured, e.g. super high deductibles. Just encourage the doctor to maintain the relationship on a yearly basis when the renewal comes up. Be reasonable, most specialists only require a yearly visit to maintain a prescription for blood pressure, cholesterol, arthritis, etc.
1. Regarding Rule R9-17-306(F)(1), Local jurisdictions should be provided notification of violations identified by the Department and updates as to corrections of the violations. 2. Rule R9-17-307 requires a dispensary to cultivate at least 70% of the medical marijuana it provides. How is the other 30% acquired? The statutes allow a medical marijuana dispensary to cultivate marijuana at its facility and one additional off-site cultivation site. If Dispensary A acquires medical marijuana from Dispensary B, is Dispensary B deemed to be the one additional off-site cultivation site for Dispensary A? This rule needs clarification. 3. Rule R9-17-313(B)(5) provides for record-keeping requirements related to medical marijuana inventory sent by a dispensary to a food establishment for infusion into an edible food product. The statutes allow for possession of medical marijuana by dispensaries, off-site cultivation sites, qualifying patients and registered caregivers. What is the authority in the statutes for a â€œfood establishmentâ€ to receive, possess and process the medical marijuana? This Rule permits a â€œfood establishmentâ€, which is an undefined entity, to possess and process a substance which is illegal under federal law. The U.S. Department of Justice has issued a letter stating that it will not pursue actions against persons using and possessing medical marijuana as long as the person is in compliance with state laws. The Arizona state law does not authorize possession by a â€œfood establishmentâ€, leaving the entity and all who work there open to prosecution for a federal crime. Either the state law needs to be amended to allow for â€œfood establishmentsâ€ as manufacturing sites or the Rules should require manufacturing (meaning infusion) to be conducted at the site of the dispensary or the one additional permitted off-site cultivation facility. Additionally, there are strict security requirements and personnel screening for dispensaries and cultivation sites, but absolutely no such regulations or requirements for the food establishment. If the Department intends to permit processing of the medical marijuana by â€œfood establishmentsâ€, there need to be restrictions on access, employees and transport to prevent the medical marijuana from leaving the premises and being used illegally.
The fencing requirements are way to high! How can caregivers and card holders come up with that?
Make fencing more reasonable for caregivers & card holders to grow outdoors. Allow them to grow in 8 ft chainlink or simliar without a covering over it. Otherwise you are pushing people to grow more expensive, more unnatural, indoor medicine. Allow people to grow for one year even if there will eventually be a dispenssary within 25 miles since it will take dispensaries so long to get up and running.
1. The draft does not specify HOW the DHH will determine WHO will receive one of the 125 Medical Marijuana Dispensary certificates. 2. The draft does not specify WHAT are the qualifications they will be using to determine who will be issued a Medical Marijuana Dispensary certificate. 3. The draft does not specify WHEN the Medical Marijuana Dispensary certificates will be issured. 4. The draft does not specify if the Applicant HAS to have a signed lease in place before subimitting their application for a Medical Marijuana Dispensay Certificate. 5. The draft is very vague on the Fusion facilities - ie; distance from worship centers, schools, residences, etc., what city health department

codes are required, security, OR can folks just make moon cakes, brownies, suckers in their kitchen?? 6. I am a professional commercial realtor working with a number of people wanting to lease space now, but unsure of getting a Medical Marijuana Dispensary Certificate to operate. Which comes first, the Certificate or the lease obligation. Too much uncertainty as to who will get them.
I saw comments that someone wants physician assistants to be able to be medical directors. I believe that would be outside the scope of a PA's duty since they must work under the direction of a doctor.
On consuming and buying medical marijuana, I noticed that caregivers, and possibly patients can be reimbursed after a year of spending money on medical marijuana. However, even though our state budget is not as badly in debt as many other states, I feel it would be easier on our budget to allow those to cultivate marijuana on a regulated basis, instead of 25 miles away. Allowing personal growth of no more than 2-4 plants, as I don't see why anyone would need more than that, would prevent massive growth of marijuana, but also ease our budget crisis. I also feel that 12 plants is a lot for personal growth for someone who is 25 miles away from the dispensary. This can be fine and dandy for a busy dispensary, but personal growth of 12 plants under 3 feet can include as much as a pound or more of marijuana a month. That amount of marijuana COULD go to dispensaries, but again, 12 plants for a dispensary would be more than plenty. Personal growth should be separate to dispensary growth, as one can build a system that allows all the processes of cultivating marijuana to be done within two weeks worth of time, again a pound or more a month. Cloning, Vegging, and Flowering could be done with 12 plants. With 2-4 plants, it's possible to do this, but you're not likely to get an excess amount of medical marijuana you won't know what to do with. This excess would certainly allow room for thinking twice about whether they should illegally sell it, because they have no need for it, and the profit that comes with selling it illegally. It could possibly be done so that personal growth can allow a continuously flow of medicinal marijuana by allowing 2 plants, 2 clones, instead of 4 plants.
The only area that I even have a suggestion is in the area of the R9-17-201, Debilitating Medical Conditions. Again, using my history as a pharmacist, a physician is allowed to prescribe a drug for any condition he or she believes the patient will benefit. This is referred to as off labeled uses. I believe that if the trust is given to the physician to recommend marijuana period, we should be able to trust that same physician to recommend or prescribe it for conditions that may improve with its use. There is an area, in the rules, to add a condition or treatment to the list, but that process is extremely lengthy and complex.
see below
The rules could be improved by removing the excessive fees for patients, caregivers, and dispensaries.I understand the desire to not have this voter approved proposition become a similar program as those in CA andCO but much of what I have read is so cumbersome that I fear many patients will continue to use marijuana in a covert and unlawful way.
â€¢ R9-17-313.A.2 is arbitrary, unreasonable and places and unusual burden on the dispensary owner. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping and the auditing of any business inventory or process every thirty days that is not required for toxic, even lethal, products. â€¢ Auditing under Generally Accepted Accounting Principles once every 30 days would require a certified public accountant to visit the site,

complete the work, and provide professional â€œcertificationâ€ services to complete the audit. The department is concerned with inventory management and accountability, I understand that. . Verifiable, reliable, timely, and accurate inventory records and be maintained without this onerous requirement of an "audit" every thirty day. Audit is not a defined term in either the regulations or the proposition. [redacted]
I also believe Mr[redacted], spokesman for the Arizona Assoc. of Dispensary Professionals has many valid points. My main personal gripe is the suggestion of a 24/7 video monitor to the health dept. What is this? Soviet style Big Brother in America? I neither want nor need this medicine, but there are plenty of folks out there getting anti-depressants and serious pain killers and , even though these are sometimes abused and re-sold for money, there are not 24/7 cameras spying on them in every pharmacy in the state. I understand if the business owner of the dispensary wants to have a security camera, and of course all transactions should be documented or we won't get any tax money out this, but in the end, the goal should be getting a medicinal product to those in need.....not impeding them every step of the way.
I'm not sure I understand the 70/30 rule for dispensaries. How is it going to be possible for a dispensary to grow 70% of their product? Shouldn't we encourage large scale cultivation sites with strict production and quality control measures in place? I can see quality issues and rising costs passed to the consumer if this is not changed. Secondly, how will the 70/30 ratio be measured? I would think that this would need to be evaluated over the course of 24 months.
CONT. 4. The legislature should impose criminal penalties for smoking marijuana in the presence of children. Rationale: Children exposed to marijuana use are desensitized to the hazards of marijuana use
ISSUES 1. A ceritificate of occupancy (CO) may have been issued years ago and is still valid for a building without any improvements being made for a dispensary. -->What is the intent by the ADHS for a CO? 2. A CO for a improved, but vacated space in a shopping center would have been given to the original and prior tenant. If this is what the ADHS wished to have as part of the application process, there is not issue. A *new* CO would not be given for that space for a dispensary; however, unless improvements are made for a dispensary. -->Again, what is the intent by the ADHS for a CO? To have improvements made by the applicant for a dispensary without any quarantees of application approval by ADHS? 3. Older buildings may not have certificates of occupancy. -->An applicant will need to make improvements to have a CO issued without a guarantee that he would be selected. SUGGESTION: Clarify that the building have an prior approved Certificate of Occupancy, but not necessarily for the intended specific use. [redacted]
Limit the usage in "cohabitation" circumstances, such as apartments, dorms, senior living situations, anywhere with shared walls of other tenants/residents. Limit usage in homes, etc where minors live.
See comments above

1. The sole purpose of P-203 was to make the use of cannabis as medication an available choice to seriously ill patients, NOT to balance the budget of the State of Arizona! Don't punish the patients with reoccurring burdensome fees. The fee for an Arizona drivers license is age dependent ($25 - $10) and good for 15 years. A diagnosis of AIDS (ect.) is permanent... if a patient qualifies for a Medical Marijuana card, why is it necessary for them to renew annually? 2. The $5000 NON-REFUNDABLE fee to "apply" for a dispensary license is unrealistic. It will only serve to eliminate many potentially qualified dispensary applicants, and those that do apply will most likely be backed by "silent" out of state financial partners. An application from the Arizona State Board Pharmacy for a pharmacy permit is $240 annually. A revenue enhancing alternative would be a "reasonable" application fee, and an additional "more substantial" licensing fee if the applicant is qualified to operate as a dispensary. 3. IF you decide to keep the $5000 NON-REFUNDABLE fee, then a provision for tracking where the money came from should be required (using the SBA loan process as a model). 4. The term "medical director" should apply to any licensed medical professional, not just an MD. 5. A Pharmacist wanting to open a dispensary should not also have to employ a "medical director".
Give out more licenses to help unemployment.
Increase the Residency requirements to 3-5 years.
More clarification on medical directors.
The draft rules can be improved by not changing the language of the initiative that was passed by the voters. The draft rules are changing the doctor patient relationship and that will result in denial of access to needed medicine to many people that the voters voted to help. In one visit I can get prescribed phamaceutical drugs that can kill me but to get medical marijuana I have to be seen for a year or have a specialist take over my primary care? Rules that restrict safe medicine to people that need it are not what the people voted for. These rules are cruel and unusual and are too restrictive, the people have spoken, now enact the law as it was written. Thank you for allowing the input of the public.
The Act does not limit dispensaries to those owned by Arizona residents. In addition, the term resident is not defined. If a person owns a home in both Arizona and another state, pays property taxes to Arizona, pays utility bills in Arizona, does contract work in Arizona, etc., is that person an Arizona resident? That person does have the "proof" under R9-17-302(3)(d), but before substantial money is invested, there should be a clear answer to whether they would at least be qualified, especially given that the residency requirement was nowhere in the Act as approved by the voters. Principal officer is also not defined. New Mexico's Act contains a more general definition which states a licensed producer "means any person or association of persons within New Mexico that the department determines to be qualified to produce, possess, disttribute and dispense cannabis pursuant to the Lynn and Erin Compassionate Use Act and that is licensed by the department." While that language is not perfect it does not hinge on residency but I assume allows the department to look at the totality of the person or association of persons.

I believe that the 5 day timeframe for for inspection seems really generous. I would prefer to see that inspections take place within 24 hours no more than 72 hours after notice is given.

Doctor/patient relationship is not a good idea for a one year requirement. Doctors come and doctors go. which means to patients a new Doctor.

1. Neither the statute nor the rules provides where the seeds or first supply of pot can be obtained.
2. Although it makes sense to require qualifying patients to have continuing/repeated physician care prior to obtaining/renewing a registry card, some physicians with questionable ethics may make a mint off of this requirement (as evidenced by a recent documentary with respect to Colorado). I would suggest including some kind of limitation on the number of qualifying patients for which a physician can recommend medical marijuana. (Note that in my opinion, the alternative provided in Section 16(b) is impractical, as virtually no ethical physician will assume "primary responsibility for providing management and routine care," particularly with respect to patients with whom they do not have long-standing professional relationships.)

I have been an emergency physician and toxicology researcher for 25 years. Currently, I am working at the [redacted]. As a researcher who has written and published multiple articles regarding toxicology, I have been concerned with the dose risk vs. benefit ratio of medication. Regarding Cannabis where the LD 50 (Lethal Dose) has not been determined, and thought to be very high, the variability of the concentration of what is currently marketed can vary widely. The variability is dependent, among other things, on cultivation methods, soil, and lighting techniques. As a physician when I write a prescription for a medication with a certain concentration, I am assured that the patient will receive that concentration and it will be consistent and accurate no matter which pharmacy that the patient patronizes. I am relatively assured that it is free from harmful chemicals and contaminates and will deliver a therapeutic dose. Such is not the case with Cannabis grown by independent growers. Anecdotal reports have shown that some plants have intentional sub-therapeutic concentrations of efficacious cannabinoids, (CBD, CGD) for patients, in favor a tetrahydrocannabinoid (THC), which offers the recreational user the desirable â€œhighâ€. However, for the medicinal user, this can have deleterious effects. Non inhalation methods , which is the suggested routes of administration by The Institute of Medicine, as well as other researchers, can cause harmful untoward side effects, if the concentration or doses are not known. I propose that dispensaries be required to provide concentration of at least 2 CBDs as well as THC to the consumer. These dispensaries would be required to send a samples of cannabis from the first and last of their for laboratory for analysis. Also, they should be required to certify that the product is herbicide and pesticide free as determined by an independent laboratory. At least one reported case of an AIDS patient who may have contracted a fungal lung disease from the inhalation of Cannabis in California. In response to the first draft of the Medical Marijuana Program guidelines, I am in complete support of Dr. Edgar Suter, who wrote in the January 3, 2011 edition of The Phoenix Times.com, that the Arizona Department of Health has no authority to dictate what constitutes the time honored physician patient relationship. For the Department of Health to even suggest that a patient, where conventional medicine has failed, wait one year before being able to legally access medical marijuana is in fact â€œcruel and unusual punishmentâ€. The appearance projected is this moratorium is in

order to conform to bureaucratic hoop jumping. Many AIDS, Hepatitis C, and Cancer patients do not have one year. Additionally, as a licensed physician in three states, I have spoken with many doctors regarding the subject of cannabis. The overwhelming majority will not make cannabis recommendations for fear of DEA sanctions. So to require that each dispensary have a medical director (estimated need of 40 physicians for the 120 dispensaries) is not reasonable and represents the need for the guidelines to possess more sensitivity towards the need of legitimate patient access. Thank you. [redacted]

Federal law requires a bona fide doctor-patient relationship before a physician prescribes a controlled substance. The same requirement should apply for medical marijuana recommendations. The definition proposed by the Board, in R9-17-101(16)(a), which requires four visits over the span of a year, may prevent some patients from obtaining the relief offered by the Act in a timely manner. Principles of medical ethics have standards for the doctor-patient relationship and the dispensing of medication. Doctors are bound to follow their medical ethics in making recommendations for medical marijuana. It would violate their ethical standards to make recommendations for medical marijuana without conducting a proper examination of the patient's health and history. Excessive government regulation, such as rules that tell the doctor how to practice "" including how many visits or length of treatment "" overstep the bounds of this rulemaking. Doctor's ethical standards, not government rules, should control the doctor-patient relationship. Part B of the definition of "ongoing," in R9-17-101(16)(b), is good to an extent, but it would prevent U.S. military veterans whose primary care physicians are at the Veterans Administration Hospitals from being able to acquire medical marijuana if it would provide them relief from a debilitating medical condition. Doctors at the Veterans Administration are not permitted to write recommendations for medical marijuana because it is still proscribed by federal law. As there are already existing legal and ethical guidelines for when a physician-patient relationship is established and because the definitions proposed by the Department would make it unnecessarily difficult for a person with a genuine medical need to obtain medical marijuana""and make it virtually impossible for veterans using the services of a VA Hospital"

Please See Below

Draft Rule R9-17-311 should be expanded to include a requirement that when verifying the qualifying patient's identity, dispensaries must employ a biometric identity verification system, such as a thumb print scan.Â DHS is mandated by the Initiative to ensure that dispensaries are only releasing medical marijuana to qualifying patients who hold a validly issued registration card.Â If DHS required biometric verification in the rules, it would ensure that counterfeiting, identity theft, or other forgeries resulting in medical marijuana falling into the wrong hands would be prevented.Â This requirement will have the best chance of preventing the type of abuse we see, for example, with underage persons purchasing alcohol using fake identification.Â By requiring biometric identity verification, it would be nearly impossible for a dispensary employee to dispense marijuana illegally.Â While it is certainly expected that dispensaries will self-police their agents, under the current Rules it would be very easy for a disreputable agent to collude with a non-patient to dispense MM under somebody else's registry number.Â In this scenario it would be extremely difficult for a dispensary owner to discover illegal transactions as the record would appear legitimate.Â Â However if that transaction must be accompanied by a cardholder's thumbprint illegal transactions would be impossible. The proposed rules require a dispensary agent to verify information from the State's medical marijuana electronic verification system and enter additional information into the

system relating to the transaction. The technology is available to allow this process to be automated so that the dispensary computer directly communicates with the medical marijuana electronic verification system without a human user being required to enter the information. This automatic communication from computer-to-computer would reduce the chances of human error while reviewing or inputting information, and thus better prevent fraud and improper dispensing of medical marijuana. It would also mean that human users could not alter or enter fraudulent information, again reducing the chances for fraud or abuse of the medical marijuana system. The rules should explicitly allow such electronic transactions by making the existing R9-17-311 part A and adding as part B: B. A dispensary may use an automated electronic system of hardware and software to verify the information required in Section A before dispensing medical marijuana to a qualifying patient or designated caregiver and to submit the required information to the medical marijuana electronic verification system.

R9-17-02 Fees A sliding scale or lower cost card should be made available for low income patients. R9-17-101 This prohibits availability of medical marijuana to military veterans and needs to be altered. R9-17-202(F)(5) It is reasonable and important to ensure that a physician has a legitimate relationship with a patient, this language seems overly restrictive R9-17-307 â€œ70/30â€ rule This provision is restrictive an unnecessary. It will hamper the development of a free enterprise, wholesale business environment which is necessary to ensure adequate supply and competitive pricing, both of which are crucial for patients. A single crop failure could cause dispensaries with small grow operations to run out of supply and patients go without their medicine. R9-17-310 Medical Director Pharmacies are not required to have a Medical Director. Most doctorâ€™s have administrators who complete the patient education and clinical practice guidelines for them. A dispensary will likely have to pay an administrator to create the guidelines and then pay a doctor to authorize the documentation. There is a professional trade organization being formed for the medical marijuana industry. The rules should be established to allow the organization to develop the educational materials, guidelines, etc working closely with medical professionals, and let the active members utilize these resources. This reduces cost to the dispensaries and patients while at the same time standardizing the materials which is in the best interest of the patients. An alternative plan would be to put the duties being required of the Medical Director onto the recommending physician, was it would likely be handled for any other medication.

1) Follow the rules already set in place. Do not change per what Mr. Humble would like. 2) Start doing the proper research and re calculate your numbers based on: - Not all plants depending on variety produce 1- 1.2 ounces. - Indica varieties produce far less than Sativa. - If you limit the amount of product then what will happen is no one will want to grow Indica which is good for nausea and neuorpathy. They will only want to produce quantity not quality. Not specific medications that fill needs. - Also you need to learn that there are two stages to Marijuana cultivation. Space is needed for vegetative growth and then a separate area for the flowering. In restricting the square footage like you did you cannot now restrict the amount produced. Of the 2000 square feet at best half of it will be used for the flowering state. So do the math at 1-2 1.2 ounces per plant. WILL NOT WORK. In addition, when calculating your numbers not all of the space can be utilized for production. You will need areas to walk etc. Just seems like you have no idea what you are talking about when you are discussing the needs of an area to grow, I went to the Tucson council meeting and the numbers they used were 1 pound per plant. THAT IS CRAZY!!!!!! We are talking about growing indoors not outdoors. I am not saying that dispensarys should produce and control their own meds, but lets use the correct figures when deciding how this works. 3) Allow for the other professionals to be the

medical director. In this way it is a win win. You get the concept of control through a medical director and the dispensaries have options that would maybe prevent them from opening or running effectively.

This constitutes the [redacted]) comments on the Arizona Department of Health Servicesâ€™ (â€œADHSâ€ or â€œDepartmentâ€) Informal Draft Rules for implementation of the Arizona Medical Marijuana Act. The Association is a non-profit, professional business organization created after the passage of Proposition 203. The Associationâ€™s [redacted] qualified this measure for the ballot and then secured its passage. The Associationâ€™s undersigned counsel authored the text of Proposition 203. The [redacted]. Thus, the Association is committed to the Actâ€™s implementation in a manner that furthers legislative intent. The Association commends the Department for producing an initial set of draft rules so soon after the Actâ€™s effective date and for the inclusion of many prospective rules designed to ensure that Arizona serves as a national model for a well-regulated medical marijuana program that exists to serve the needs of patients with debilitating medical conditions. But the Association has serious concerns about whether a number of provisions, even if well-intentioned, are contrary to the intent of the Act. Some of the proposed regulations are invalid as impermissibly limiting the Act. Others exceed the Actâ€™s grant of authority to the Department and are inconsistent with or in conflict with the Act. In commenting on the proposed rules, the Association will endeavor to highlight those provisions that it applauds as well as those that give it concern. Although the Association has reviewed the initial draft rules and offers its comments below, it has not commented on every aspect of the initial draft rules. The Associationâ€™s failure to comment on specific provisions is not intended to signify its agreement with those provisions. The Association expects to continue studying the proposed rules and expressly reserves the right to make future, additional comments about any rules contained in the Departmentâ€™s initial draft. Rulemaking Authority The Departmentâ€™s rulemaking authority is found in A.R.S. Â§ 36-2803(A). The Department was not given the broad authority to â€œadopt rules necessary to carry out this chapter.â€ Rather, it is authorized only â€œto adopt the rules set forth in subsection A.â€ Permissible rules are those: 1. Governing the manner of adding to the list of debilitating medical conditions; 2. Establishing the form and content of registration and renewal applications; 3. Governing the manner in which it shall consider applications for and renewals of registry identification cards; 4. Governing nonprofit medical marijuana dispensariesâ€”for the purpose of protecting against diversion and theft without imposing an undue burden on nonprofit medical marijuana dispensaries or compromising the confidentiality of cardholdersâ€”including: (a) The manner in which the department shall consider applications for and renewals of registration certificates; (b) Minimum oversight requirements for dispensaries; (c) Minimum recordkeeping requirements for dispensaries; (d) Minimum security requirements for dispensaries, including requirements for protection of each registered nonprofit medical marijuana dispensary location by a fully operational security alarm system; (e) Procedures for suspending or revoking the registration certificate of dispensaries that violate the Act or rules adopted pursuant to the Act; and 5. Establishing registration and renewal fees. All other rules are outside the scope of the Departmentâ€™s rulemaking power. Each initial draft rule should be closely examined by the Department to ensure that it is authorized pursuant to A.R.S. Â§ 36-2803(A). The 70% Cultivation Rule The 70% production provision contained in proposed R9-17-307(C) appears to be drawn from the Colorado legislation (House Bill 1284) passed in May 2010. It requires that every medical marijuana center â€œmust certify that it is producing at least 70% of its own medicine.â€ This and

other amendments were intended to bring better governance to an insufficiently controlled cultivation environment that resulted from shortcomings in the original Colorado medical marijuana law. Since the Arizona Act provides for strict controls for all medical marijuana cultivation in the state, this restriction is unnecessary and may, in fact, be bad public policy for Arizona. The Act requires the establishment of at least 124 dispensaries in the State. It does not necessarily require the creation of at least 124 cultivation facilities, unless the proposed subsection R9-17-307(C) is enacted. It can be argued that fewer, larger, cultivation facilities decrease the potential for public nuisance, reduce ADHS oversight requirements and costs, increase security, and provide economies of scale that can reduce patient costs. Establishing an unimpeded market where any registered dispensary can choose to order its usable marijuana from any other registered cultivation facility will likely result in the greatest economic efficiencies and best prices for patients. Many medical professionals or other entities that would otherwise be motivated and highly qualified to operate a dispensary may be deterred due to the technical, financial and liability issues associated with operating a cultivation facility. Under the Act, every registered dispensary has the right to operate a cultivation facility to meet the needs of its qualified patients. However, nothing in the Act precludes a stand-alone dispensary from arranging to obtain its usable marijuana from the cultivation facilities of one or more other dispensaries. Creating a regulatory environment that allows cooperative interaction between registered dispensaries and their associated cultivation facilities will structure an Arizona medical marijuana industry that rewards efficiency; with the foreseeable result of better-managed dispensaries and fewer, more efficient, cultivation facilities. A proposed regulatory environment that allows commercial cooperation between registered dispensaries can be readily managed through rules that require cultivation facilities to establish procedures for verifying that a dispensary placing a order for usable marijuana has a registration certificate in good standing, that the usable marijuana is delivered in a secure manner, and that all orders are labeled, packaged, tracked and accounted for in a manner that prevents diversion. The Department has the authority to adopt rules governing nonprofit medical marijuana dispensaries, for the purpose of protecting against diversion and theft without imposing an undue burden on dispensaries or compromising the confidentiality of cardholders, including minimum oversight requirements for dispensaries. Requiring each dispensary to cultivate at least 70% of the medical marijuana it dispenses does not serve the purpose of protecting against diversion and theft and imposes an undue burden on dispensaries. More importantly, in A.R.S. Â§ 36-2816(B) and (C), the Act specifically prohibits a dispensary from dispensing to or acquiring marijuana from any person other than another registered dispensary, a registered qualifying patient or a registered designated caregiver. Had the Act intended to limit transfers between dispensaries, it would have said so. Thus, the proposed rule is in conflict with the Act. If the Department believes a rule is necessary in addition to A.R.S. Â§ 36-2816(B) and (C), the Association suggests the following: R9-17-307. Administration C. A dispensary: 1. Shall cultivate at least 70% of the medical marijuana the dispensary provides to qualifying patients or designated caregivers; 2.1. Shall MAY only provide medical marijuana cultivated or acquired by the dispensary to another dispensary in Arizona, a qualifying patient or a designated caregiver authorized by A.R.S. Title 36, Chapter 28.1 and this Chapter to acquire medical marijuana. 3.2. May only acquire medical marijuana from another dispensary in Arizona, a qualifying patient, or a designated caregiver. 4. May acquire up to 30% of the medical marijuana the dispensary provides to qualifying patients and designated caregivers from another dispensary in Arizona, a qualifying patient, or a designated caregiver; and 5. Shall not provide more than 30% of the medical marijuana cultivated by the dispensary to other dispensaries. The Physician/Patient Relationship The Association believes that the existence of a legitimate physician/patient relationship is contemplated by the Actâ€™s requirement that a qualifying patient be diagnosed by a physician as having a debilitating medical condition and that the physician provide

a written certification that, in his professional opinion, â€œthe patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patientâ€™s debilitating medical condition or symptoms associated with the debilitating medical conditionâ€ after the physician has completed a full assessment of the qualifying patientâ€™s medical history. The Departmentâ€™s rulemaking authority set forth in A.R.S. Â§ 36-2803 of the Act does not include adopting rules concerning the physician/patient relationship. A.R.S. Â§ 36-2803(A)(3) provides that ADHS shall adopt rules â€œestablishing the form and content of registration and renewal applications submitted under this chapter.â€ Butâ€"unlike the authority granted with respect to the consideration of dispensary registration certificatesâ€"the statute does not grant ADHS the authority to adopt rules for the consideration of patient applications for registration cards. Accordingly, the Department is not authorized to add substantive requirements to the content of a qualifying patientâ€™s application or renewal beyond those set forth in the Act. A.R.S. Â§ 36-2804.02 requires that a qualifying patient applying for a registration card submit (1) the physicianâ€™s written certification, (2) the application fee, and (3) the application. A.R.S. Â§ 36-2801(18) specifies the content of the written certification. Although the physicianâ€™s written certification must accompany the patientâ€™s applicant, it is separate from the application itself and the Department does not have the rulemaking authority to specify its content. In the case of proposed R9-17-202(F)(5), the patient would be required to provide far more information than contemplated by A.R.S. Â§ 36-2804.02, particularly with respect to the physicianâ€™s written certification. Although proposed R9-17-202(F)(5)(e)(i), (ii) requires the physician to state the nature of his relationship with the patient in the alternative, both (i) and (ii) are objectionable as overly burdensome to the patients who are the Actâ€™s intended beneficiaries by dramatically impacting patient access. Consider this example. A patient diagnosed with cancer is referred to an oncologist. That patientâ€™s reaction to the chemotherapy administered by the oncologist involves such severe nausea that the patientâ€™s overall strength is severely diminished and his overall health and ability to withstand additional treatment is further compromised. The oncologist has only been treating the patient for a matter of weeks but is willing to write a recommendation for the patientâ€™s use of medical marijuana. Under this scenario, the physician could not make the statement required by R9-17-202(F)(5)(e)(i) and might have serious difficulty making the alternative statement required by R9-17-202(F)(e)(ii). Notwithstanding any assertions the Department may make concerning the wisdom or substantive merit of these additional proposed physician certifications, the Associationâ€™s position is that they are not authorized by the Act and would unlawfully require certifications beyond what the Act has mandated. Time-Frames The Act sets forth a number of time deadlines for the Department to perform various tasks. For example, A.R.S. Â§ 36-2804 provides that the Department shall register a dispensary and issue a registration certificate â€œnot later than ninety daysâ€ after receiving a dispensary application if the dispensary applicant has submitted certain specified items. The Association wholeheartedly supports the Departmentâ€™s proposal to ensure that the statutory time period does not begin to run until the application is complete as well as the proposals to give the Department a limited period of time to review applications for completeness and to give the applicant a period of time to provide missing information. But the Associationâ€™s position is that a dispensaryâ€™s registration certificate must be issued not later than ninety calendar days from the date on which the Department has a completed application. The Departmentâ€™s proposed rules change the statutory time periods to â€œworking days,â€ significantly lengthen the time periods and are in conflict with the statute. This issue exists with respect to all statutory time periods set forth in Table 1.1. In addition to the aforementioned problems with the time-frames listed in Table 1.1, there are numerous errors in Table 1.1 with respect to the â€œstatutory authorityâ€ citations. These citations should be corrected in the next draft. Outdoor Cultivation The Association

commends the Department for including provisions related to outdoor cultivation. But the proposed definition of â€œenclosedâ€ in draft R9-17-101(10) requires one or another cumbersome barrier covering the top area. The association proposes the following amendment: 10. â€œEnclosedâ€ means EITHER: a. A building with four walls and a roof or an indoor room or closet. b. An area surrounded by four solid 12-foot walls constructed of metal, concrete, or stone with a one-inch thick metal gate and a barrier covering the top of the area that is: i. Welded or woven wire mesh, with minimum wire thickness of 0.25 inches and maximum gap between wires of 1 inch; ii. Welded metal wire grid, with minimum wire thickness of 0.25 inches and maximum gap between wires of 3 inches; iii. Metal chain-link weave, with gauge no less than 9 and no more than 11.5; iv. A panel of metal vertical bars, with minimum bar thickness of 0.5 inches and maximum gap between bars of 4 inches; or v. Constructed of iron or other metallic material and similar to the examples in subsections (10)(b)(i) through (10)(b)(iv), if approved by the Department. c. AN AREA SURROUNDED BY FOUR SOLID 12-FOOT WALLS, TOPPED WITH CONCERTINA WIRE, CONSTRUCTED OF METAL, CONCRETE, OR STONE WITH A ONE-INCH THICK METAL GATE AND WITH 24-HOUR VIDEO SURVEILLANCE OF THE ENTIRE OUTER PERIMETER. Inventory Controls To more effectively inventory and track all usable marijuana, the AzMMA respectfully suggests that the ADHS augment its proposed â€œstrainâ€ and â€œregistry identificationâ€ system with a â€œBatchâ€ designator. Under this proposal, a â€œBatchâ€ is simply one or more seeds or cuttings that are planted and harvested at the same time at a given cultivation site. Each Batch would be assigned a unique â€œBatch Numberâ€ by the dispensary operating the cultivation site. The cultivation site would also record: 1. Whether the Batch originated from seeds or cuttings; 2. The origin and strain of the seeds or cuttings; 3. The number of seeds or cuttings planted; 4. The date the seeds or cuttings were planted; 5. A list of all chemical additives, including non-organic pesticides, herbicides, and fertilizers, used in the cultivation and production of the medical marijuana; 6. The number and disposition of any male, failed, or otherwise unusable plants; 7. The number of female plants grown to maturity; 8. The harvest date of the mature female plants; and 9. The final processed usable marijuana yield weight of the Batch. The AzMMA also believes that regulations R9-17-313, and R9-17-314 may benefit from making certain differentiations between inventory controls and labeling requirements for dispensaries and those requirements for cultivation sites. Accordingly, the Association submits the following proposed changes to the Departmentâ€™s initial draft regulations: R9-17-101. Definitions: Add the following definitions and renumber accordingly: 4. â€œBATCHâ€ MEANS A SPECIFIC LOT OF MEDICAL MARIJUANA GROWN FROM ONE OR MORE SEEDS OR CUTTINGS THAT ARE PLANTED AND HARVESTED AT THE SAME TIME AT A CULTIVATION SITE. 5. â€œBATCH NUMBERâ€ MEANS A UNIQUE NUMERIC, OR ALPHA-NUMERIC, DESIGNATOR ASSIGNED TO A BATCH BY A DISPENSARY AT ITS CULTIVATION SITE. R9-17-313. Inventory Control System A. A dispensary shall designate in writing a dispensary agent who has oversight of the dispensary's medical marijuana inventory control system. B. A dispensary shall establish and implement an inventory control system for the dispensaryâ€™s medical USABLE marijuana LOCATED AT THE DISPENSARY that documents: 1. Each day's beginning inventory, acquisitions, harvests, sales, disbursements, disposal of unusable marijuana, and ending inventory BY AMOUNT, BATCH NUMBER AND REGISTRY NUMBER; 2. For acquiring medical marijuana from a qualifying patient, designated caregiver, or another dispensary OR CULTIVATION SITE: a. A description of the medical marijuana acquired including the amount and strain BATCH NUMBER; b. The name and registry identification number of the qualifying patient, designated caregiver, or dispensary and dispensary agent who provided the medical marijuana; c. The name and registry identification number of the dispensary agent receiving the medical marijuana on behalf of the dispensary; and d. The date of acquisition;. 3. For cultivation: a. The strain of marijuana seed planted, type of soil used, date seeds were planted, and the watering schedule; b.

Harvest information including: i. Date of harvest; ii. Amount of medical marijuana harvested, including the amount of marijuana and the amount of usable marijuana; iii. Name and registry identification number of the dispensary agent responsible for the harvest; and c. The disposal of medical marijuana that is not usable marijuana including the: i. Date of disposal, ii. Method of disposal, and iii. Name and registry identification number of the dispensary agent responsible for the disposal; 3. FOR ACQUIRING MEDICAL MARIJUANA FROM A QUALIFYING PATIENT OR DESIGNATED CAREGIVER: a. A DESCRIPTION OF THE MEDICAL MARIJUANA ACQUIRED INCLUDING THE AMOUNT AND STRAIN; b. THE NAME AND REGISTRY IDENTIFICATION NUMBER OF THE QUALIFYING PATIENT OR DESIGNATED CAREGIVER WHO PROVIDED THE MEDICAL MARIJUANA; AND c. THE DATE OF ACQUISITION. 4. For providing medical marijuana to another dispensary: a. The amount and strain BATCH NUMBER of THE medical marijuana provided,; b. The name and registry identification number of the other dispensary,; c. The name and registry identification number of the dispensary agent who received the medical marijuana on behalf of the other dispensary,; and d. The date the medical marijuana was provided;. 5. For providing medical marijuana to a food establishment for infusion into an edible food product: a. A description of the medical marijuana provided including the amount and strain BATCH NUMBER; b. The name and registry identification number of the designated agent who: i. Provided the medical marijuana to the food establishment on behalf of the dispensary, and ii. Received the medical marijuana on behalf of the food establishment; and. c. The date the medical marijuana was provided to the food establishment; and. 6. For receiving edible food products infused with medical marijuana from a food establishment: a. The date the medical marijuana used to infuse the edible food products was received by the food establishment and the amount AND BATCH NUMBER of THE medical marijuana received; b. A description of the edible food products received from the food establishment, including total weight of each edible food product and estimated amount AND BATCH NUMBER of THE medical marijuana infused in each edible food product; c. Total estimated amount AND BATCH NUMBER of THE medical marijuana infused in edible food products; d. A description of any reduction in the amount of medical marijuana; e. For any unusable marijuana disposed of at the food establishment: i. A description of the unusable marijuana, ii. The amount AND BATCH NUMBER of THE unusable marijuana disposed of, iii. Date of disposal, iv. Method of disposal, and v. Name and registry identification number of the dispensary agent responsible for the disposal at the food establishment; and. f. The name and registry identification number of the designated agent who: i. Provided the edible food products to the dispensary on behalf of the food establishment, and ii. Received the edible food products on behalf of the dispensary. g. The date the edible food products were provided to the dispensary. C. A DISPENSARY CULTIVATION SITE SHALL ESTABLISH AND IMPLEMENT AN INVENTORY CONTROL SYSTEM THAT DOCUMENTS: 1. EACH DAY'S BEGINNING INVENTORY, DELIVERIES, AND ENDING INVENTORY BY BATCH NUMBER, INCLUDING WHETHER EACH BATCH ON HAND IS IN CULTIVATION, IN PROCESSING, OR STORED AS PROCESSED USABLE MARIJUANA; 2. THE AMOUNT AND BATCH NUMBER OF ALL PROCESSED USABLE MARIJUANA STORED OR OTHERWISE LOCATED AT THE CULTIVATION SITE; 3. FOR MEDICAL MARIJUANA PROVIDED TO ANOTHER DISPENSARY: A. THE AMOUNT AND BATCH NUMBER OF THE MEDICAL MARIJUANA PROVIDED; B. THE NAME AND REGISTRY IDENTIFICATION NUMBER OF THE OTHER DISPENSARY; C. THE NAME AND REGISTRY IDENTIFICATION NUMBER OF THE DISPENSARY AGENT WHO RECEIVED THE MEDICAL MARIJUANA ON BEHALF OF THE OTHER DISPENSARY; AND D. THE DATE THE MEDICAL MARIJUANA WAS PROVIDED. 4. FOR MEDICAL MARIJUANA PROVIDED TO A FOOD ESTABLISHMENT FOR INFUSION INTO AN EDIBLE FOOD PRODUCT: A. A DESCRIPTION OF THE MEDICAL MARIJUANA PROVIDED INCLUDING THE AMOUNT AND BATCH NUMBER; AND B. THE DATE THE MEDICAL MARIJUANA WAS PROVIDED TO THE FOOD ESTABLISHMENT. 5. HARVEST INFORMATION INCLUDING: A. DATE OF HARVEST FOR EACH BATCH; B. AMOUNT OF MEDICAL

MARIJUANA HARVESTED IN EACH BATCH, INCLUDING THE AMOUNT OF USABLE MARIJUANA AND THE AMOUNT OF NOT USABLE MARIJUANA; C. THE DISPOSAL OF MEDICAL MARIJUANA THAT IS NOT USABLE MARIJUANA INCLUDING THE: I. BATCH NUMBER AND AMOUNT; II. DATE OF DISPOSAL; AND III. METHOD OF DISPOSAL. CD. The individual designated in subsection (A) shall conduct and document an audit of the dispensary's inventory according to generally accepted accounting principles at least once every 30 calendar days. 1. If the audit identifies a reduction in the amount of medical marijuana in the dispensary's inventory not due to documented causes, the dispensary shall determine where the loss has occurred and take and document corrective action. 2. If the reduction in the amount of medical marijuana in the dispensary's inventory is due to suspected criminal activity by a dispensary agent, the dispensary shall report the dispensary agent to the Department and to the local law enforcement authorities. DE. A dispensary shall: 1. Maintain the documentation required in subsections (B) and (C) at the dispensary for five years from the date on the document, and 2. Provide the documentation required in subsections (B) and (C) to the Department for review upon request. R9-17-314. Product Labeling and Analysis A. A dispensary shall ensure that medical marijuana provided by the dispensary to a qualifying patient or a designated caregiver is labeled with: 1. The dispensary's registry identification number; 2. The amount, BATCH NUMBER and strain of medical marijuana; 3. If not cultivated by the dispensary, whether the medical marijuana was obtained from a qualifying patient, a designated caregiver, or another dispensary; 4. The date of manufacture, harvest, or sale; 5. A list of all chemical additives, including nonorganic NON-ORGANIC pesticides, herbicides, and fertilizers, used in the cultivation and production of the medical marijuana; and 6. The registry identification number of the qualifying patient. B. A DISPENSARY CULTIVATION SITE SHALL ENSURE THAT EACH PACKAGE OF MEDICAL MARIJUANA PROVIDED BY THE CULTIVATION SITE TO A DISPENSARY IS LABELED WITH: 1. THE DISPENSARY CULTIVATION SITE'S REGISTRY IDENTIFICATION NUMBER; 2. THE AMOUNT, BATCH NUMBER AND STRAIN OF THE MEDICAL MARIJUANA; 3. THE DATE OF MANUFACTURE, HARVEST, OR SALE; AND 4. A LIST OF ALL CHEMICAL ADDITIVES, INCLUDING NON-ORGANIC PESTICIDES, HERBICIDES, AND FERTILIZERS, USED IN THE CULTIVATION AND PRODUCTION OF THE MEDICAL MARIJUANA. BC. If medical marijuana is provided as part of an edible food product, a dispensary, shall, in addition to the information in subsection (A), include on the label: 1. The total weight of the edible food product; and 2. The following statement â€œThis product is infused with medical marijuana and was produced without regulatory oversight for health, safety, or efficacy. There may be health risks associated with the consumption of the product.â€ CD. A dispensary shall provide to the Department upon request a sample of the dispensary's medical marijuana inventory of sufficient quantity to enable the Department to conduct an analysis of the medical marijuana. Certificate of Occupancy Proposed R9-17-302 sets forth the contents of the application for a dispensary certification. One of those requirements is â€œ[a] copy of the certificate of occupancy or other documentation issued by the local jurisdiction to the applicant authorizing occupancy of the building as a dispensary and, if applicable, as the dispensaryâ€™s cultivation site.â€ R9-17-302(B)(5). This imposes an undue burden on dispensaries to make the major capital investments necessary in order to prepare a site for occupancy as a dispensary or cultivation site without any assurance that certification will be granted. Although the Department has the authority to adopt rules governing nonprofit medical marijuana dispensaries for the purpose of protecting against diversion and theft, those rules cannot impose â€œan undue burden on nonprofit medical marijuana dispensaries.â€ A.R.S. Â§ 36-2803(A)(4). Requiring a certificate of occupancy to be issued to a proposed dispensary before it even has preliminary approval from the Department is also an undue burden on counties and municipalities. In contrast, the Departmentâ€™s proposed R9-17-107 contemplates that an application may be completed over time and that the Department may issue a preliminary approval of the dispensary registration certificate and identification number

pending approval of at least one principal officer or board member as a dispensary agent. The Association welcomes this sort of tiered approach to the application process and suggests that the requirement for producing a certificate of occupancy be moved to a later stage by delaying the final approval or effective date of the certification until the appropriate certificates of occupancy have been issued. Audits Proposed R9-17-305(2) and (3) requires that a dispensary applying for renewal must provide a copy of an audited financial statement for the previous year. Because a registration certificate is effective for only one year and the renewal application must be made 30 days prior to expiration, it will be impossible to provided a full, annual financial statement. This requirement needs to be revisited and revised so that it is not internally inconsistent. The Association fully supports requiring dispensaries to provide the financial information necessary to determine that it is operating as a nonprofit and that funds are not being diverted, etc. But an audited financial statement seems to exceed what it necessary and the cost would be unduly burdensome to entities required to operate as non-profits. The Association suggests that the Department consider other alternatives. For example, a compilation as well as copies of the entityâ€™s tax returns may provide the information the Department needs in a less burdensome way. Medical Director The Association sees value to a dispensary affiliation with a Medical Director, but suggests that it is more consistent with the scope of the Departmentâ€™s rulemaking authority to use the existence of a Medical Director as an evaluation criterion rather than as a mandatory requirement for all dispensaries. Proposed R9-17-101(15) defines a Medical Director in such a way that all Medical Directors must be medical doctors or osteopaths even though the Act allows medical doctors, osteopaths, naturopaths and homeopaths to certify a patient for the medical use of marijuana. In addition, R9-17-310 limits a Medical Director to serving only three dispensaries at any time. Together, these provisions may make it extremely difficult for dispensaries to operate in Arizonaâ€™s rural counties. The Department should state its rationale for these provisions so that the public can evaluate whether they impermissibly limit the Act. Security Requirements The Association supports strong security requirements and believes that they are not only good public policy but further the purpose of the Act. However, the Association is concerned that the requirement, in proposed R9-17-306, that a dispensary provide the Department with authorized remote access to the dispensaryâ€™s electronic monitoring system is problematic. If the Department wants a live feed, there must be very strong encryption to protect patient confidentiality. The system requirements for a live feed may be unduly burdensome for dispensaries. Other alternatives should be considered such as requiring a minimum of 30-days storage of the electronic monitoring system images. Transportation Requirements The Departmentâ€™s initial draft rules contain no provisions relative to the transportation of medical marijuana between dispensaries, cultivation sites, patients, etc. The Association believes such rules are necessary and appropriate for the Department to promulgate. Some suggestions in this regard are that: â€¢ Vehicles used for delivery not bear any identifying markings. â€¢ The dispensary must maintain current commercial motor vehicle insurance as required by Arizona law. â€¢ Only registered dispensary agents with access to a form of secure communication with the dispensary may staff any vehicle during the delivery of usable marijuana. â€¢ All usable marijuana be transported in a locked container that is locked in the trunk or otherwise secured within the vehicle used to transport the marijuana. Pharmacist / Surety Bond Information Proposed R9-17-302 sets forth the contents of a dispensary application. R9-17-302(B)(15) proposes to ask whether â€œ[a] registered pharmacist will be onsite or on-call during regular business hoursâ€ and â€œ[w]hether the dispensary has a surety bond and, if so, how much.â€ The Association is unclear as to whether the Department seeks to require these items or whether they will be used as evaluation criteria. If intended to be a requirement, the pharmacist provision is extremely problematic and unduly burdensome for dispensaries. And the reference to a surety bond, generally required to guarantee performance of a

legal obligation, does not appear to make any sense in this context. In short, some further explanation from the Department is necessary to permit informed comment. Notice of Inspection A.R.S. Â§ 38-3806(H) provides that medical marijuana dispensaries are subject to reasonable inspection by the Department and that the â€œDepartment shall give reasonable notice of an inspection under this subsection.â€ Proposed R9-17-306 goes beyond defining â€œreasonable notice of an inspection.â€ Proposed R9-17-306(A) provides that the submission of an application constitutes permission for entry to and inspection of the dispensary. It does not reference any â€œreasonable notice requirementâ€ and does not limit this inspection to the inspection associated with the Departmentâ€™s review of a dispensary application (proposed R9-17-306(C) provides for 5 working days notice of a certification or compliance inspection). The application of the 5-day notice to the inspection refer

the Association is available to discuss any portion of this rule comment or to answer any questions you may have. Please let us know if we can be of assistance. Sincerely

Draft Rule R9-17-311 should be expanded to include a requirement that when verifying the qualifying patient's identity, dispensaries must employ a biometric identity verification system, such as a thumb print scan.Â DHS is mandated by the Initiative to ensure that dispensaries are only releasing medical marijuana to qualifying patients who hold a validly issued registration card.Â If DHS required biometric verification in the rules, it would ensure that counterfeiting, identity theft, or other forgeries resulting in medical marijuana falling into the wrong hands would be prevented.Â This requirement will have the best chance of preventing the type of abuse we see, for example, with underage persons purchasing alcohol using fake identification.Â By requiring biometric identity verification, it would be nearly impossible for a dispensary employee to dispense marijuana illegally.Â While it is certainly expected that dispensaries will self-police their agents, under the current Rules it would be very easy for a disreputable agent to collude with a non-patient to dispense MM under somebody else's registry number.Â In this scenario it would be extremely difficult for a dispensary owner to discover illegal transactions as the record would appear legitimate.Â Â However if that transaction must be accompanied by a cardholder's thumbprint illegal transactions would be impossible. The proposed rules require a dispensary agent to verify information from the State's medical marijuana electronic verification system and enter additional information into the system relating to the transaction. The technology is available to allow this process to be automated so that the dispensary computer directly communicates with the medical marijuana electronic verification system without a human user being required to enter the information. This automatic communication from computer-to-computer would reduce the chances of human error while reviewing or inputting information, and thus better prevent fraud and improper dispensing of medical marijuana. It would also mean that human users could not alter or enter fraudulent information, again reducing the chances for fraud or abuse of the medical marijuana system. The rules should explicitly allow such electronic transactions by making the existing R9-17-311 part A and adding as part B: B. A dispensary may use an automated electronic system of hardware and software to verify the information required in Section A before dispensing medical marijuana to a qualifying patient or designated caregiver and to submit the required information to the medical marijuana electronic verification system.

Require all NFP entities to use the state created system for transparency. If you allow all of the

providers to create their own systems they will be able to hide information from the state agencies. Look to ADOT IID Ignition Interlock Device system for some sample issues that you will run into

As discussed above we believe the Draft Rules are an excellent starting point for a well regulated and functional program. The intent, clearly, is to create a program that is as safe, secure, and transparent as possible while at the same time ensuring that reputable dispensaries can adequately operate to provide medicine to legitimate patients. The revisions we suggest below are intended to help achieve this goal. 1. Demonstration of Financial Securityâ€"Surety Bond In order to ensure that only the most capable and reputable applicants are awarded dispensary licenses, it is incumbent upon DHS to ensure that prospective applicants have the financial ability and fiscal responsibility necessary to operate a dispensary. Operating a reputable, safe and viable dispensary will be a very expensive and financially risky endeavor. It would be a disservice to both the State and to qualifying patients to allow applicants that do not have the required financial wherewithal or fiscal integrity to proceed. The Draft Rules clearly attempt to address this issue with provisions addressing unpaid taxes and the posting of a surety bond. See R9-17-302(B)(1)(f). However the Rules do not provide any details regarding the surety bond. Furthermore, according to our research and discussions with underwriters, they are unable and unwilling to issue a bond without specific guidelines from the State regarding why and when the bond would be called. This may make timely compliance with the rule impractical if not impossible. As a remedy to this uncertainty, we suggest allowing applicants to demonstrate financial capability with additional options such as a letter of credit, or preferably documentation of a specified amount deposited in an escrow account. We suggest that an appropriate sum for this requirement is $250,000. This will ensure that dispensary applicants are able to fulfill the facility, security and operational expenses that they would incur in establishing a fully compliant dispensary. We have provided specific language and edits to the Rules below. 2. Prior Local Land Use Approvalâ€"Certificate of Occupancy As discussed above, the Rules properly require local land use approval as a prerequisite to a complete application. However as currently written, the Rules appear to go beyond this by requiring a Certificate of Occupancy as evidence of local approval of the use. See R9-17-302 (B)(5). This is problematic and not at all feasible. In order to obtain a Certificate of Occupancy, an applicant would have to actually construct all the necessary improvements for the property including obtaining all building permits and passing all inspections. This is particularly burdensome because these facilities are going to require substantial improvements before being suitable for cultivation or dispensary operations. These improvements are likely to include significant structural modifications to meet the stringent security requirements. It is simply not feasible to require prospective applicants to invest the capital and time required to make these improvements without knowing whether or not they will obtain a license. In addition to this unnecessary risk, it would be a waste of valuable local resources and funds to issue permits and perform inspections on facilities that ultimately may not be awarded a license. The effect of this would be to discourage rational and responsible applicants; an undesirable and certainly unintended consequence. However, the intent of this provision (i.e. ensuring local jurisdiction approval and land use compatibility) can be achieved without these problems by revising this section to simply require evidence from the local jurisdiction that the Applicantâ€™s proposed facility complies with all local zoning restrictions and land use regulations and will be required to obtain building permits and certificates of occupancy prior to beginning operations. We suggest specific language below which will ensure local approval without the undue burden and unintended consequences of the Certificate of Occupancy. 3. Medical Director Qualificationâ€"Naturopathic Doctors We applaud the inclusion

of the Medical Director requirement, however the qualifications for this positions as stated in the Draft Rules have inappropriately omitted Naturopathic Doctors from eligibility. Naturopaths have education and licensing requirements that are as stringent and sometimes more expansive than M.D.s or D.O.s. Further, naturopaths are uniquely qualified to serve as Director to a MMJ Dispensary because of their education and experience in alternative healing methods and in particular herbal therapies. To omit Naturopaths from this role would do a disservice to patients and seems illogical and unjustified. 4. Cultivationâ€"70/30 Split Requirement. The requirement in the Draft Rules that Dispensaries must cultivate at least 70% of their product (allowing only up to 30% to be obtained from other dispensaries/caregivers) is very troubling (See R9-17-307(C)). First and foremost, it is difficult to determine what the point of this Rule is. Second, regardless of its goal, inclusion of this Rule is likely to result in unintended consequences that run contrary to the intent of the Initiative and the Rules. Such a requirement will force those who wish to operate a dispensary into cultivation, and those who wish only to cultivate into retail dispensing. The end result of this would be to provide patients with less consistent quality medicine. As those who have interest and expertise in one aspect of the industry do not necessarily have interest or expertise in the other. Take the example of an applicant who has a unique talent for growing high quality medical marijuana and a strong background in growing but either has no desire or lacks the knowhow to run a safe, secure, and well functioning dispensary business. In the alternative, one can imagine a career pharmacist who has successfully operated pharmacies for years but lacks the knowledge of how to grow high quality, medical grade marijuana. It would appear that each of these individuals should be encouraged to be applicants but that it is in no oneâ€™s interest for these people to be forced into the part of the business that they are not properly trained to excel at. The State should want to encourage responsible and quality growers and dispensers of medical marijuana. The 70/30 requirement on the other hand encourages applicants to reach into segments of the business they might not be good at. By mandating this, DHS prevents optimization of the industry which will lead to both failed dispensaries and less consistent quality of medicine for patients. Furthermore, if the intent of the draft Rule is to facilitate tracking of all MMJ from seed to sale, the 70/30 split hinders this goal rather than advancing it. If the intent of the Rule is to more easily track and control MMJ inventory, it seems like it would make sense for the State to consolidate the growing as much as possible into fewer locations. Consolidation is good as there are fewer such sites for law enforcement and the State to monitor; the 70/30 rule on the other hand means every dispensary owner must cultivate as well, leading to a proliferation of grow facilities. A greater number of facilities are not only more difficult to keep safe and monitory, but it also increases the temptation and opportunity for less reputable licensees to divert MMJ. Finally, by mandating a program that has more growers with less expertise, DHS is essentially mandating that some (many) patients will receive less consistent quality of medicine. To be clear, we do feel that people should be allowed to own both a dispensary and a cultivation location but it should not be mandated as such. 5. Cultivation Facility Requirements--Greenhouses As discussed above the Draft Rules do an excellent job of contemplating the necessary security measures and protocols to ensure that cultivation facilities are not compromised by prospective criminals. However one particular provision of the Rules may go unnecessarily far in its pursuit of this goal. Pursuant to the language of the Initiative all cultivation must occur inside an â€œEnclosedâ€ facility. The Rules define Enclosed as having a solid roof or being covered by a welded or woven metal top. It is important that these Rules are flexible enough to allow a locked and secured greenhouse facility to qualify for cultivation. It would be wasteful and unnecessary to prevent cultivators from utilizing natural light as a resource. Indoor Cultivation requires massive amounts of electricity and can be a strain on the existing electric grid. Allowing a secure greenhouse on the other hand is more environmentally friendly, more cost effective and can still be accomplished in a safe secure manner. 6. Product Testing The Rules

should require cultivators to test their product for contaminants and for THC levels and cannabinoid profiles. Without this information it will be very difficult for patients to identify which strain of MMJ works best for their particular condition. Further, patients have a right to know that their medicine is free from contaminants such as mold and pesticides. 7. Initial MMJ Cropsâ€"Seeds or Clones The Rules are so far are silent as to how a dispensary is allowed to start their initial crop. However, the only way to be certain that patients have access to quality medicine from the beginning is to allow dispensaries to utilize clones from plants with a history of producing quality medicine. If on the contrary, DHS decided to require all cultivation to begin from seed it would be impossible to know whether the resulting crop would be of sufficient quality. 8. Applicant Selectionâ€"Competitive Process Currently, it appears that the Rules will award applicants based on a first-come-first-served basis. While this may ultimately prove workable as the stringent requirements will likely discourage many applicants, we are concerned about what would happen if there are more qualified applicants than available licenses and those applicants have exactly the same time frame. In this scenario, we believe it is incumbent upon DHS to have a fallback Rule which implements a competitive selection process, potentially administered by a third party. This is the only way DHS can ensure that the limited licenses go to the best possible applicants. This system could also be used when another license becomes available either through growth of the program or revocation of an existing license.

The definition/requirements for patient-physician relationship are troublesome. Not only do the restrictions interfere with doctor/patient confidentiality, they restrict a valid patients ability to receive a medical marijuana recommendation if their primary care physician refuses to write any medical marijuana recommendations. The requirement that dispensaries cultivate 70% of their own product is troublesome. Valid, legitimate, and professionally run dispensaries may be burdened by meeting the high threshold to cultivate their own medical marijuana. Whereas more illegitimate dispensary owners that do not hold special medical or legal credentials will specialize in cultivating the product but not running a professional dispensary. The definition of a medical director is troublesome. Naturopathic physicians (N.M.D.) and physician assistant (P.A.) should also be included under persons able to qualify as medical directors. Registered nurses, however, should not be included as they have not received a substantial amount of education to that of D.O.s, M.D.s, P.A.s, or N.M.D.s.

KEEP OTHER STATES / RESIDENTS OUT

R9-17-310. Please remove the need for an on-site Pharmacist and/or Medical Doctor.

Specify what medical training must be completed for prescribers.

Marijuana and Lupus Dear Will, I am a Lupus patient and hope and pray that the ADHS will add Lupus to the list of diseases. ---------- Cannabis May Suppress Immune System Could Lead to New Autoimmune Disorder Treatments, Say Researchers By Jeanie Lerche Davis WebMD Medical News Reviewed By Michael Smith, MD on Tuesday, April 15, 2003 April 15, 2003 -- Cannabis may offer hope to people with autoimmune disorders such as lupus and rheumatoid arthritis. Cannabis seems to decrease inflammation in the body by suppressing certain parts of the immune system. Researchers are hoping this finding will lead

to new treatments. Previous studies have hinted at immune system abnormalities among cannabis users -- specifically, in the function of immune system cells called T lymphocytes and natural killer cells. While these cells help the body fight infections, no direct link with lowered immunity has yet been shown. {Moderator's Note: bold applied. Note that this lowered immunity has been found not to be a contraindication in the use of smoked marijuana for treatment of AID wasting disease in HIV+ individuals. See: Dr. Abrams work at San Francisco Medical hematology/oncology} In this study, researchers tested the blood of 29 cannabis smokers -- 13 occasional users and 16 regular users (weekly or daily use). They compared the results with a group of 32 nonsmokers. Again, researchers found that cannabis smokers had fewer immune-enhancing natural killer cells and lymphocytes, and higher levels of a protein that may promote tumor growth, called interleukin-10. {Moderator's Note: however cannabinoids have also been isolated which contain chemicals that cause tumor necrosis -- death of tumor cells-- and cell apostosis which is the removal of dead cell tissue from the body as waste material} These changes can dampen the immune system's response to infection, increasing susceptibility to infections and promoting growth of tumors, states lead researcher Roberta Pacifici, PhD, with the Instituto Superiore di Sanita in Rome, Italy. But researchers also say this finding could lead to new treatments for people with autoimmune disorders. Current treatments suppress the immune system -- thereby calming the abnormal immune response that plagues people with the conditions. Cannabis lowers levels of the inflammation-promoting protein interleukin-2 and raises levels of the anti-inflammatory protein interleukin-10. Both of these findings could be of potential benefit for treating autoimmune disorders one day. {Moderator's Notes: this would include both systemic Lupus and Rheumatoid Arthritis} ---------- SOURCE: The Journal of the American Medical Association, April 16, 2003. Medical Marijuana - Marijuana is sometimes prescribed to Lupus patients for nausea or pain. It is only legal in some states and there are federal laws to consider. Self medication should not be done. Always speak to your doctor before taking ANY drug or medication. more info on where it is legal... Lupus Treatments Medical Marijuana - Marijuana is sometimes prescribed to Lupus patients for nausea or pain. It is only legal in some states and there are federal laws to ... Does medical marijuana help with the pain of lupus & rheumatoid arthritis? Hello, I have lupus & rheumatoid arthritis and I'm at the end of my rope. My doctors can't treat my condition & I have tried everything. Right now I'm on a medicine "cocktail" of morphine, vicodin & oxycodone which I'm sure is killing my liver. I have never done marijuana- not even in my younger days. I recently talked to someone else with lupus & they told me that medical marijuana helps her get through her day. Does anyone have insight or experience with this? I'm not sure what to do at this point..... I'm just in pain.... 2 years ago Report Abuse by Mountain Girl Member since: April 28, 2006 Total points: 10,008 (Level 6) Add Contact Block Best Answer - Chosen by Voters I have also been through this myself. On Fentanyl patches, other painkillers, muscle relaxers, sleep meds, etc. I have severe fibromyalgia, CFIDS and arthritic pain. But cannabis is the only thing that helps when the pain meds and muscle relaxers won't. And it also doesn't make me groggy & lose sight of what I should be doing. I just feel normal when I use it. If I'm in a very bad flare up, it may not make me able to do a regular day's worth of stuff, but I can tolerate the pain much, much better. I have no side effects from it as I do from other medications. I'd be more than happy to tell you everything I know about medical cannabis (which is a lot), all about my personal experience and what the research says. Just email me if you'd like more information. I'd love to help. You can message me through my Yahoo Answers profile. Peace to you. Source(s): medical marijuana user & chronic pain sufferer 2 years ago Report Abuse 100% 1 Vote 1 person rated this as good Not the right answer? Try Yahoo! Search Search Yahoo! for Search spaige88â€¦ I would like more information on the medical cannabis please. I suffer from Lupus, Fibromyalgia and many many more painful diseases and take more medicine then i woulds like to and have never

smoked a day in my life but have had doctors even hint around herbal methods:) Report Abuse Charlottâ€¦ I have SLE lupus and I am a mother of 3 and sometimes 2 nieces. I was always a go getter now I can hardley do half of what I used to. I also have Fibromyalgia and Rheumatoid Arthritis I am on perscription pain killers, but nothing has worked better than cannabis! Report Abuse * You must be logged into Answers to add comments. Sign in or Register. Other Answers (2) by Chris M Member since: November 06, 2008 Total points: 103 (Level 1) Add Contact Block I use marijuana to help me with pain. I have a bad body. my shoulders, knees, and back are the things that cause me daily pain. I have only been smoking it for a year now. and i will tell you that i can make it though the day. My pain get so bad that i can not move. when i smoke it help my body lossen up and alows me to move. Smoking one or two boals and taking a hot shower works wonders. at least that is what i found out. have a nice day. 2 years ago Report Abuse 0% 0 Votes 1 person rated this as good by jancoole... Member since: July 13, 2007 Total points: 153 (Level 1) Add Contact Block My daughter in law has lupus.She was in such pain,my son heard that pot could help so he went and got her some(they had never smoked pot)She swears by it.Says when her lupus is real bad, the pot is her only relief.They have 5 children so she has to stay on her toes.hope this helps. 2 years ago Report Abuse

At first glance, I did see two things that I did not like. They are 1) The requirement of a 1-year doctor-patient-relationship prior to a medical marijuana recommendation and 2) The requirement of dispensaries to self-produce 70% of their medicine. Here is why: If a potential patientâ€™s primary doctor will not write a recommendation (for whatever reason, whether personal beliefs or fear or federal law) and that patient needs to go elsewhere to obtain a recommendation for this natural medicine that works for them, under these current rules it is impossible for them to get their medication for another year or without seeing another physician at least 4 times. A cancer patient or HIV/ AIDS patient simply does not have that sort of excess time to wait for symptom relief. I think this could be handled in a more humane fashion. Secondly, regarding the 70% piece, many of the small business owners who Iâ€™ve spoken with who have interest in entering this field have expressed that they are either specifically proficient on the business side, or are particularly talented in the field of horticulture. This part of the rules makes it impossible for people to align their work with where their specialties lie. If a businessperson is great with business and not so much with gardening, s/he should have the option to forgo the entire (strenuous and demanding) cultivation side and buy wholesale. I see this portion limiting potential dispensary owners and just generally being unnecessarily restrictive. Iâ€™d love to see these parts amended, but so far, I commend DHS on their hard work! This is definitely a lengthy process and I appreciate what youâ€™re doing for the state.

1. R9-17-106 2. How can a lay person be expected to produce evidence that her medical condition should be added prior to a hearing? A lay person's primary evidence will be anecdotal accounts or personal experience. There should be a preliminary hearing for comments by the requester and public. This should be much easier to obtain. If the department determines the proposed condition may be alleviated by medical marijuana then there should be a final hearing with doctors and more public debate.

Take out language regarding prior "excluded felony offense." in regards to persons applying to open a dispensary or being on the board of directors. If these persons had a prior drug conviction such as possession of small amounts of marijuana or paraphenalia, this should not determine whether those persons can qualify. Each case should be looked at and considered instead of the blanket statement in

R9-17-302 number 3a.

Draft Rule R9-17-311 should be expanded to include a requirement that when verifying the qualifying patient's identity, dispensaries must employ a biometric identity verification system, such as a thumb print scan. DHS is mandated by the Initiative to ensure that dispensaries are only releasing medical marijuana to qualifying patients who hold a validly issued registration card. If DHS required biometric verification in the rules, it would ensure that counterfeiting, identity theft, or other forgeries resulting in medical marijuana falling into the wrong hands would be prevented. This requirement will have the best chance of preventing the type of abuse we see, for example, with underage persons purchasing alcohol using fake identification. By requiring biometric identity verification, it would be nearly impossible for a dispensary employee to dispense marijuana illegally. While it is certainly expected that dispensaries will self-police their agents, under the current Rules it would be very easy for a disreputable agent to collude with a non-patient to dispense MM under somebody else's registry number. In this scenario it would be extremely difficult for a dispensary owner to discover illegal transactions as the record would appear legitimate. However if that transaction must be accompanied by a cardholder's thumbprint illegal transactions would be impossible. The proposed rules require a dispensary agent to verify information from the State's medical marijuana electronic verification system and enter additional information into the system relating to the transaction. The technology is available to allow this process to be automated so that the dispensary computer directly communicates with the medical marijuana electronic verification system without a human user being required to enter the information. This automatic communication from computer-to-computer would reduce the chances of human error while reviewing or inputting information, and thus better prevent fraud and improper dispensing of medical marijuana. It would also mean that human users could not alter or enter fraudulent information, again reducing the chances for fraud or abuse of the medical marijuana system. The rules should explicitly allow such electronic transactions by making the existing R9-17-311 part A and adding as part B: B. A dispensary may use an automated electronic system of hardware and software to verify the information required in Section A before dispensing medical marijuana to a qualifying patient or designated caregiver and to submit the required information to the medical marijuana electronic verification system.

R9-17-02 Fees A sliding scale or lower cost card should be made available for low income patients. R9-17-101 This prohibits availability of medical marijuana to military veterans and needs to be altered. R9-17-202(F)(5) It is reasonable and important to ensure that a physician has a legitimate relationship with a patient, this language seems overly restrictive R9-17-307 â€œ70/30â€ rule This provision is restrictive an unnecessary. It will hamper the development of a free enterprise, wholesale business environment which is necessary to ensure adequate supply and competitive pricing, both of which are crucial for patients. A single crop failure could cause dispensaries with small grow operations to run out of supply and patients go without their medicine. R9-17-310 Medical Director Pharmacies are not required to have a Medical Director. Most doctorâ€™s have administrators who complete the patient education and clinical practice guidelines for them. A dispensary will likely have to pay an administrator to create the guidelines and then pay a doctor to authorize the documentation. There is a professional trade organization being formed for the medical marijuana industry. The rules should be established to allow the organization to develop the educational materials, guidelines, etc working closely with medical professionals, and let the active

members utilize these resources. This reduces cost to the dispensaries and patients while at the same time standardizing the materials which is in the best interest of the patients. An alternative plan would be to put the duties being required of the Medical Director onto the recommending physician, was it would likely be handled for any other medication.

There are a few sections of the Draft Regulations that I should be revised or removed, and they primarily concerned with the patient-physician relationship definitions and restrictions. As required by ARS 36-2803.4 of the Arizona Medical Marijuana Act, the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." However, I have a number of concerns in the Regulations that I believe are in violation with this section of the Act: â€¢ R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. â€¢ â€¢ ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly out comes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application) â€¢ R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. â€¢ R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. â€¢ R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. â€¢ R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. â€¢ R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information â€¢ R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. â€¢ R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided

substantive misinformation. â€¢ R9-17-320 is not clearly defined and could be arbitrary. The Department should identify the â€œprovided format.â€ â€¢ R9-17-302.1B(h) creates an undue hardship as leasing a facility before acquiring a license will be very expensive and an unacceptable term of leasing. Each dispensary has set back restrictions, if the Department accepts a dispensary application before mine, then my location would be negated. â€¢ R9-17-320.6 is arbitrary, unreasonable and creates an undue hardship. Unless the applicant is an attorney or judge, no one can certify compliance with zoning restrictions. Management may be able to assert a reasonable assurance that all zoning has been complied with, but certification is impossible. â€¢ R9-17-302.9 â€¢ R9-17-302.10 is arbitrary, unreasonable and creates an undue hardship. This cannot be done until a suitable location can be found. Each dispensary has set back restrictions, if the Department accepts a dispensary application before mine, then my location would be negated. â€¢ â€¢ R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. â€¢ R9-17-310.5 are cruel, arbitrary, unreasonable, and beyond the scope of the authority of the Department. The department does not have the authority to require a certificate of occupancy, require surety bonds, require specific security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal substances stored at and dispensed from offices), require educational materials beyond what the law requires, require constant, intrusive, or warrantless surveillanceâ€¦or Provide approval subject to successfully completing either a comprehensive or supplemental request. â€¢ R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. â€¢ R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. â€¢ R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. â€¢ R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. â€¢ R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. â€¢ R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998

Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse. As a Certified Public Account, I understand the need for sound policies, compliance, data and procedures that are verifiable, reliable, consistent, and relevant. Thank you . [redacted]

Many people who will qualify for use of medical marijuana live, as we and many others do, in rural areas with limited local available medical facilities. I see the difficulties that my partner (a recovering cancer victim with her entire colon removed, back injuries and resultant chronic pain) has had in getting necessary pain and other controlled medications due to prejudice of primary caregivers. I believe that a significant number of primary physicians may, due to their beliefs, attitudes, credos and simple lack of familiarity with a new (and unconventional) treatment method be reticent to provide the necessary recommendation for a fully qualifying patient to receive a medical marijuana card. This gives patients several choices; to live without the benefits of medical marijuana, to seek marijuana illegally or travel excessive, hardship producing distances to seek out sympathetic primary medical care. Standard medical practice in other cases is, "If you feel it necessary, seek out a second opinion". I believe this holds true here. I would like to see allowance for a reasonable method of obtaining a diagnosis from a doctor other than one's primary care physician. I am not referring to "scamming the doctors" here. The "secondary" physician should have the same requirements of patient diagnostic review and assessment and the "primary" care physician should be kept informed of the patient process.

Se below.

1. No jail time for rule violators due to simple negligence. The Regulations are voluminous, and expansive. Eventually, someone will inadvertently break one of the many rules. These people should not be prosecuted. It is wrong, and Arizonans cannot afford to waste money punishing them through criminal prosecution and housing them in our state penal system. 2. The requirement of R9-17-202 5e. seems wholly unnecessary. If someone learns they have terminal cancer or full-blown AIDS, what good does it do to force them wait 1 year to receive medical marijuana? What if this person also lacks insurance and a primary care physician. A doctor's conclusion that a debilitating condition exists, such as from a blood test or CT scan, should be enough. See suggested language at 1. below.

In the Inititive, Page 7, 36-2803 Rulemaking When I read this again, it seems that people who Donate to the Cause will have more influence on this Department and that the fees should be sufficient. I thought Arizona voters voted for this to pass because in California it produced Huge Tax Benefits for the State. I know that is certainly why I voted for it. Medical Marijuana Dispensaries should not be Tax Excempt. I thought this period of 120 days was to make Rules.

[redacted] COMMENTS ON INITIAL DRAFT RULES ARIZONA MEDICAL MARIJUANA INITIATIVE January 7, 2011 I. ABOUT [redacted] 1. [redacted] is a coalition of over one thousand Yavapai County citizens dedicated to eliminating substance abuse and its effects in Yavapai County. Since its founding in 2006, [redacted] has played a major role in reducing the use of methamphetamine and other recreational drugs in Yavapai County, particularly among teenagers. [redacted] efforts have also led to a significant reduction in drug related crime in Yavapai County. In 2009, [redacted] was awarded the national â€œGot Outcomes

Coalition of Excellence Awardâ€ award by CADCA. II. GUIDING POLICIES 1. Cultivation, sale, transportation, possession and use of marijuana are criminal offenses in the state of Arizona. Medical marijuana is a narrow exception to that policy. It is the policy of the State of Arizona that marijuana production, possession, use, sale or transportation are all felony offenses. Through the initiative process the people of Arizona have carved out a narrow exception to the criminalization of marijuana. The initiative allows those individuals that have a bona-fide medical need for marijuana use to acquire, possess, and use marijuana to treat symptoms associated with a narrow range of medical conditions. However, the guiding policy of this state â€“ and the federal government â€“ is that it remains a crime to produce, use, sell or transport marijuana in Arizona. In other states such as California and Colorado, insufficient regulation and enforcement has allowed the â€œexceptionâ€ of medical marijuana to swallow the â€œruleâ€ of marijuana criminalization. This must not be allowed to happen in Arizona. In order to enforce Arizonaâ€™s strong policy of marijuana criminalization, policies and procedures developed by DHS and the legislature under the medical use exception should, to the greatest extent possible, control marijuana production, transportation, sale, possession and use to insure that marijuana is allowed for medical purposes only. Medical marijuana should not be allowed to become a source of illicit marijuana; production should be limited to only what is necessary to supply legitimate demand and should be strictly tracked; medical need should be based on medical facts subject to objective review; employers should not be forced to tolerate impaired employees or protect employees that are in violation of federal law. To these ends we suggest the following: III. DISPENSARIES 1. DHS must require geographic dispersion of dispensaries. Rationale: The initiative allows individuals and caregivers to produce their own marijuana if they live more than 25 miles from a licensed dispensary (the 25 mile circle surrounding a dispensary have been called â€œhalos.â€) Individual production of marijuana is far more difficult to monitor and control than production by dispensaries. This marijuana can easily be converted to illicit use and the production location will attract criminal activity as well. Lawful marijuana production for medical purposes by individuals should be eliminated to the greatest extent possible. DHS should adopt policies that mandate dispensary locations that cover the state in dispensary â€œhalosâ€ that have the effect of preventing individual marijuana production. DHS should have the ability to consider in its sole discretion whether or not the geographic location of a proposed dispensary is appropriate. DHS regulations should allow DHS to award exclusive dispensary rights to geographic areas. DHS regulations should allow DHS to mandate that an applicant, as a condition of granting a dispensary certificate, also apply for and obtain a dispensary certificate at another location in the state designated by DHS. In short, DHS policies must insure that most if not all of the state is covered with dispensary â€œhalosâ€ so that no individual will be permitted to produce their own marijuana. This may be best accomplished by requiring dispensaries in urban areas to operate dispensaries in rural locations as a condition of their dispensary licenses. Implementation: Substitute for R9-17-107(F) as follows: â€œThe Department may in its sole discretion consider the geographic location of the proposed dispensary in determining whether to grant a certificate. In its sole discretion, the Department may grant exclusive dispensary certification to any geographic area of the State. The Department may as a condition of granting a certificate pursuant to A.R.S. Title 36 Chapter 28.1 and this Chapter, require the applicant for dispensary registration to apply for, obtain, and maintain another dispensary within the state of Arizona within 2 miles from a location designated by the Department.â€ DISPENSARIES, CONT. 2. Each location where marijuana is produced, infused or sold must have a separate dispensary certification. Rationale: The Rules as currently written would double and possibly triple the number of dispensaries within the state. The Rules as written allow a dispensary to both have a separate location for cultivation and a separate location for infusion. A.R.S.Â§36-2801 defines â€œNonprofit medical marijuana dispensaryâ€ as an entity that

acquires, possesses, cultivates, manufactures, delivers, transports supplies, sells or dispenses marijuana . . .â€. A.R.S. Â§36-2804(C) limits the number of dispensary certificates to approximately 124. A.R.S. Â§36-2806(C) requires each certified nonprofit marijuana dispensary to have a single secure entrance. If the holder of a single dispensary certificate is allowed to have multiple locations for sale or cultivation, or to contract with others to infuse food, it would be physically impossible for the dispensary certificate holder to comply with A.R.S.Â§36-2806(C). Thus, when these sections are read together, it is clear the intent of the initiative is to require each physical location where marijuana is produced, infused or sold have a separate dispensary certificate that counts toward the total allowed in the state under A.R.S.Â§36-2804(C). This rationale also comports with the overall goal of maintaining tight control over medical marijuana use so it cannot be diverted to illicit use. Implementation: (a) Modify R9-17-302(B)(5) by striking â€œand, if applicable, as the dispensaryâ€™s cultivation site.â€ (b) Modify R9-17-304 to strike all references to a Dispensaryâ€™s Cultivation Site. (c) Modify R9-17-306 to strike all references to a dispensaryâ€™s cultivation site. (d) Modify R9-17-307 to clarify that cultivation sites require separate dispensary certification. (e) Modify R9-17-313(B)(5) and (6) to clarify that food infusion sites require separate dispensary certification. (f) Modify R9-17-315 to clarify that cultivation and infusion sites require separate dispensary certification. (g) Modify R9-17-316 to clarify that infusion sites require separate dispensary certification. (h) Strike R9-17-101(6) DISPENSARIES, CONT. 3. DHS may delegate inspection of dispensaries to local authorities. Rationale: Pursuant to A.R.S. Â§36-136, DHS may delegate to local authorities their power to regulate matters of health and welfare in the state. Nothing in the initiative forbids delegation of inspection authority to local governments. The ability to delegate this authority will allow DHS to better effectuate control of dispensaries, and will give local authorities the ability to better control the health and safety impacts of dispensaries in their communities. Implementation: Add R9-17-306(H): â€œThe Department may delegate its authority under this section to local authority pursuant to A.R.S. Â§36-136.â€ DISPENSARIES, CONT. 4. Reasonable notice of routine inspections should be 24 hours, and occur within posted business hours. Rationale: Inspection of dispensaries is designed to insure that the dispensary is operating within the limits of the law. The rule as currently written gives the dispensary the option of refusing a time suggested by DHS. The initiative requires only that the inspection be reasonable. Given the strong policy of this state against marijuana possession or use, it is imperative that DHS inspections provide an accurate picture of the dispensaryâ€™s operation. 24 hour notice of an inspection to occur during posted business hours fulfills the statewide policy against illicit marijuana use and fulfills the â€œreasonable noticeâ€ provision of the initiative. Implementation: Modify R9-17-306(C) as follows: â€œExcept as provided in subsection (E), routine on-site inspection of a dispensary shall occur no earlier than 24 hours after the Department submits written notice of the Departmentâ€™s intent to inspect the dispensary. Routine inspections under this subsection shall occur during the dispensaryâ€™s normal business hoursâ€ DISPENSARIES, CONT. 5. Dispensaries must dispense marijuana and marijuana infused products in DHS approved and supplied containers. Rationale: In order to strictly control medical marijuana, it is important that DHS and law enforcement be able to clearly and easily distinguish between marijuana possessed, sold, or transported pursuant to the initiative. The containers must be distinctive and traceable with bar codes or other computerized tracking system. Distinctive containers that are registered or supplied by DHS that can be easily identified will help DHS and law enforcement insure that marijuana encountered is in fact produced pursuant to the initiative and is used strictly for medical use. The containers should be sealed when dispensed. DHS should strongly consider developing standardized containers and requiring dispensaries to obtain those containers from DHS. Implementation: Add to R9-17-314(A)(7): â€œThe marijuana shall be dispensed in a sealed container approved by the

Department. The containers shall contain a bar code or other computerized tracking system approved by the Department.â€ DISPENSARIES, CONT. 6. Dispensaries may not dispense a smokeable form of marijuana unless the qualifying patient is approved by DHS to receive it. Rationale: Based on the proven health risk of smoking, for the past 45 years the medical community has worked to curtail the use of smoking in the United States. In November, 2006 Arizona voters passed the Smoke-Free Arizona Act (A.R.S. Â§36-601.01), severely curtailing the use of smoking in the state. For most people, marijuanaâ€™s alleged therapeutic benefits are effective when it is consumed orally. Given the serious negative health effects that come with smoking any product (including marijuana), the smoking of marijuana should be strongly discouraged. Implementation: Modify R9-17-311 to require the dispensary verify the patient is authorized to receive marijuana in a smokable form prior to dispensing. Include the requirement that all smokeable marijuana must be dispensed in a container that prominently displays a warning in substantially the following form: â€œMarijuana smoke contains known carcinogens and has been determined to be carcinogenic by the Arizona Department of Health Services. Although preliminary research shows marijuana may contain substances that may help in the treatment of cancer, this research also shows that smoking marijuana may be linked to cancer of the lung, skin of the head and neck, testicle and bladder.â€ DISPENSARIES, CONT. 7. Dispensaries should be required to file public reports providing information on the number of customers, marijuana sales volume, and financial status of the dispensary. Rationale: In order to insure that dispensaries are not operating illicitly, it is important that the legislature, DHS, local authorities, and the public have information regarding a dispensaryâ€™s number of customers, volume of marijuana, and financial condition. A dispensary need not reveal specific information about individual customers in order to publish public reports regarding the number of customers, the volume of marijuana dispensed, the kind of marijuana dispensed (smokeable or infused food), the receipts of sales and costs expended. This information will allow the legislature, DHS, local law enforcement and the public to insure that the dispensary is not in reality a â€œfrontâ€ for criminal activity, and that the marijuana produced and dispensed only to those with legitimate medical need. Implementation: Add as R9-17-312(E): â€œNot less than annually and prior to recertification under R9-17-305, a dispensary shall submit to the Department a report covering the period from the last certificate was issued to that dispensary that contains the following information: (1) the total number of sales of marijuana products, detailing each kind of product sold; (2) the total amount of usable marijuana sold; (3) the total amount of usable marijuana produced or otherwise procured; (4) the total amount of marijuana on hand; (5) the total amount of cash or other reimbursement realized for the sale of marijuana; (6) the total amount of cash or other reimbursements paid for producing or acquiring marijuana.â€ IV. PATIENTS, CAREGIVERS AND DISPENSARY AGENTS 1. Caregivers must pay a separate fee for each patient they care for. Rationale: Caregivers may possess and assist in the use of marijuana for up to 5 qualifying patients under the act. Each patient that designates a caregiver requires additional administrative scrutiny by DHS, increasing administrative costs. A.R.S. Â§36-2803(A)(5)(a) requires that the total revenue from the fees for registry identification cards and dispensary registration certificates must be sufficient to implement and administer the program. Given the additional administrative costs inherent in a caregiver assisting multiple patients, and to insure that caregiver activity is adequately monitored, it is reasonable that a caregiver be required to pay additional fees for additional patients. Implementation: Modify R9-17-102(5)(b) and (6)(b) as follows: â€œDesignated Caregiver, $200 per patient for which caregiving services are provided.â€ PATIENTS, CAREGIVERS AND DISPENSARY AGENTS, CONT. 2. Caregivers must undergo training (at least 8 hours) on, and pass a test on, the effect and hazards of marijuana, the terms of the initiative, and DHS rules governing medical marijuana. Rationale: Caregivers under the initiative administer marijuana to qualifying patients.

They are the link between the patient and the dispensary, and need to know the effects and alternatives to marijuana to properly administer medical marijuana. Without adequate training, the caregiver runs the risk of improperly procuring or administering marijuana to the patient. Implementation: (a) Add R9-17-202(F)(6)(l): â€œCertification of completion of a Caregiver Training Class administered or approved by the Department.â€ (b) Add R9-17-206: â€œThe Department shall develop a Caregiver Training Class of no less than 8 hours to teach caregiver applicants about the effects and hazards of marijuana, alternatives to marijuana use, the terms of the Arizona Medical Marijuana Initiative, and these rules. The class shall include a test designed to reasonably test caregivers about the subjects taught in the class. Before issuing a certificate of completion to caregiver applicants, the applicant shall pass the test with a score of at least 80%.â€ PATIENTS, CAREGIVERS AND DISPENSARY AGENTS, CONT. 3. Caregivers, Cardholders and Dispensary Agents must be residents of Arizona and must possess an Arizona driverâ€™s license or identification card. Rationale: The initiative declares that its purpose is to remove state-level criminal penalties for medical marijuana use for the citizens of Arizona. Other states such as California and Colorado have allowed non-citizens to participate in medical marijuana programs, which resulted in a tremendous increase of illicit use of marijuana due to cross-border smuggling of marijuana. The use or administration of marijuana under the initiative should be narrowly tailored for the use and benefit of Arizona citizens that are in need of medical marijuana. Patients, Caregivers, and Dispensing Agents should be required to prove they are citizens of the State of Arizona by producing identification cards issued only to Arizona citizens â€“ an Arizona Driverâ€™s License, or an Arizona Identification Card. The current draft of rules allows a patient or caregiver to obtain a registry card by showing a U.S. passport as proof of identity. A U.S. passport contains no information about the personâ€™s state of residency. In addition, because of the potential for criminal activity inherent in a personâ€™s possession of marijuana, registry with the Department of Public Safetyâ€™s driverâ€™s license/identification card system will allow law enforcement to obtain additional information about a caregiver/patient that is involved with criminal activity. Implementation: (a) Strike R9-17-105(F) (b) Strike R9-17-107(F)(1)(d)(iv) (c) Strike R9-17-202(F)(2)(d) (d) Strike R9-17-202(F)(6)(i)(iv) (e) Strike R9-17-202(G)(6)(d) (f) Strike R9-17-203(A)(2)(i)(c) (g) Strike R9-17-204(A)(5)(f)(iv) (h) Strike R9-17-308(5)(d) PATIENTS, CAREGIVERS AND DISPENSARY AGENTS, CONT. 4. Caregivers must be subject to the same security, inspection and reporting requirements as dispensaries. Rationale: Caregivers are operating small dispensaries. They acquire marijuana in the same fashion as dispensaries, and distribute the marijuana to others. They are subject to the same security risks as dispensaries, and have the same potential for diverting marijuana to illicit activities as dispensaries. Implementation: Apply appropriate provisions of Article 3 (R9-17-301 to R9-17-320) to caregivers allowed to cultivate marijuana for patients. PATIENTS, CAREGIVERS AND DISPENSARY AGENTS, CONT. 5. Patients, or caregivers acting on behalf of patients, may not possess smokeable marijuana unless specifically authorized by DHS. Rationale: Based on the proven health risk of smoking, for the past 45 years the medical community has worked to curtail the use of smoking in the United States. In November, 2006 Arizona voters passed the Smoke-Free Arizona Act (A.R.S. Â§36-601.01), severely curtailing smoking in the state. For most people, marijuanaâ€™s alleged therapeutic benefits are effective when it is consumed orally. Given the serious negative health effects that come with smoking any product (including marijuana), the smoking of marijuana should be strongly discouraged. Implementation: (a) Add to R9-17-202(F)(5) the following: â€œIf the physician is recommending the patient be dispensed a smokeable form of marijuana, then a statement detailing the at least 3 efforts of the physician and patient to administer infused marijuana, a statement detailing why such attempts were unsuccessful, and a declaration from the physician why only smokeable marijuana will alleviate the patientâ€™s condition.â€ (b) Add to R9-17-202(G)(13) the following: â€œIf the

physician is recommending the patient be dispensed a smokeable form of marijuana, then a statement detailing the at least 3 efforts of the physician and patient to administer infused marijuana, a statement detailing why such attempts were unsuccessful, and a declaration from the physician why only smokeable marijuana will alleviate the patientâ€™s condition.â€ (c) Add to R9-17-204(B)(4)(f) and R9-17-204(B)(4)(g) the following: â€œIf the physician is recommending the patient be dispensed a smokeable form of marijuana, then a statement detailing the at least 3 efforts of the physician and patient to administer infused marijuana, a statement detailing why such attempts were unsuccessful, and a declaration from the physician why only smokeable marijuana will alleviate the patientâ€™s condition.â€ (c) Issue patient and caregiver cards that clearly indicate if the patient is allowed to possess smokeable marijuana. (d) Indicate in the Department data base available to dispensaries and law enforcement whether the patient or caregiver is allowed to possess smokeable marijuana. PATIENTS, CAREGIVERS AND DISPENSARY AGENTS, CONT. 6. Private marijuana use â€œclubsâ€ should be prohibited. Rationale: As written, Rule R9-17-101(18) (a) would exclude private clubs from the definition of public place. This would allow marijuana users to form private â€œsmokingâ€ clubs where marijuana users could gather and use marijuana. The goal of the initiative is to provide medical marijuana that qualifying patients and their caregivers may administer for medical purposes, not to establish private marijuana use clubs. Private â€œsmoking clubsâ€ create opportunities to divert medical marijuana to illicit use, and pose a safety and security threat to the communities in which they are located. Implementation: Modify R9-17-101(18)(a) to read as follows: â€œ[Public place:] Means any location, facility, or venue that is not intended for the regular exclusive use of an individual or the non-commercial use of a specific group of not more than 5 individuals.â€ PATIENTS, CAREGIVERS AND DISPENSARY AGENTS, CONT. 7. The Rules and statute should clearly state that the use of medical marijuana by Visiting Qualifying Patients should be limited to only those conditions and circumstances allowed to Patients under Arizona law. Rationale: With the exception of obtaining marijuana from a dispensary, A.R.S. Â§36-2804.03(C) limits the rights of a Visiting Qualifying Patient to the rights of a registration card holder in Arizona. Thus this section limits the medical conditions that qualify a Visiting Qualifying Patient for the protections of the initiative to those conditions that qualify an Arizona patient for a registration card. The Visiting Qualifying Patient should be required by statute to provide proof that they medically qualify for a registration card under Arizona law. A Visiting Qualifying Patientâ€™s is also limited to cultivation of marijuana by those that are residents of Arizona for less than 30 days and that reside outside of the 25 mile dispensary limit, and only for the 30 day limit. A Visiting Qualifying Patients that does not reside in Arizona is not allowed to cultivate marijuana, because they do not have a residence in the state (see Patients, Caregivers and Dispensary Agents #3, above). Statutory changes should make this clear. Implementation: DHS should propose legislation that requires a Visiting Qualifying Patient to prove they have a Debilitating Medical Condition as defined by A.R.S. Â§36-2801(3) before they are given the same protection as a registry card issued by DHS. The legislation should also clarify that cultivation of marijuana by a Visiting Qualifying Patient is a criminal offense. V. MEDICAL PROFESSIONALS 1. Policy Statement Three different types of medical professionals are authorized to provide certification for medical marijuana use under the initiative. All are governed by a different licensing board, and none of the licensing boards actively govern their respective charges with regard to medical marijuana. Unless DHS monitors the activities of these medical professionals, there is no central authority to monitor and govern the actions of medical professionals authorized to certify medical marijuana use under the initiative. Under the initiative, DHS is charged with regulating possession and use of medical marijuana. DHS thus has the authority to qualify medical professionals designated under the act as appropriate to issue certification for medical marijuana use. Such a system would ensure a centralized authority to monitor medical professionals for abusive or illicit

issuance of certifications, preventing fraud and abuse. MEDICAL PROFESSIONALS, CONT. 2. Medical professionals that wish to issue medical marijuana certificates must be registered with DHS in order to issue certifications and a reasonable fee should be charged. Rationale: Registration with DHS would allow the Department to determine the qualifications of medical professionals that wish to certify medical marijuana use. DHS can examine proof of the medical professionalâ€™s certification as a medical doctor, osteopath, or naturopath, and of their primary practice in Arizona. DHS can determine if the medical professional is currently undergoing discipline or substance abuse counseling. DHS can determine the number of patients the medical professional has certified for marijuana use, and can monitor the number and quality of contacts between the patient and the medical professional. DHS can monitor the number and justification for certifications of smokeable medical marijuana use. Implementation: Create Article 4 for the Medical Marijuana Program in DHS Rules that governs medical professionals wishing to issue medical marijuana certifications in Arizona. Medical professionals must meet the following requirements: (a) DHS must create and administer a medical professional certification registry. (b) Qualified medical professionals that wish to issue certificates under the initiative must register annual with DHS and pay a reasonable annual fee to offset the cost of registry administration. (a) Medical professionals must be Arizona licensed in and primarily practice in Arizona. (b) No more than 30 active patient registry cards may be issued based on the certification of an individual medical professional at any one time. (c) Medical professionals must see their certified patient at least once every 6 months, face to face, and document they have done so in annual certifications. (d) Medical professionals may not issue certificates to themselves or immediate family. (e) Medical professionals undergoing discipline or substance abuse problems must not be authorized to certifications. (f) Medical professionals recommending the patient be dispensed a smokeable form of marijuana, must provide a statement detailing the at least 3 efforts of the medical professional and patient to administer infused marijuana, a statement detailing why such attempts were unsuccessful, and a declaration from the medical professional why only smokeable marijuana will alleviate the patientâ€™s condition. MEDICAL PROFESSIONALS, CONT. 3. The medical professional issuing the certification should be given the authority to revoke a patientâ€™s certification at any time. In addition, the medical professional should be required to revoke if they havenâ€™t seen the patient within 6 months. Rationale: Medical marijuana is the narrow exception to the criminalization of marijuana in Arizona. In addition to rules requiring previous and ongoing relationship between a certifying medical professional and a patient, the medical professional must be able to de-certify a patient if they believe the patient no longer qualifies for medical marijuana. In addition, the medical professional must de-certify the patient if they have not seen the patient within 6 months. Once de-certified, the patient must be presumed to no longer qualify for medical marijuana unless re-certified by two different medical professionals that are aware of the previous de-certification. This would insure that patients are seeing their medical professionals on a regular basis, and insure that medical marijuana is continued to be needed by the patient. It would also encourage medical professionals to act ethically in certifying, and prevent â€œdoctor shopping.â€ If certification is revoked, the patient must present certifications from two other medical professionals, both of whom state they are aware of the patientâ€™s certification revocation, before a new registry card may be issued. Implementation: (a) Add to new Article 4 a requirement that the medical professional must notify the Department within 3 business days if the patient no longer qualifies for certification for medical marijuana, or if the medical professional has not had a face to face contact with the patient for more than 180 days. (b) Add R9-17-205(I) to require the Department to revoke a Qualifying Patientâ€™s Registry Identification Card upon notification by the certifying medical professional that the patient no longer qualifies for certification or that the medical professional has not had a face to face contact with the

patient for more than 180 days. (c) Add to R9-17-202, 203, and 204 a section that requires certification from two medical professionals for any person applying for a registry identification card after having had a previous one revoked under R9-17-205(I), and require both certifications state that the medical professional is aware of the grounds for prior de-certification. VI. LEGISLATIVE ACTION 1. The legislature should set a presumptive THC metabolite level for impairment (similar to presumptive blood alcohol level) effective in situations of driving, machinery operation and employment Rationale: The initiative authorizes the use of marijuana for medical purposes, but does not allow a user to be impaired while employed or operating automobiles or other machinery. Use of marijuana impairs a personâ€™s ability to operate automobiles and other machinery, and to properly perform their job. Impairment is difficult to determine without presumptive standards. Marijuana impairment can be compared to use of alcohol, which is legal but impairment is not allowed when a person is operating automobiles or other machinery or by most employers. Levels of presumptive alcohol impairment are codified in law so employers and law enforcement may more easily determine if a person is impaired. Scientific tests are available to determine the level of Tetrahydrocannabinol (THC) the active ingredient in marijuana, and standards exist that prove a person is impaired at blood levels of THC of 2.0 nanograms per milliliter (ng/ml) or greater. Presumptive levels of marijuana impairment for both employment and operation of automobiles and other machinery must be adopted by the legislature in order to allow employers and law enforcement to quickly and easily determine if probable cause exists that a person is impaired, and to take appropriate action to protect the person, the employer, and the public. Implementation: DHS must propose legislation that sets a presumptive level of marijuana impairment at a concentration of 2.0 ng/ml of blood THC for purposes of operating automobiles or other machinery, and for purposes of employment. LEGISLATIVE ACTION, CONT. 2. The legislature should set enhanced penalties for cardholders, caregivers, and dispensary agents that produce, transport, sell, or possess marijuana outside of the terms of their authority granted by the initiative. Rationale: Arizona has a strong public policy against marijuana. The initiative has carved out a narrow exception to that policy for medical use. To uphold Arizonaâ€™s prohibition against marijuana, it is imperative that those individuals granted access to marijuana through the initiative be strongly discouraged from using their access to marijuana to add to the supply of illicit marijuana in the state, or to supply it to those without authorization to possess marijuana. One of the best ways this may be accomplished is for the legislature to specify and clarify what constitutes illegal marijuana activity by dispensaries, cardholders and caregivers, and to enhance the punishments for those offenses. Such legislation will discourage dispensaries, cardholders and caregivers from using their access to marijuana for illicit purposes. Offenses should include cultivation without permission, transfer of marijuana to those not entitled to possession, consuming, transporting, selling, cultivating marijuana without the appropriate registry card in immediate possession. Implementation: DHS, working with state and law enforcement officials, should draft and propose legislation that

working with state and law enforcement officials

To help keep the cost of cultivating Medical Marijuana low, Dispensories should be able to grow their crop outside in an enclosed structure so that natural light can be used instead of grow lights. that will reduce the cost to produce the medicinal marijuana. This will help keep the Medical Marijuana available to low income patients.

R9-17-107 When the Dept of Health provides a list of deficiencies, does that mean they are on to receive a License if they comply within the 60 days? There is quite a bit of expense going in and there has to be a better way to determine if any one stands a chance beside those associated with AZ Medical Marijuana Policy Project. The AZ Corporation Commissioner has people filing for 40 to 60 Trade Names. While those Trade Names are just that, it seems that deep pockets are wanting to Monopolize this covetted License.

Draft Rule R9-17-311 should be expanded to include a requirement that when verifying the qualifying patient's identity, dispensaries must employ a biometric identity verification system, such as a thumb print scan. DHS is mandated by the Initiative to ensure that dispensaries are only releasing medical marijuana to qualifying patients who hold a validly issued registration card. If DHS required biometric verification in the rules, it would ensure that counterfeiting, identity theft, or other forgeries resulting in medical marijuana falling into the wrong hands would be prevented. This requirement will have the best chance of preventing the type of abuse we see, for example, with underage persons purchasing alcohol using fake identification. By requiring biometric identity verification, it would be nearly impossible for a dispensary employee to dispense marijuana illegally. While it is certainly expected that dispensaries will self-police their agents, under the current Rules it would be very easy for a disreputable agent to collude with a non-patient to dispense MM under somebody else's registry number. In this scenario it would be extremely difficult for a dispensary owner to discover illegal transactions as the record would appear legitimate. However if that transaction must be accompanied by a cardholder's thumbprint illegal transactions would be impossible. The proposed rules require a dispensary agent to verify information from the State's medical marijuana electronic verification system and enter additional information into the system relating to the transaction. The technology is available to allow this process to be automated so that the dispensary computer directly communicates with the medical marijuana electronic verification system without a human user being required to enter the information. This automatic communication from computer-to-computer would reduce the chances of human error while reviewing or inputting information, and thus better prevent fraud and improper dispensing of medical marijuana. It would also mean that human users could not alter or enter fraudulent information, again reducing the chances for fraud or abuse of the medical marijuana system. The rules should explicitly allow such electronic transactions by making the existing R9-17-311 part A and adding as part B:

Remove duplication, example, when reapplying, I don't see the need to resubmit finger print information. What if a person does not have email - a lot homeless people probably do not have email. I think some of the fees are way out of line, especially the application fees and some should be waved for individuals with low income. Why have a separate Medical Marijuana Card, can access to medical marijuana be linked to the state ID or Drivers License. Show your AZ drivers license/ ID and the dispensary can look up the ID number and verify eligibility. Standard forms should be made so so to be consistence for each request This would also make the review process more streamed lined. the one year doctor/patient relationship is too long

costs to the patients required 4 visits Doctor or medical person on staff Most sick patients cannot work and have little money to buy food

They are defining the work day as Monday â€“ Friday 8 to 5. What about employers who have shift hours? There are no rules about people working in safety sensitive positions. Shouldnâ€™t there be

a minimum requirement that employees must not use medical marijuana at least _____ number of hours prior to working in a safety sensitive position? Bus drivers? Pilots? Forklift Operators? Machine Operators? Teachers? What about guidance on pre-employment and/or for cause drug screens that are positive? If there is a zero-tolerance workplace, how is this impacted? The law allows for termination for on the job use, but it seems that this is open to interpretation, e.g., law suits for wrongful termination. If a person who is in an accident in a company vehicle or on company property, what is the employerâ€™s liability? What is the standard to being â€œunder the influenceâ€ of marijuana? It doesnâ€™t exist as it does for alcohol. How must employer drug testing programs be revised to accommodate the law? The discrimination rule also has an exception. Because marijuana is illegal under federal law, this gives companies with federal contracts an "out," allowing them to avoid employing medical-marijuana users so they don't risk losing contracts or funding.
1. I was informed today by my Physician, one of many in a multi location health practice in the Phoenix metro area, that the Practice will not be prescribing medical marijuana and would not even offer a referral. I'm pretty sure that this may not be the only practice doing so. Now I must find a new physician for prescribing and this could cause unnecessary delay (searching for a physician and transferring medical records) in my receiving medication. In addition, I'm not sure i want to sever the relationship with my current physician just because he isn't prescribing. Is there a way to clarify how two physicians can be treating the same illness? Is there a way to have a directory available to the citizens of Arizona in April of prescribing physicians? 2. There are many people of limited financial means that would find the $150.00 registry identification card fee a hardship. A sliding scale fee would be better.
The Draft can require that the Medical Marijuana pay Taxes. The inititive states that they are tax exempt.
The definition of â€˜Medical Directorâ€™ should include Naturopathic Physicians, as defined in A.R.S. Title 32, Chapter 14. Naturopathic Doctors are licensed primary care physicians. They have pharmaceutical prescription privileges, and are covered by many insurances here in Arizona. These doctors specialize in managing pain through other means than just narcotics. I believe that they would be valuable people to be involved in the process of managing patients.
The draft rules state that the facility must be ready for inspection. This is a reasonable request in regards to cleanliness, prep area, bathroom facilities, and overall environment knowledge. It should not be required to have all security tools implemented i.e.: alarms, cameras, etc. Why would a business owner want to spend thousands of dollars on a security system if they do not receive the dispensary license? If a dispensary applicant is not awarded the license, they don't need that serious of a security system if they proceed to open a boutique or real estate office. Are they supposed to take down all the equipment and try to get a refund of those thousands of dollars?
The biggest problem with the way the rules have been proposed relates to the requirement that applicants have a leased space in place before the applicant even knows if they will get a dispensary license. This would create a very large upfront expense to a dispensary applicant without them knowing if they are going to be approved for a license. The suggestion would be to have the applicants evaluated on their business plan and financials and a clear background check. Once the 124 licenses have been granted, then the licensees would go to the various cities to secure a location

that fits both the city's and the state's requirements. There also needs to be clarification on how the dispensaries and the the growers are licensed/affiliated. It would make more sense for the growers to have their own license with a requirement that they have a contract to supply one or more licensed dispensaries. To require each dispensary to have their own grow makes it much more difficult to make this industry work, and creates more grow sites than necessary. One grower should be able to contract with several dispensaries to supply them product. The dispensary owner should not be held responsible for the actions of the growers.

The draft rules state that the facility must be ready for inspection. This is a reasonable request in regards to cleanliness, prep area, bathroom facilities, and overall environment knowledge. It should not be required to have all security tools implemented i.e.: alarms, cameras, etc. Why would a business owner want to spend thousands of dollars on a security system if they do not receive the dispensary license? If a dispensary applicant is not awarded the license, they don't need that serious of a security system if they proceed to open a boutique or real estate office. Are they supposed to take down all the equipment and try to get a refund of those thousands of dollars?

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There should be language incorporated into the rules tht state the same person or group of people should not be permitted to operate more than one dispensary. The language needs to state that these rules are drafted for the benefit of Arizona residents and that the State Department is doing all they can to insure fairness in teh selection.

As a [redacted] I'm concerned over language that would require marijuana-infused foods to be processed in County-licensed food establishments. As a non-approved food ingredient (with pharmacological properties) it would be handled in the same kitchen as deli sandwiches, etc. ... this would be akin to handling prescription or OTC meds around other customers' foods (in the Food Code, that can lead to a cited critical violation). Also, I do not see how a County could issue a license/permit to a dispensary that chooses to infuse and make its own food products, yet will be exempt from the County's "regulatory oversight". How can we work with local Planning&Building to determine the suitability of the dispensary food preparation area if we have no authority (entreprenuers would balk at putting in a three-compartment sink, for example, and challenge any requirements due to our lack of regulatory oversight)? And once a license/permit is issued, on what do we base renewal or revocation?

Rewrite the rules to allow engineers and architects to design buildings that are reasonably secure and that will function as their intended purpose as a dispensary or cultivation facility respectively.

There are a few provisions in the first working draft of the rules that I believe might be improved through revision. I recommend to you the following additions and modifications: 1. Medical Director and Certifying Physician â€“ The definition of â€œMedical directorâ€ in R9-17-101(15) and

the remainder of the rules do not appear to require that the medical director or certifying physician be in good standing with Medicare or be free from any restrictions on their licensure. Such a requirement should be inserted, perhaps in the definitions within R9-17-101. 2. Denial or Revocation of Card â€“ R9-17-205(C)(2) provides that the Department may deny a patient card or decline renewal of a patient card if the patient or designated caregiver provides false or misleading information to the Department. The Department also should have the discretion to deny issuance or renewal of a card if the patient or designated caregiver has provided false or misleading information on an application in any other state. 3. Dispensary agents â€“ There does not appear to be any prohibition against employing as dispensary agents or having board members whose privileges have been revoked for some reason other than having been employed by a dispensary that had its certification revoked. Such a restriction should be inserted, perhaps in R9-17-301 or R9-17-302. 4. â€œPrincipal officer or board memberâ€ â€“ The term â€œprincipal officer or board memberâ€ is used repeatedly. See, e.g., R9-17-302(A); R9-17-302(B)(1)(f); etc. This term should be defined in R9-17-101 or should be replaced with a broader and more inclusive term. As it is now used, it appears to exclude member or associates of less formally-structured legal entities and is not clarified by R9-17-301. It could be argued that the rules, as drafted, do not require individuals who are not â€œprincipal officers or board membersâ€ of their respective organizations to comply with the dispensary rules, including the prohibition against some felons. 5. GAAP â€“ R9-17-302(B)(4) lists four areas in which policies and procedures must be adopted and implemented by dispensaries; a fifth should be added for maintaining and keeping financial transaction and accounting records according to generally accepted accounting principles (GAAP), and there should be an audit requirement regarding the financial statements, as there is regarding the inventory. 6. Local Zoning Compliance Certification â€“ An applicant for a dispensary registration certificate should be required to certify that not only the dispensary, but also any off-site cultivation location associated with the dispensary, is in compliance with local zoning restrictions. In addition, the applicant for a dispensary registration certificate should be required to send the local jurisdictionâ€™s chief zoning official a copy of the R9-17-302(B)(6) certification swearing that the dispensary would be in compliance with local zoning restrictions. The reason for the copy to the local jurisdiction is to ensure that it receives timely notice enabling it to verify the accuracy of the certification. Similarly an applicant for renewal of such certification should face the same requirements - namely the requirement to submit a certification that it remains in compliance with local zoning restrictions and the requirement to send a copy to the local jurisdiction. This could be inserted into R9-17-305. 7. Corrective Actions â€“ There is mention in R9-17-306(F) of â€œcorrective actionsâ€ being undertaken to remedy violations discovered during inspections of dispensaries or cultivation sites; however, there is no follow-up or approval mechanism set forth as is the case with other regulated health entities and food establishments. Such a mechanism should be established in the rules. 8. Inventory Control System - The provision for auditing a dispensaryâ€™s inventory according to generally accepted accounting principles (GAAP) every 30 days is curious. Typically, pharmacies do not use GAAP for inventory purposes, and there are heavy penalties for keeping inaccurate records. So, it is unclear why ADHS would require that methodology here. Moreover, GAAP prescribes financial accounting principles; whereas, there are different standards for audits, such as generally accepted auditing standards (GAAS). Regular inventory reporting is extremely important, and the 30-day requirement is excellent. This comment is simply intended to suggest re-consideration of the specific wording in R9-17-313(C). 9. Testing Marijuana Samples â€“ R9-17-314 allows ADHS to obtain samples of marijuana for testing. ADHS should retain the ability to sample marijuana but should add a requirement for regular testing to be imposed upon the dispensaries and cultivation operations. They should be required to obtain regular lab testing of their inventory for quality and safety, and this should be at their expense. ADHS should retain the authority

to determine which labs are acceptable for this testing. A list of â€œapprovedâ€ labs perhaps could be issued by ADHS. Dispensaries should be required to submit the lab testing results to ADHS. 10. Product Labeling and Analysis â€“ There is no requirement in the draft rules that the marijuana at the dispensaries be organized, displayed, labeled or advertised according to the medical condition it is designed to treat, the particular effect it is intended to produce, or the strain or potency of the specific marijuana plant or product. New Mexico requires marijuana products to be labeled as to strain and potency. ADHS should do the same in its rules. It could be inserted in R9-17-314. There also should be a prohibition on the use in or on marijuana of any chemicals prohibited by law from being used in or on tobacco and cigarettes. 11. Security and Transportation â€“ Delivery of marijuana to the patient by someone other than a caregiver would be permissible under R9-17-315 as it is currently drafted. This presents a security and public safety concern. It should be prohibited by ADHS rules, as has been the case under local zoning ordinances in Pima County. It is important to expressly prohibit the delivery of marijuana by anyone under the age of 18 so that dispensaries do not hire juveniles as delivery persons. 12. Food Establishments â€“ The â€œfood establishment contracted with the dispensary to prepare edible food products infused with medical marijuanaâ€ that appears in R9-17-315(B)(4) and R9-17-316 seems to open the control system to abuse. While it has food safety benefits, it does not appear to require any kind of control over the marijuana while it is at the â€œfood establishmentâ€ or provide any qualifications for â€œfood establishmentâ€ employees who handle the marijuana. It appears to permit a person handling marijuana at a bakery to be someone who would be prohibited from being a dispensary worker or caregiver. This presents a public safety concern. On the other hand, R9-17-313(B)(5)(b) seems to imply that the person receiving the medical marijuana on behalf of the food establishment also must be a dispensary agent. This should be clarified and made explicit. 13. Local Building, Zoning, and Fire Code Compliance â€“ The physical plant for a dispensary and cultivation location should be required to comply with local Building and Zoning and Fire Codes. This requirement could be inserted into R9-17-318. 14. Physical plant â€“ With respect to the 500â€™ spacing requirement from schools, ADHS should impose rules requiring additional and heightened scrutiny of applications and/or additional information in the application for facilities located within a 1000â€™ of a school. This is consistent with state law requiring a â€œdrug free school zoneâ€ of 1000 feet. 15. Consequence of Local Code Violation â€“ A dispensaryâ€™s registration certificate should be denied or revoked in the event the dispensary or its cultivation location fails to maintain compliance with or violates a local building, zoning, or fire code. Perhaps a cure period could be inserted for already registered dispensaries, such that the failure to correct a violation within 90 days would give rise to revocation. This could be inserted into R9-17-319. 16. Denial or Revocation of Dispensary Registration Certificate â€“ R9-17-319(B)(6) provides that the Department may deny an application for a dispensary registration certificate if the principal officer or board member of the dispensary provides false or misleading information to the Department. The Department also should have the discretion to revoke a dispensaryâ€™s registration certificate on this basis and also the authority to deny or revoke a dispensary registration certificate if the principal officer or board member of the dispensary has provided false or misleading information on an application in any other state. 17. Reporting Law Enforcement Interactions â€“ There does not appear to be any requirement for a dispensary operator or caregiver to report criminal convictions, indictments, or arrests to the Department. Such a requirement would be beneficial and should be added. Perhaps there should be a requirement that dispensary agents file an annual sworn affidavit that no employee or operator of a dispensary has been arrested, indicted or convicted of a misdemeanor drug offense or any felony. A similar sworn affidavit could be required of caregivers. Thank you again for providing the opportunity for public comment on the first working draft set of rules concerning Arizonaâ€™s Medical Marijuana Program. Sincerely, [redacted]

[redacted]

I am personally am affected by fibromyalgia and have had a hard time getting any treatment for this chronic condition. I have not even been able to find a doctor in my area that will treat me. I have to drive 70 miles to get to a doctor for any help. I'm suffering everyday with daily activities. I do believe that fibromyalgia and some other chronic conditions should be added. I do not understand the 25 mile limit for patient/caregiver cultivation, because as stated above I have to drive 70 miles just to get to a doctor for treatment of my condition. The fee structure should be looked at more due to alot more arizonians being in low-income and/or limited income situations. Also, I do believe that the definition/requirements for the patient-phsician relationship need clearification. As well as the rules/requirements of the patient themselves.

The proposed patient fee of $150.00 represents a potential hardship for patients with chronic conditions, many of whom are on disability, are under- or unemployed. Instead, there should be a sliding fee-scale to take these circumstances into account. Requirements for security measures should not exceed those of traditional pharmacies, which have in their inventories drugs and other chemicals that are known to be potentially deadly. Marijuana has proven to be safe, and no deaths solely from its ingestion have ever been documented. Traditional pharmaceuticals, on the other hand, such as narcotics, amphetamines, barbiturates, chemotherapeutic drugs and other chemicals are known to have caused many deaths. Security measures specifically aimed at preventing theft, access to persons who do not qualify under the qualifying rules, minors or those seeking to profit from theft of dispensary inventory are necessary and beneficial. While reasonable measures should be taken to ensure that patients have been under the care of a physician for their chronic or acute qualifying condition (s), patients must also have the option of providing records from the physician who is their primary health care provider AND a recommendation for the use of medical marijuana from a separate licensed, qualified physician. This is necessary because of the strict rules physicians must adhere to when prescribing other medications, particularly narcotic pain relievers. Many physicians are understandably wary of coming under the scrutiny of the FDA and may fear for their prescribing privileges should their recommendation of medical marijuana come to the attention of that and/or other regulatory agencies. Though the requirement that a patient provide documentation of his or her qualifying condition is necessary and should remain, patients may find it necessary to seek out a physician who is not their primary prescribing health care provider, and rules must be implemented to allow this within reason.

1. The draft rules can be improved by distinguishing â€œdesignated caregiverâ€ from Direct Care Professionals and Caregivers by simply re- naming â€œdesignated caregiverâ€ to â€œdesignated cannabis caregiverâ€ or â€œdesignated marijuana caregiverâ€ or â€œdesignated medical marijuana caregiverâ€ or â€œdesignated cultivatorâ€ or â€œdesignated gardenerâ€ or â€œdesignated growerâ€. Direct Care Professionals (DCPSs) are certified after completing the â€œPrinciples of Caregiving Curriculum Projectâ€ https://www.azdes.gov/main.aspx?menu=28&id=1046 designed in collaboration by the Arizona Department of Economic Security, the Arizona Department of Health Services, AHCCCS/ALTCS, advocacy groups, provider agencies, and colleges in Arizona. DCPs and Caregivers are required to have current certifications for CPR and Basic First Aid. I believe â€œdesignated caregiversâ€ should also be required to have current certifications for CPR and First Aid considering the patient populations they will be working with. Eventually, I would like â€œdesignated caregiversâ€ to be required to be certified Direct Care Professionals to ensure higher quality of care for patients to

prevent potential patient neglect and/or abuse and to promote education and safety for the â€œdesignated caregiversâ€, especially when working with patients with blood-borne communicable diseases such as HIV, AIDS, and Hepatitis C. DCPs and Caregivers are required to show proof of negative results for tuberculosis. I believe â€œdesignated caregiversâ€ should also provide proof of negative TB results. 2. Renewal fees for dispensaries are twenty percent of the dispensary application fee. Renewal fees for patients, caregivers, and dispensary agents are 100% of their respective application fees. I believe renewal fees for patients should be thirty dollars per year and renewal fees for caregivers and dispensary agents should be forty dollars per year. 3. Insure that patient confidentiality is preserved if a public hearing is applicable when petitioning to add a new debilitating medical condition. 4. Open the petition window for adding a debilitating medical condition from only the months of January and July to all twelve months of the year.
An extension of the 2 year residency rule to a more respectable 5-7 year Arizona residency rule. This will help keep and protect as a priority the best interest of are local economy in the State of Arizona.
Include Naturopathic and Homeopathic Doctors as Medical Directors of Dispensaries
The problem will always be law enforcement so i think each person that is subscribe MM should have an idea saying that this person has the right to carry marijuana with him. The bud should be in small contaiers when sold or in a sealed bag and put that in another normal looking bag so when there on there way home from the dispensary and they do get stopped they can show that they got there medicine but have not yet opened it. this is important because lets say im a patient and i have a friend in the car with me... i can easily smoke it with him and MM will be getting on the wrong hands and thats why they shouldnt open there medicine till there home. May i also say that there should be like little rooms in each dispensary lest say someone needs there medication asap they can chill at the dispensaries smoking room and take a hit or two so they dont do it in public and get caught and go to jail. If that is possible that would really also help the people stay out of trouble in the streets because all the MM patients want is to take there medication and what better way then when they purchase it and do it in a "legal" place instead of in the public..... You never know this people have serious problems or aches and they need there mediation asap and maybe they cant wait and end up smoking in there car and get caught there should be someone checking out the dispensaries and making sure there selling the right medication because over in california there started selling hash and kief and other stuff more powerful and this is a MM act not hash or oil or nothing like that basically make sure there in compliance with the law
By specifying temperature requirements for "running water." The current rules allow for only cold water to be used.
By requiring that patients have a one year relationship with a doctor you eliminate all VETERANS who use the VA Health Care System. VA doctors are not allowed to prescribe Medical Marijuana. I meet the patient requirements on several different levels. However because I use the VA for all my medical needs and due to the one year doctor relationship requirement I will not be able to find out if this might bring me some relief. In my situation and so many others, I will have to find a civilian doctor and visit that doctor for one year in order to meet these proposed guidelines even tho I obviously meet all the medical requirements. If anybody deserves the opportunity to see if this may provide

relief its our VETERANS. As it is currently proposed all veterans who use the VA system exclusively (which they have earned) will have have go outside the system, doctor shop, and visit that physician for at least a year. I urge you to take a hard look at this. I am not a lawyer but it seems to me that this is a potential law suit from VETERANS and VETERANS RIGHTS GROUPS. Thank you for listening.
Improve the rule by the elimination of the requirement that a dispensary shall cultivate at least 70% of the medical marijuana the dispensary provides and that all marijuana must come from sources in Arizona. Opening the market between dispensaries or even allowing importation of marijuana from other states would improve the diversity of products and may help to keep prices of marijuana more reasonable.
Ease up the time periods, while people are dying. Rules can and will be changed later, until they fit the situation. Many doctors may have fears and a stigmas in prescribing said substance. This can be an inappropriate determinant for its non-prescribing and non-use. List of doctors that do prescribe Mariuana should be available. A doctor and/or a patient should not feel like they are breaking the law in any manor. The rules and guidelines must be drawn in a clear and understandable fashion and not cluttered with legal jargon. Marijuana must be considered a medication first and foremost, not stigmatized or targeted for every person with an attitude. We can't have Marijuana Mills appearing like bars do. I feel that the government has done an excellent job in seeing to this potential abuse problem. Facilities should be setup for those patients that will be taking the medication and an expert should be there and is, at first anyway to help *if necessary" guide the patient through side effects that will be damaging to it's potential benefits. A feeling of social correctness and not resentment must be shown. People who are very sick already feel inadequate.
1: Remove the one inch thick outside gate provision, one inch thick metal plates are not readily available anywhere, and this would appear to be a purposefully prohibitive restriction. A simple locking gate would suffice, if a person can cut through a fence to gain illegal access, they would certainly do this to avoid a inch thick metal plate. 2: Change the one year prior doctors/patient relationship requirement. There will be many doctors afraid to run up against the federal government, who have patients that clearly qualify for this benefit, who will not recommend marijuana. For these patients, allow a second doctor (one willing to recommend marijuana should the patient qualify) to review patient case files.
What parts of the draft rules do you believe are effective? 1) Sections R9-17-202.F.5.e, f, and h, R9-17-202.G.13.e-g, R9-17-204.A.4.e-i, along with R9-17-204.B.4.f-g, all adequately address my concern that a would-be "patient" or "caregiver" turned diverter would be able to "doctor shop" and obtain an excess of marijuana to sell for personal profit, so long as DHS has the resources and motivation to really audit these requirements. 2) The requirements for criminal records checks in sections R9-17-202.F.6.k, R9-17-202.G.9, R9-17-203.A.2.k, R9-17-204.A.5.k, R9-17-204.B.6, R9-17-204.C.1.j, R9-17-302.B.3.c, R9-17-308.7, and R9-17-309.5 are sound policy, again, if DHS has the resources and motivation to follow-up on any suspicious results from these records checks. 3) The mention of fingerprint requirements in sections R9-17-107.F.a, R9-17-202.F.6.k.i, R9-17-202.G.9.a, R9-17-203.A.2.k.i, R9-17-203.A.5.k.i, R9-17-203.B.6.a, R9-17-204.C.1.j.i, R9-17-302.B.3.c.i, R9-17-308.7.a, and

R9-17-309.5.a-b helps me believe that there is a way to make sure those with criminal history cannot be involved in the sale of medical marijuana. Once again, it depends on the resources available to DHS for oversight. 4) R9-17-319.A.1 designating that a dispensary be located away from schools is helpful. 5) R9-17-319.A.2.b and R9-17-319.C.1-2 allowing denial and/or revocation of privileges based on felony history are helpful. 6) R9-17-306.E allowing DHS to perform an unannounced on-site inspection if a tip is received about noncompliance will help curb illegal activity. How can the draft rules be improved? 1) One of the biggest flaws in the law as written and voted upon is the ability of a qualifying patient to grow their own medical marijuana. This is unheard of- that a person could manufacture their own medications on the level of a DEA controlled substance! DHS should set up geographic dispersion of the dispensaries so that it minimizes the number of people eligible to grow their own. 2) With the state in such a financial crisis, it will be difficult for DHS to feasibly cover their oversight responsibilities, thus creating opportunities for the illicit distribution of medical marijuana to potentially "slip through the cracks." Policies should be included that allows the Department to delegate some of the oversight to local law enforcement. 3) In order to encourage dispensaries to maintain compliance, the timeframe for a mutually agreed upon, announced on-site inspection in R9-17-306.C should be within a 24-hour period. 4) While R9-17-319.A.1 attempts to keep medical marijuana dispensing facilities away from school children, the distance should be much more than 500 feet, which is less than a tenth of a mile and can be covered at a leisure walking pace in less than 3 minutes. A minimum of a quarter of a mile would be more effective. Has anything been left out that should be in the rules? 1) A policy should be enacted that requires a qualifying patient, a dispensary agent, or a board member is a legal resident of the state of Arizona. Allowing people to cross state borders in the trade of medical marijuana creates opportunities for the increase of illicit inter-state marijuana transportation as has been found in states like California and Colorado, who also have medical marijuana laws. 2) The medical professional overseeing the care of a qualifying patient should be allowed to revoke the patient's certification any time he or she has reasonable knowledge that they are diverting marijuana for illicit use, or if they have not seen the patient within a reasonable time period, such as six months. This is in line with what is allowed with other prescriptions such as pain medications. 3) Dispensaries should be required to post all transaction to the PMP database, just as with other controlled substances. 4) While this suggestion may not be within the purview of DHS and the medical marijuana issue, the legislature needs to set a presumptive THC metabolite level to aid law enforcement and employers in deciding if a person is under the influence of marijuana to a sufficient level as to be impaired and/or a danger to others. 5) Throughout the draft regulations, there is no mention of criminal penalties for anyone who is out of compliance, other than a dispensary possibly losing their license. In order to balance the legitimate use of medical marijuana with the need to prevent illicit use by others, DHS policies must require the turning over of those out of compliance to law enforcement.

many docotors refuse to even talk about this , leading people to find new docotors that are open minded. Your rule about 1 year docotor and a second docotor to sign off is just wrong and will just make people go to the black market and not support the local taxes that will be implied for store sales to qualifying patients. i under stand your concern about headache abusers but the fact is you cant punish the sick to help your agenda. The law was voted on and this set of rules seems extreme for patients to get legal help. please recondsider the time frame and amount of visits to allow a card. again dont punish the sick , patients rights give them the right to see other docotors for medical help and a second opionion.

KISS THE DRS AND LETS GET STARTED

I would suggest clarifying the fees - specifically it was a little vague that both a dispensary registration and dispensary agent registration are required. Too, are separate dispensary agent application fee's required if all applicants work for the same dispensary? Regarding R9-17-108 A, 1, b - clarify whether the qualified patient's/designated caregiver's ID card needs to be presented each time. Do qualified patients less than 18 years of age have to reapply at the time of his/her 18th birthday? I wondered whether a designated caregiver could hold both a qualified patient and a designated caregiver card. There's a typographical error, page 23, first sentence, letter f, "If the qualifying patient is designated" - should be designating. Are fingerprints for dispensary agents required at each renewal? Will the State be restricting/limiting the operation hours of a dispensary? For those of us who don't know, what is a proper method of disposal?
Eliminate page 14, section e (ii)...which provides for a new doc to evaluate the patient. I think this opens the door wide to doctor-shopping. I think the patient should be under treatment by a physician for a full year before deciding that medical marijuana is a reasonable therapy to default to.
I would like to see the year long waiting time waived, requiring a history with a physician before you can get medical marijuana if you are a cancer patient and in need of it immediately. Thank you.
I would like to see a change in the definition of â€œenclosedâ€ as it applies to a dispensery cultivation site; specifically the requirement of 12â€™ concrete or metal walls with metal coverings over the enclosed area. This seems to make it impossible to cultivate in a greenhouse, which is the most efficient means of light and environmental control here in Arizona. Not only do these requirements cause an extreme financial burden on constructing a greenhouse cultivation site, but they also would block out a majority of the natural light available to the greenhouse and dramatically decrease airflow for environmental control. I suggest that a way to ensure security for the cultivation site can be found in focusing on the perimeter of the property, rather than enclosing a greenhouse with a security barrier.
My 85 year old mother has Glaucoma, a badly torn rotator cuff in her right sholder and osteoporosis in her back. both give her much pain. I think she will try to get some relief from medical maijuana. It seems that your rule to put dispensories in commercial areas ,off of the beaton path, gives the dispensories and patients a stigma that they are doing something wrong. I think you should reconcider attaching this stigma of wrong doing to the process.
the state can make a lot of money that is currently going to Mexico. people with cards should be able to smoke in public.
I do not think a "doctor-patient" relationship for a year prior to making an application for medical marijuana is good for all the people seeking medical marijuana. Does a doctor have to have a year long relationship with a patient before narcotics are prescribed for treatment of some type of pain? So, assuming the answer is "No", medical marijuana should not have "special" terms or conditions out

of the norm when it comes to doctors prescribing pain management medications. If terms or conditions like a year long doctor-patient relationship is necessary for medical marijuana, the ADHS will be wide open for lawsuits. The afore mentioned "doctor-patient" year long relationship is not applicable nor does it seem to address the issue of getting people medical marijuana that need it! The reason people have started using marijuana for medical treatments is due to many people can not afford regular doctors care, such is my case. Furthermore, many people prefer a natural pain management substance such as marijuana over pharmacutical prescription drugs that effect so many other parts of the body. you can get addicted to pain drugs, but you can not get addicted to marijuana, nor can you "overdose". I need an affordable, usable medication for my treatment of Hepititus C now! I have never had a regular doctor for over thirty years, simply because I can not afford the office visits and costly, ineffective gamit of tests that doctors like to do. My disease is treatable but tottaly unpracticable for myself as well as for others in similar positions such as mine. Marijuana gives me an appetite, helps with constant joint pain, and helps me deal with depression and fatigue. Please consider individuals like me, when all is said and done ,on the implication of these requirements for issuing medical marijuana certification. The rules need to be fair and affordable for all citizens of Arizona that voted and need such medication. Thanks [redacted]

The draft rules should be the same as Liquor Rules. Don't make it so difficult to place these dispensaries on the outskirts of town away from neighborhood. Should allow these dispensaries on a c-1 zone, 300 feet from a school. Keep it simple but only so many allowed in different sectors of town. Not to allow so many like liquor license, only one within certain sectors.

Any individual with prior drug arrest or convictions should not be allowed to own or operate a dispensary. For example, [redacted] who campaigned hard to get this initiative passed has multiple arrest for cocaine dealing. He should not be allowed to own a dispensary as he plans to do.

When creating the law needed to cover our new "medical marijuana" legislation, it should be stated that only pharmacies would be allowed to fill prescriptions for medical marijuana, in pill form. We are not California. The law should also state that only pharmaceutical grade marijuana would be acceptable. This will not only eliminate drug cartels from moving into our towns and cities with storefront dispensaries, but will provide a pharmaceutical grade product not grown by drug dealers in Mexico. By having pharmacies distribute this drug in pill form only, anyone "smoking" the drug -- or baking it into brownies and other baked goods -- can still be prosecuted. Pharmacists will also be able to report suspicious prescriptions to doctors and the proper authorities. Pharmacists follow laws already in place. [redacted]

please see below

I believe the fees listed in the draft rules (R9-17-102. Fees) are way too high. When comparing to

Colorado, they charge $90. And that is not per year, it is one time. They lowered it from $110 before. They assess the fee yearly to ensure it covers the cost of the program. If Arizona is going to require yearly renewals and such, the initial fee should be more like $25 and $10 for a renewal, as less work will be required to renew a patient card. If Colorado can maintain a system with one time fees of $90, then AZ should have no problem maintaining one with smaller recurring fees. I like the fact that Arizona is making them renew yearly as a persons condition can change where they no longer need the current medication.

Marijuana is a drug that in this case is being used to relieve chronic pain. In this sense it is no different from other drugs currently available in pharmacies. Many of those drugs are far more powerful and addictive, with potentially much more threatening side effects. Therefore marijuana should be regulated in a similar manner. I understand the legal need for separate dispensaries, but the regulations should parallel those for the much more powerful drugs currently available in pharmacies. This means that the physical location and licensing requirements for the dispensaries should be the same as those for pharmacies. Dispensaries should be able to freely trade inventory with other dispensaries without the 30% limit, as long as strict inventory control is maintained, just as is done for other drugs. Likewise, the requirements for doctor-patient relationship should be the same as what is required for the prescription of more powerful drugs, such as codeine.

The rules need to be less controlling. Licenses should be issued before investments are required. Growing techniques, watering and soil types should not be required above that of any other crop Medical directors should not be restricted. Any doctors who is allowed to prescribe a drug should be allowed to prescribe this under exactly the same conditions as for any other drug. Small operators should be considered more favorably under the proposed rules as these are only for big operators. Intitial licences should be extended to allow for ramp up of operations and amortization of investments Rules should be rewritten to make the legal availablity easier.

I don't see how you can require that as a physician you need to have a relationship going back a year with at least four visits. Many patients seeking this form of help are doing so due to lack of health insurance. Inability to afford expensive prescription medicine, etc. Being able to grow their own would be a huge advantage in being able to treat their symptoms in a manner that will not drain on the states economy with excessive emergency room visits that go unpaid. I strongly encourage this language be removed because it has nothing to do with the care of the patient but rather gouge the patient for money. It Also means that any patient who has a current doctor with a moral delimea with this treatment a patient will now have to find a compassionate doctor, visit four time and not be able to receive treatment for a year. Many cancer patients as you know do not have a year and make them suffer with symptoms that could be treated is immoral and cruel. Please take this into consideration and do not give in to the greed of a few looking to drain money out of people already suffering. If a patient can go to a doctor and in one visit get a prescription for a highly addictive opiate for random unconfirmed pain like headaches or joint pain they should not have to jump through these kind of hoops for a naturally occurring, nonaddictive treatment like medical marijuana. There are people who will certainly abuse both but I think we can agree opiate abuse is much worse on the patient, society, and the criminal system as a whole. Thank you in advance for your consideration.

1) One of the biggest flaws in the law as written and voted upon is the ability of a qualifying patient to grow their own medical marijuana. This is unheard of- that a person could manufacture their own medications on the level of a DEA controlled substance! DHS should set up geographic dispersion of

the dispensaries so that it minimizes the number of people eligible to grow their own. 2) With the state in such a financial crisis, it will be difficult for DHS to feasibly cover their oversight responsibilities, thus creating opportunities for the illicit distribution of medical marijuana to potentially "slip through the cracks." Policies should be included that allows the Department to delegate some of the oversight to local law enforcement. 3) In order to encourage dispensaries to maintain compliance, the timeframe for a mutually agreed upon, announced on-site inspection in R9-17-306.C should be within a 24-hour period. 4) While R9-17-319.A.1 attempts to keep medical marijuana dispensing facilities away from school children, the distance should be much more than 500 feet, which is less than a tenth of a mile and can be covered at a leisure walking pace in less than 3 minutes. A minimum of a quarter of a mile would be more effective.

There are many areas of the draft that can be improved upon. The first one is in reference to R9-17-302, it goes into detail to ensure the individuals, members, partners, and company are looked at thoroughly. However, investors are not taken into account. Colorado put into their rules and regulations a statement on any investor of 5% or more would need their background checked. I think this is huge to ensure we don't have investors from other states coming in and creating the toxic environment they have developed in other states. I also think this is a good idea because I am most fearful of the drug cartels from Mexico, and other organized crime in my community. -R9-17-302.B.15.a asks whether a pharmacist is on-site or on-call. Is this relevant if there is truly no prescriptions being made? Also is this a requirement? If not why is this question in here? -R9-17-302.B.15.b talks about relaying information on the "importance of physical activity and nutrition onsite." I feel this is good information the dispensaries should provide. However, I don't believe this will always pertain to every patient. Some patients will not be able to perform physical activity or have extreme dietary problems. -R9-17-302.B.15.d states "Whether the dispensary has a surety bond and, if so, how much." What is the reason for this question? Is a surety bond a requirement? Will the Department of Health Services be following up on the surety bond to make sure its not from a questionable source. *Also I have been informed of Marijuana Policy Project and Arizona Medical Marijuana Association involvement with the Department of Health Services in creating rules and regulations on the Application Review Board. Due to their involvement it should be mandated per R9-17-319.a.2.g that any member of Marijuana Policy Project or Arizona Medical Marijuana Association should be denied a registration certificate due to the large conflict in interest.

I believe the portion of the draft rules pertaining to the medical director in R9-17-310 is unnecessary. A patient has to have a relationship with their doctor prior to getting a recommendation. They should be calling a doctor familiar with their condition for concerns, not a doctor that does not know their medical history. You specifically state the patient should not have a patient/physician relationship with the medical director. The sections of that rule state things their doctor should already be doing with them. And your rule specifically states the medical director should not have a patient/physician relationship. Some of the section listed are just that, like creating a log book for pain (this is very typical for patients with pain management doctors). Also the policies and procedures about abuse in part C cross into that patient/physician relationship. This is also something their recommending doctor and/or other doctors they patient sees should be responsible for. The educational materials dispensaries are required to have will also point them to an outside source for that information that would be better suited to address those concerns.

- In section R9-17-307 Administration, Number 3, clarification on the maximum amount of medical marijuana a dispensary is allowed to cultivate. The Draft Rules specify that each dispensary shall

cultivate at least 70% of the medical marijuana the dispens
1. The year long requirement for patient doctor relationship. This seems a little excessive. I note that there is an attempt to limit the number of recreational users and prescriptions drops as have developed in other jurisdictions. I like the exception that was availabe; however, presenting too many hurdles to cross will cause patients to seek illicit marijuana. A period of 30 days, would stil stop the instant granign of a card, while requireing that at least the patient has a minimal wait. keep in mind that this is not the only delay they will incur, but also the delay of the processing etc. Was there any mention about the patients ability to grow if a dispensary is not within certain distance? what standard of measure will be used (google maps?). 500 feet, from the edge of the schools property or from the building location? what about school owned property that is not used for holding and teaching students?
Quads and paraplegics should be specifically mentioned as qualifying.
Make them simpler. If you qualify - you get it.
Draft Rule R9-17-311 should be expanded to include a requirement that when verifying the qualifying patient's identity, dispensaries must employ a biometric identity verification system, such as a thumb print scan. DHS is mandated by the Initiative to ensure that dispensaries are only releasing medical marijuana to qualifying patients who hold a validly issued registration card. If DHS required biometric verification in the rules, it would ensure that counterfeiting, identity theft, or other forgeries resulting in medical marijuana falling into the wrong hands would be prevented. This requirement will have the best chance of preventing the type of abuse we see, for example, with underage persons purchasing alcohol using fake identification. By requiring biometric identity verification, it would be nearly impossible for a dispensary employee to dispense marijuana illegally. While it is certainly expected that dispensaries will self-police their agents, under the current Rules it would be very easy for a disreputable agent to collude with a non-patient to dispense MM under somebody else's registry number. In this scenario it would be extremely difficult for a dispensary owner to discover illegal transactions as the record would appear legitimate. However if that transaction must be accompanied by a cardholder's thumbprint illegal transactions would be impossible. The proposed rules require a dispensary agent to verify information from the State's medical marijuana electronic verification system and enter additional information into the system relating to the transaction. The technology is available to allow this process to be automated so that the dispensary computer directly communicates with the medical marijuana electronic verification system without a human user being required to enter the information. This automatic communication from computer-to-computer would reduce the chances of human error while reviewing or inputting information, and thus better prevent fraud and improper dispensing of medical marijuana. It would also mean that human users could not alter or enter fraudulent information, again reducing the chances for fraud or abuse of the medical marijuana system. The rules should explicitly allow such electronic transactions by making the existing R9-17-311 part A and adding as part B: B. A dispensary may use an automated electronic system of hardware and software to verify the information required in Section A before dispensing medical marijuana to a qualifying patient or designated caregiver and to submit the required information to the medical marijuana electronic verification system.
Draft Rule R9-17-311 should be expanded to include a requirement that when verifying the

qualifying patient's identity, dispensaries must employ a biometric identity verification system, such as a thumb print scan. DHS is mandated by the Initiative to ensure that dispensaries are only releasing medical marijuana to qualifying patients who hold a validly issued registration card. If DHS required biometric verification in the rules, it would ensure that counterfeiting, identity theft, or other forgeries resulting in medical marijuana falling into the wrong hands would be prevented. This requirement will have the best chance of preventing the type of abuse we see, for example, with underage persons purchasing alcohol using fake identification. By requiring biometric identity verification, it would be nearly impossible for a dispensary employee to dispense marijuana illegally. While it is certainly expected that dispensaries will self-police their agents, under the current Rules it would be very easy for a disreputable agent to collude with a non-patient to dispense MM under somebody else's registry number. In this scenario it would be extremely difficult for a dispensary owner to discover illegal transactions as the record would appear legitimate. However if that transaction must be accompanied by a cardholder's thumbprint illegal transactions would be impossible. The proposed rules require a dispensary agent to verify information from the State's medical marijuana electronic verification system and enter additional information into the system relating to the transaction. The technology is available to allow this process to be automated so that the dispensary computer directly communicates with the medical marijuana electronic verification system without a human user being required to enter the information. This automatic communication from computer-to-computer would reduce the chances of human error while reviewing or inputting information, and thus better prevent fraud and improper dispensing of medical marijuana. It would also mean that human users could not alter or enter fraudulent information, again reducing the chances for fraud or abuse of the medical marijuana system. The rules should explicitly allow such electronic transactions by making the existing R9-17-311 part A and adding as part B: B. A dispensary may use an automated electronic system of hardware and software to verify the information required in Section A before dispensing medical marijuana to a qualifying patient or designated caregiver and to submit the required information to the medical marijuana electronic verification system.

START OVER OR THE LEGISLATURE WILL BE FORCED TO RESOLVE THIS ISSUE IN THE NEXT ELECTION.

The rules need to be specific about an "in-person" exam and follow-up visits with doctors recommending marijuana. No internet recommendations. And, no internet sales of marijuana. The rules, as drafted, leave open the possibility that "patients" can receive recommendations and purchase marijuana over the internet. Also, there needs to be tracing of all marijuana grown by dispensaries from "cradle to grave." Colorado is considering rules concerning this. There should be no marijuana whatsoever unaccounted for.

ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable

regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-

302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse.

Patients must not be required to shift their entire care in cases when their primary care / specialist cannot or will not provide medical marijuana in cases where it's efficacy is clearly indicated. The doctor/patient definitions are already defined, and any sudden encroachments are sure to be challenged in court. Let us use pragmatism and compassion be our guide. As long as a single doctor, ANY doctor, is willing to provide annual checkups for a medical marijuana patient, that should have NO bearing on their primary care physician, specialist or anything else. Please drop the stipulations altogether on defining this relationship. We will just have to accept some diversion and abuse. We do the same for opiates and anxiolytics because of their efficacy in their given roles. Marijuana has the same efficacy for nausea, pain suppression, appetite stimulation, and is breaking more ground daily. Opiates and other drugs are far more serious cases of diversion, but again, AZ law hasn't re-defined any special doctor/patient privileges for those because they are known to be effective where indicated. We can only hope that abusers seek help eventually, and that diverters will be caught eventually. Nothing is perfect, nor will this implementation be. We are only human. Let the patient's needs dictate the [lack of] language, not the diversion or recreational use. As for requiring listening software daemons and arbitrary numbers of kilobytes directionally to dispensaries,

that is just over the top and as an IT guy, I had a chuckle. As long as you have daily access to database files, this role of "384K" and stateful listening daemons on the dispensary end are just technobabble. Please omit this superfluous requirement. Can you imagine such a thing in a pharmacy setting ? It is almost funny. We do not need security cameras poised to wait for someone to pocket a flower. Panic buttons are adequate to identify any security risks. Continuity in stock and records will tell the tales adequately. These camera requirements are way over the top.

It appears, from the different City meetings I have attended, that big out of State operators represented by $400 per hour Law Firms (lobbyists) have missed the point on the INTENT of the bill which is to be for Non-Profit organizations. Why are they coming here to Arizona in droves? To support local Arizona Non-Profits? I don't think so. The 2 year residency requirement for Board Members is a start but I feel it should be taken one step further as was done with the States Charitable Bingo Statutes/Rules which designate that to obtain a License, An Arizona non-profit must have been in business as a non-profit in the State for 2 years. Non Profits in the State are looking closely at this as a fund raiser for their charities. With donations down and city/state and federal funding slashed, they are struggling to keep their doors open. Lets make the 2 year requirement for existing ARIZONA Non-profit organizations. This will help insure that the net proceeds from these ventures go towards what they were intended. SECURITY: Lets insure that the operations have security systems that allow the police department to access at any time to help insure that the srong element is not operating or entering these premises.

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outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The

department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse.

Draft Rule R9-17-311 should be expanded to include a requirement that when verifying the qualifying patient's identity, dispensaries must employ a biometric identity verification system, such as a thumb print scan. DHS is mandated by the Initiative to ensure that dispensaries are only releasing medical marijuana to qualifying patients who hold a validly issued registration card. If DHS required biometric verification in the rules, it would ensure that counterfeiting, identity theft, or other forgeries resulting in medical marijuana falling into the wrong hands would be prevented. This requirement will have the best chance of preventing the type of abuse we see, for example, with underage persons purchasing alcohol using fake identification. By requiring biometric identity verification, it would be nearly impossible for a dispensary employee to dispense marijuana illegally. While it is certainly expected that dispensaries will self-police their agents, under the current Rules it would be very easy for a disreputable agent to collude with a non-patient to dispense MM under somebody else's registry number. In this scenario it would be extremely difficult for a dispensary owner to discover illegal transactions as the record would appear legitimate. However if that transaction must be accompanied by a cardholder's thumbprint illegal transactions would be impossible. The proposed rules require a dispensary agent to verify information from the State's medical marijuana electronic verification system and enter additional information into the system relating to the transaction. The technology is available to allow this process to be automated so that the dispensary computer directly communicates with the medical marijuana electronic verification system without a human user being required to enter the information. This automatic communication from computer-to-computer would reduce the chances of human error while reviewing or inputting information, and thus better prevent fraud and improper dispensing of medical marijuana. It would also mean that human users could not alter or enter fraudulent information, again reducing the chances for fraud or abuse of the medical marijuana system. The rules should explicitly allow such electronic transactions by making the existing R9-17-311 part A and adding as part B: B. A dispensary may use an automated electronic system of hardware and software to verify the information required in Section A before dispensing medical marijuana to a qualifying patient or designated caregiver and to submit the required information to the medical marijuana electronic verification system.

* A dispensary may provide only 30% of its cultivated marijuana to other registered dispensaries and may acquire only 30% of its own marijuana supply from other registered dispensaries. This will likely

create acute shortages in rural areas and drive costs up. Patients within 25 miles of a rural dispensary unable to meet demand will have no secondary option for safe access to their medicine. We need to create an open wholesale relationship between dispensaries. This will assure consistent supply to rural Arizona, easy access for all qualifying patients, and lower costs due to increased competition of organizations trying to meet demand (R9-Ââ€17-Ââ€307)

Throughout the document Please replace the term physician with approved medical care-giver to be consistent with other Arizona Department of Health Programs language. R9-17-102. Fees- overall the fee schedule is totally unrealistic for an individual with a chronic disease or is on disability. The pricing structure isnâ€™t conducive to â€œrealâ€ non-profit orgs setting up dispensaries â€“I understand there is a motivation of this adding to the states struggling coffers- but the reality that needs to be faced is the â€œpatientsâ€ needs-not the states. I know there is a the â€œsnickerâ€ through out the population that medical marijuana is only a way for marijuana partiers to get marijuana legally and thus needs to be treated with a â€œsinâ€ tax mentality. In reality for chronically ill individuals it is a true medication and should be priced affordably. See below : 1. For registration of a dispensary, $5,000;-Too high- not practical for small business or non profit to do legit 2. To renew the registration of a dispensary, $1,000; too high not practical for small business or non profit 3. To change the location of a dispensary, $2,500;-too high not practical for small business or non profit 4. To change the location of a dispensary's cultivation site, $2,500;-too high not practical for small business or non profit Fee schedule is not appropriate for the patients who will be seeking the medication. Gives no advantage to use "legal" stream marijuana-The patient population that should be seeking this medication is generally on fixed incomes and disability. see suggested re-pricing below. 5. For a registry identification card for a: a. Qualifying patient; $150;-too high for patients on fixed income or disability - needs to be at $50 or less. b. Designated caregiver, $200; and too high needs to be a max of $50-why should a caregiver have to be licensed? I am thinking of the 60 year old parent taking care of the 30 year old cancer patient-whose sole job is to drive to pick the medication up or prepare it for smoking or cook with it? c. Dispensary agent, $200; too high needs to be a max of $50 6. For renewing a registry identification card for a a. Qualifying patient, $150; too high needs to be a max of $40.00 b. Designated caregiver, $200; and too high c. Dispensary agent, $200; tooooo high 7. For amending or changing a registry identification card, $10; and 8. For requesting a replacement registry identification card, $10. R9-17-202 Subsection 5 e Time frames for patient /physician relationship are inappropriate in the scope of modern clinical practice. In multi practice care giver practices the potential of seeing the same MD 4 times in a row is limited. - The concept of wasting 4 units of a health care professionals expensive time to prescribe an herbal substance where as controlled much more lethal and dangerous drugs can be prescribe in one 10 minute visit with limited chart review makes no sense. Again patients applying for this medication are on limited incomes or do not have the ability to be easily transported. In the current state of Medcaid s fiscal condition wasting time with 4 appoints is unnecessary and fiscally irresponsible. Additionally patients seeking Medical Marijuana who are on other pain management medications should not be driving unnessarily. An identification of one or more of the debilitating medical conditions in R9-17-201 as the qualifying patient's specific debilitating medical condition; The following are all burdensome and not required for other schedule medications â€“ at no point is an MD required to do any of the following for the prescription of other mood or mind altering medications on most formularies. The written prescription is the MD/Caregivers testimony of need. At any point in time an individual can walk into any Urgent Care facility and in in 10 minutes time leave with prescriptions for more dangerous controlled substances with no chart review, or formal attesting to patient need. Thus the below is in the realm of ridiculous and inappropriate. An addition example might be the model for the

morning after pill- where a pharmacist asks the persons age, verifies age explains product usage and dispenses in less than 5 minutes time-the medication in the morning after pill has much higher health risks and long term side effect potential. i. A statement, initialed by the physician, that the physician: (1) Has a professional relationship with the qualifying patient that has existed for at least one year and the physician has seen or assessed the qualifying patient on at least four visits for the patient's debilitating medical condition during the course of the professional relationship; or (2) Has assumed primary responsibility for providing management and routine care of the qualifying patient's debilitating medical condition after conducting a comprehensive medical history and physical examination, including a personal review of the qualifying patient's medical record maintained by other treating physicians that may include the qualifying patient's reaction and response to conventional medical therapies; ii. A statement, initialed by the physician, that the physician has explained the potential risks and benefits of the use of the medical marijuana to the qualifying patient's custodial parent or legal guardian responsible for the health care decisions for the qualifying patient; and iii. A statement, initialed by the physician, that the physician plans to continue to assess the qualifying patient and the qualifying patient's use of medical marijuana during the course of the physician-patient relationship; f. For the physician listed in subsection (G)(11), a statement, initialed by the physician, that the physician conducted a comprehensive review of the qualifying patient's medical records from other treating physicians; g. A statement that, in the physician's professional opinion, the qualifying patient is likely to receive therapeutic or palliative benefit from the qualifying patient's medical use of marijuana to treat or alleviate the qualifying patient's debilitating medical condition; Where the rules need to be strengthened and reviewed are in the category of Administrations, operations and accountability. The rules need to include language that requires use of electronic double entry accounting systems and Point of Sale Systems(costs under $1000). The department should in order to stream line management should look to a standard POS and off the shelf accounting system for all dispensaries. The current language leaves too many loop holes for dishonest accounting/double books. R9-17-307. Administration A. A dispensary shall: 1. Develop, document, and implement policies and procedures regarding: a. Job descriptions and employment contracts, including personnel duties, authority, responsibilities, and qualifications; personnel supervision; training in and adherence to confidentiality requirements; periodic performance evaluations; and disciplinary actions; b. Business records, including manual or computerized records of assets and liabilities, monetary transactions, journals, ledgers, and supporting documents, including agreements, checks, invoices, and vouchers; c. Inventory control, including tracking, packaging, accepting marijuana from qualifying patients and designated caregivers, and disposing of unusable marijuana; d. Qualifying patient records, including purchases, denial of sale, delivery options, if any, confidentiality, and retention; e. Patient education and support, including availability of different strains of marijuana and the effects of the different strains, information about and effectiveness of various forms and routes of medical marijuana administration, methods of tracking the effects on a qualifying patient of different strains and forms of marijuana, routes of administration of marijuana, and prohibition on the smoking of medical marijuana in public places; 2. Maintain copies of the policies and procedures at the dispensary and provide copies to the Department for review upon request; 3. Employ or contract with a medical director; 4. Not allow an individual who does not possess a dispensary agent registry identification card issued under the dispensary registration certificate to: a. Serve as a principal officer or board member for the dispensary, b. Serve as the medical director for the dispensary; c. Be employed by the dispensary, d. Have access to medical marijuana at a food establishment contracted to infuse medical marijuana into edible food products for the dispensary; or e. Provide volunteer services at or on behalf of the dispensary; and 5. Provide written notice to the Department, including the date of the event within ten days after the date, when

a dispensary agent no longer: a. Serves as a principal officer or board member for the dispensary, b. Serves as the medical director for the dispensary, c. Is employed by the dispensary, d. Has access to medical marijuana at a food establishment contracted to infuse medical marijuana into edible food products for the dispensary, or e. Provides volunteer services at or on behalf of the dispensary. The following rules are unrealistic in commercial plant husbandry and cultivation. Please consult a greenhouse growing specialist. Have you calculated the potential product production per square foot of grow space? C. A dispensary: 1. Shall cultivate at least 70% of the medical marijuana the dispensary provides to qualifying patients or designated caregivers; 2. Shall only provide medical marijuana cultivated or acquired by the dispensary to another dispensary in Arizona, a qualifying patient, or a designated caregiver authorized by A.R.S. Title 36, Chapter 28.1 and this Chapter to acquire medical marijuana; DRAFT 12/17/10 36 12/17/10 3. May only acquire medical marijuana from another dispensary in Arizona, a qualifying patient, or a designated caregiver; 4. May acquire up to 30% of the medical marijuana the dispensary provides to qualifying patients and designated caregivers from another dispensary in Arizona, a qualifying patient, or a designated caregiver; and 5. Shall not provide more than 30% of the medical marijuana cultivated by the dispensary to other dispensaries. The below R9-17-310 represents an undo burden on patient, and caregiver. - Few other specialty drugs/conditions require such cumbersome requirements- For the much more dangerous HIV medications there is no "tracking" of symptoms, rating scale for pain or additional time wasting activities. Pharmacists do not ask you to rate or track your pain when they fill a script for any other pain reliever. R9-17-310. Medical Director A system for a qualifying patient or the qualifying patient's designated caregiver to document the qualifying patient's pain, cachexia or wasting syndrome, nausea, seizures, muscle spasms, or agitation that includes: a. A log book, maintained by the qualifying patient and or the qualifying patient's designated caregiver, to track the use and effects of specific medical marijuana strains and products; b. A rating scale for pain, cachexia or wasting syndrome, nausea, seizures, muscles spasms, and agitation; c. Guidelines for the qualifying patient's self-assessment or, if applicable R9-17-314. Product Labeling and Analysis- current scripted pharmaceuticals, food products or tobacco product labeling does not require the labeling of materials used in the growing of the product. The use of organic vs non organic in the terms of fertilizers and pesticides is in appropriate and misleading. Organic Nicotine insect compounds have more lethality potential than off the shelf compounds. R9-17-317. Cleaning and Sanitation Insufficient definition and direction â€“ not appropriate this section needs to broken into more subsections with each addressing cultivation area, food preparation, retail front. In commercial green house management there needs to be issues addressing cross contamination, plant disease, the use of chemical sterilents, the use of gloves during processing or cutting of plant materials. Item B.1 cleaning the dispensary agents hands and exposed portions of arms in hand washing sink needs to be fleshed out to include the method, and duration type of soap or sanitizing agent used. There needs to be a â€œgloveâ€requirement put into rule before the handling of any food, equipment, utensil- this needs to be identical to food handling code and rule. R9-17-318. Physical Plant Though truly minimal the rules need to be addressed requiring a public accessible bathroom in each retail space (think chemo therapy patients and access) Hand washing sinks should meet safe food handling requirements and have WARM water available. â€¢ Signage and labeling shall be required for storage areas and cupboards. â€¢ If food product is prepared or portioned on site a three compartment sink and hotwater suppy â€¢ Commercial dishwasher that attains temp of 180 degrees â€¢ Uses only approved commercial sterilizing agents.

PHYSICIAN: Drop the rule of seeing a physician 4 times. A licensed physician is the primary person who can offer compassionate care to any individual in need of medical marijuana. The requirement of four times is just a way to deny a person who really needs medical marijuana. It seems to be a slap in the face of people who voted to make medical marijuana legal. THE 70/30 RULE: The State will already have a means of tracking producition and dissemination of the grown marijuana. The cultivation factory has to be able to sell its product to other dispensaries if it is to survive in this highly regulated enviornment. SCRAP THE 70/30% RULE. MEDICAL DIRECTOR: This provision only adds to the cost of medical marijuana, SCRAP IT! COST OF SETTING UP A DISPENSARY: Set up a preliminary approval system where one could get a license to operate based on the proper location and approval by the City Where the cultivation building or Dispensary would be located. Then inspect and apply the rules that the cultivation or dispensary would have to meet in order to finalize its license. Make the time limits as you like, but don't expect someone to put all the money out up front with no idea that he or she may not be approved.

As discussed above we believe the Draft Rules are an excellent starting point for a well regulated and functional program. The intent, clearly, is to create a program that is as safe, secure, and transparent as possible while at the same time ensuring that reputable dispensaries can adequately operate to provide medicine to legitimate patients. The revisions we suggest below are intended to help achieve this goal. 1. Demonstration of Financial Securityâ€"Surety Bond In order to ensure that only the most capable and reputable applicants are awarded dispensary licenses, it is incumbent upon DHS to ensure that prospective applicants have the financial ability and fiscal responsibility necessary to operate a dispensary. Operating a reputable, safe and viable dispensary will be a very expensive and financially risky endeavor. It would be a disservice to both the State and to qualifying patients to allow applicants that do not have the required financial wherewithal or fiscal integrity to proceed. The Draft Rules clearly attempt to address this issue with provisions addressing unpaid taxes and the posting of a surety bond. See R9-17-302(B)(1)(f). However the Rules do not provide any details regarding the surety bond. Furthermore, according to our research and discussions with underwriters, they are unable and unwilling to issue a bond without specific guidelines from the State regarding why and when the bond would be called. This may make timely compliance with the rule impractical if not impossible. As a remedy to this uncertainty, we suggest allowing applicants to demonstrate financial capability with additional options such as a letter of credit, or preferably documentation of a specified amount deposited in an escrow account. We suggest that an appropriate sum for this requirement is $250,000. This will ensure that dispensary applicants are able to fulfill the facility, security and operational expenses that they would incur in establishing a fully compliant dispensary. We have provided specific language and edits to the Rules below. 2. Prior Local Land Use Approvalâ€"Certificate of Occupancy As discussed above, the Rules properly require local land use approval as a prerequisite to a complete application. However as currently written, the Rules appear to go beyond this by requiring a Certificate of Occupancy as evidence of local approval of the use. See R9-17-302 (B)(5). This is problematic and not at all feasible. In order to obtain a Certificate of Occupancy, an applicant would have to actually construct all the necessary improvements for the property including obtaining all building permits and passing all inspections. This is particularly burdensome because these facilities are going to require substantial improvements before being suitable for cultivation or dispensary operations. These improvements are likely to include significant structural modifications to meet the stringent security requirements. It is simply not feasible to require prospective applicants to invest the capital and time required to make these improvements without knowing whether or not they will obtain a license. In addition to this unnecessary risk, it would be a waste of valuable local resources and funds to issue permits and

perform inspections on facilities that ultimately may not be awarded a license. The effect of this would be to discourage rational and responsible applicants; an undesirable and certainly unintended consequence. However, the intent of this provision (i.e. ensuring local jurisdiction approval and land use compatibility) can be achieved without these problems by revising this section to simply require evidence from the local jurisdiction that the Applicantâ€™s proposed facility complies with all local zoning restrictions and land use regulations and will be required to obtain building permits and certificates of occupancy prior to beginning operations. We suggest specific language below which will ensure local approval without the undue burden and unintended consequences of the Certificate of Occupancy. 3. Medical Director Qualificationâ€"Naturopathic Doctors We applaud the inclusion of the Medical Director requirement, however the qualifications for this positions as stated in the Draft Rules have inappropriately omitted Naturopathic Doctors from eligibility. Naturopaths have education and licensing requirements that are as stringent and sometimes more expansive than M.D.s or D.O.s. Further, naturopaths are uniquely qualified to serve as Director to a MMJ Dispensary because of their education and experience in alternative healing methods and in particular herbal therapies. To omit Naturopaths from this role would do a disservice to patients and seems illogical and unjustified. 4. Ensuring Secure Patient Access--Biometrics Crucial to the success of the Initiative and the Rules is ensuring safe secure patient access, and preventing unauthorized users from obtaining MMJ. The patient database and registry ID cards requirements in the Rules go a long way towards achieving that goal. Unfortunately this system still leaves an easily exploitable loophole which could be used to obtain MMJ illegally. The system, as proposed, requires a patient to have a valid registry ID card. However there is no way to be 100% certain that the patient is actually the valid cardholder. For example, the card could be a fake, or the cardholder could look very similar to the actual patient whose card was lost or stolen. In addition, by working in tandem with a disreputable Dispensary Agent, a fake patient could purchase MMJ using a valid patientâ€™s ID card without leaving evidence of the illegal transaction. All of this could be eliminated by requiring Dispensaries to verify a patientâ€™s identity using biometrics (e.g. a thumbprint). This will prevent illegal transactions from occurring and will help ensure that any potential bad actors are identified and reported. The proposed rules require a dispensary agent to verify information from the Stateâ€™s medical marijuana electronic verification system and enter additional information into the system relating to the transaction. The technology is available to allow this process to be automated so that the dispensary computer directly communicates with the medical marijuana electronic verification system without a human user being required to enter the information. This automatic communication from computer-to-computer would reduce the chances of human error while reviewing or inputting information, and thus better prevent fraud and improper dispensing of medical marijuana. It would also mean that human users could not alter or enter fraudulent information, again reducing the chances for fraud or abuse of the medical marijuana system. 5. Cultivationâ€"70/30 Split Requirement. The requirement in the Draft Rules that Dispensaries must cultivate at least 70% of their product (allowing only up to 30% to be obtained from other dispensaries/caregivers) is very troubling (See R9-17-307(C)). First and foremost, it is difficult to determine what the point of this Rule is. Second, regardless of its goal, inclusion of this Rule is likely to result in unintended consequences that run contrary to the intent of the Initiative and the Rules. Such a requirement will force those who wish to operate a dispensary into cultivation, and those who wish only to cultivate into retail dispensing. The end result of this would be to provide patients with less consistent quality medicine. As those who have interest and expertise in one aspect of the industry do not necessarily have interest or expertise in the other. Take the example of an applicant who has a unique talent for growing high quality medical marijuana and a strong background in growing but either has no desire or lacks the knowhow to run a safe, secure, and well functioning dispensary business. In the

alternative, one can imagine a career pharmacist who has successfully operated pharmacies for years but lacks the knowledge of how to grow high quality, medical grade marijuana. It would appear that each of these individuals should be encouraged to be applicants but that it is in no oneâ€™s interest for these people to be forced into the part of the business that they are not properly trained to excel at. The State should want to encourage responsible and quality growers and dispensers of medical marijuana. The 70/30 requirement on the other hand encourages applicants to reach into segments of the business they might not be good at. By mandating this, DHS prevents optimization of the industry which will lead to both failed dispensaries and less consistent quality of medicine for patients. Furthermore, if the intent of the draft Rule is to facilitate tracking of all MMJ from seed to sale, the 70/30 split hinders this goal rather than advancing it. If the intent of the Rule is to more easily track and control MMJ inventory, it seems like it would make sense for the State to consolidate the growing as much as possible into fewer locations. Consolidation is good as there are fewer such sites for law enforcement and the State to monitor; the 70/30 rule on the other hand means every dispensary owner must cultivate as well, leading to a proliferation of grow facilities. A greater number of facilities are not only more difficult to keep safe and monitory, but it also increases the temptation and opportunity for less reputable licensees to divert MMJ. Finally, by mandating a program that has more growers with less expertise, DHS is essentially mandating that some (many) patients will receive less consistent quality of medicine. To be clear, we do feel that people should be allowed to own both a dispensary and a cultivation location but it should not be mandated as such. 6. Cultivation Facility Requirements--Greenhouses As discussed above the Draft Rules do an excellent job of contemplating the necessary security measures and protocols to ensure that cultivation facilities are not compromised by prospective criminals. However one particular provision of the Rules may go unnecessarily far in its pursuit of this goal. Pursuant to the language of the Initiative all cultivation must occur inside an â€œEnclosedâ€ facility. The Rules define Enclosed as having a solid roof or being covered by a welded or woven metal top. It is important that these Rules are flexible enough to allow a locked and secured greenhouse facility to qualify for cultivation. It would be wasteful and unnecessary to prevent cultivators from utilizing natural light as a resource. Indoor Cultivation requires massive amounts of electricity and can be a strain on the existing electric grid. Allowing a secure greenhouse on the other hand is more environmentally friendly, more cost effective and can still be accomplished in a safe secure manner. 7. Product Testing The Rules should require cultivators to test their product for contaminants and for THC levels and cannabinoid profiles. Without this information it will be very difficult for patients to identify which strain of MMJ works best for their particular condition. Further, patients have a right to know that their medicine is free from contaminants such as mold and pesticides. 8. Employee Education The Rules should require a basic level of education for all dispensary employees and volunteers. Education of dispensary employees and cultivation employees should be mandatory and should be pursued at a reputable and accredited institution. Dispensary owners and employees need education in regulatory compliance, accounting, strain education, and medical education. Cultivators and their employees require years of training in growing techniques, use of pesticides, strain identification, testing methods, botany, nutrients, construction, lighting, HVAC, environmental issue, pesticides, biology, etc. The only way to get the best medicine to the patient is for cultivators to be trained in the latest techniques from experts in the industry. The Rules should also encourage patients to seek educational opportunities and should require dispensaries to offer information on where patients can get further educational information. 9. Initial MMJ Cropsâ€"Seeds or Clones The Rules are so far are silent as to how a dispensary is allowed to start their initial crop. However, the only way to be certain that patients have access to quality medicine from the beginning is to allow dispensaries to utilize clones from plants with a history of producing quality medicine. If on the contrary, DHS decided to require all cultivation

to begin from seed it would be impossible to know whether the resulting crop would be of sufficient quality. 10. Applicant Selectionâ€"Competitive Process Currently, it appears that the Rules will award applicants based on a first-come-first-served basis. While this may ultimately prove workable as the stringent requirements will likely discourage many applicants, we are concerned about what would happen if there are more qualified applicants than available licenses and those applicants have exactly the same time frame. In this scenario, we believe it is incumbent upon DHS to have a fallback Rule which implements a competitive selection process, potentially administered by a third party. This is the only way DHS can ensure that the limited licenses go to the best possible applicants. This system could also be used when another license becomes available either through growth of the program or revocation of an existing license.

How are you going to select companies to get the 124 licenses? This needs to be publisized. Need to look at the requirement for a Dr. Director. This will add cost to the end product. Their is no real value add here. The patient's own doctor should be the responsible party. We need to look to reduce the cost of medicine to the patient! To drive the costs down, not add too much overhead. Therefore: 1) Allow the dispensary to form a stragegic partnership with a grower. Within those partnerships, make sure each party keeps auditable records for shipment / deliveries. Eliminate the 70/30 rule. The ability to create the product needed in sufficent quantity, will drive the prices down thru competition and better growing practices. 2) Do not allow them to purchase from anyone that has product to sell! Too many gray areas. 3) Keep the AZ only language in the document. We Arizonan's can figure out how to produce product cheaply and drive the price down to the $100 level. 4) Dispensary / growers - allow them to find locations after the award of licenses. Give them 90 days to find and get approval of location on a first come first serve basis. The number of applications will greatly outweight the allowed number of dispensaries licenses. This will help us who are trying to get into this business.

Nope sorry. Lighten up 1. Lower Fees 2. Expand condition list 3. Lighten time regulations 4. Eliminate 25 mile rule Making someone wait one year under doctor's care??? Are you kidding. What kind of joke is this? It is obvious the department has no idea of how the treatment can immediately improve coditions. You are also not allowing others that need this treatment to have access with only including very limited conditions. Expand the condition list!!!!!!!!!!!!!!!!!! Depression, Pain (you want people who suffer with pain to jump through more hoops?) fibromyalgia??? Do you want me to continue to add to the black market and support the Mexican cartels???? What are you afraid of. Loosen up big brother regulators! This isn't crack people. Secondly a medical director. This is an insult. You want taxpayers to pay for a person to oversee the distribution and needs a medical designation. What a waste to time and money. We are talking about distributing material grown from a plant right? I have been self medicating myself for many years. I am an upstanding citizen of the community and pay my taxes and hold a regular job. My condition is not listed in your draft, so I am out of luck? It helps me live and function properly. Why should you be albe to determine if I can use or can't if i am responsible? [redacted] you if you block me.

I have a qualifying disability. Yesterday my doctor advised me that he is not allowed to make a medical marijuana recommendation due to his clinic's policies. It is the largest clinic in northern Arizona and is

the only service provider in many of the small rural communities. My insurance will not allow me to see anyone else. I need to keep my physician but I also need medical marijuana. Please allow me to keep my physician but also see another physician for a recommendation.
Simplify, simplify, simplify! I have read the suggetions from [redacted], and I believe they are the most clear of any, and they make greater sense.
By killing drug cartels and other people that would do harm to the innocent civilians and their children, and all citizens of this great state. Oh, and stop letting them pay off politicians.
If I understand the language correctly, it appears that dispesaries and cultivation sites must be fully functioning minus any product prior to certification. I am concerned that the dispensary requirements are so stringent that there will be few that qualify for certification. The lack of dispencaries may result in a large numbers of patients that must cultivate their own marijuana. Personal cultivation may be difficult if not impossible for many patients. HIPAA rules must be applied to all sections of R917-203. Remote surviellance of security camers and customers activity should be protected and not reviewed without proper reason such as criminal investigations. The requirement of surviellance does not specify who may access the video and under what conditions. All measure must be taken to protect a patients privacy. Due to the controversial nature of R9-17202, the opportunity for abuse of patient information is significant.
I am concerned about the potential for misuse of medical marijuana. Therefore, below are some of my suggestions:
If a qualified, licensed physician determines a patient can benefit from a recommendation for marijuana use, and the patient is comfortable with the recommendation, the recommendation should be issued without delay. No other prescription for medicine, not even narcotics, are treated with such scrutiny that a patient must suffer with a debilitating condition for a year before relief is given. I don't understand the delay given the terminal condition of the patients meeting the criteria.
Most of our concerns are around the issue of edibles: - Can a dispensary subcontract with another entity to prepare the edibles? If yes, what are the rules for the subcontractor? Must they comply with the same rules as the dispensary regarding inventory, security, etc.? - If a dispensary can subcontract for edibles, and it appears they can, will there be additional rules addressing co-mingling with other food products. That is, the marijuana will need to be ground to a flour type consistency or infused in an oil to be made into edibles. If the subcontractor also produces food products other than medical marijuana edibles as well, there will be a need to address sanitation of surfaces between uses, etc. If these rules don't address this, local ordinances will need to be developed, and you could have fifteen different sets of rules by ordinance. - R9-17-314 B. states that if medical marijuana is provided as part of an edible food product must also include a statement that "This product...was produced without regulatory oversight for health, safety or efficacy..."). R9-17-316A.1. requires that the facility "...has a food establishment permit pursuant to 9.A.A.C.8, Article 1 and that local ordinances and requirements of the local health department..." These statements seem to conflict. A food permit assumes regulatory oversight. Please clarify what is meant in R9-17-314 B about lack of regulatory oversight. - A.R.S. 36-901 does not include marijuana as a food additive. Will these rules,

in essence, add marijuana as an additive or will there be new rules to address adding medical marijuana as a food additive under this statute (36-901)? While the Smokefree Arizona statute is silent on smoking related to medical marijuana, can and should the rules address this gap. Items to consider: smoking in dispensaries, other public buildings, outdoor patios and parks, public places with children. Since Smokefree Arizona is not pre-emptive, local ordinance could be more restrictive (as it is in Coconino County and some of the cities and towns in Coconino County). Will the use of vaporizers (hookahs) be allowed in dispensaries? If not generally, will it be allowed for the purpose of teaching patients how to use it? Will hookahs be allowed in other public places?

The requirement for site inspection as a condition of dispencary license approval should be modified to state that on-going site inspections are a requirement for RETENTION of the license. The initial site inspection can certainly be a condition of "release for retail" - that is inspection must be completed before retail transactions can be made. The requirement for site inspection BEFORE license approval will prevent a fair entry into this opportunity for those who are inventsing substantial money to build NEW facilities from the ground up, leveraging state-of-the-art security, controls, and safety measures. Even a preliminary granting of a license - contingent on a subsequent successful site inspection would be far more equitable.

Repugnant assumptions in the draft regulations The unstated but evident fundamental assumptions of the regulations are immoral, lawless, cruel, elitist, and demagogic, utterly incompatible with moral imperatives of a decent free nation. These repugnant assumptions are: 1) the lives of Arizona's citizens belong to the State; the State, not the patient, will decide if, when, and what care patients will receive; 2) the department of Health Services is, as its spokesperson has indicated, above the law and may disregard the 1998 Arizona Voter Protection Act to usurp authority; and 3) the department may patronize the wealthy and elite to their advantage and to the disadvantage of the suffering, dying, and good citizens at large. In your introduction of the draft regulations you even opined that you drafted the regulations for the â€œgoodâ€ of the opponents of the Arizona Medical Marijuana Act, a bizarre concept akin to â€œSegregation is no longer the law, but the department is obliged draft rules to satisfy segregationists.â€ Reminders Patients, not the State, own their own lives, so have the right to choose if, who, when, and what kind of medical care they will seek. Marijuana is completely safe in itself, cannot be lethal, and so should be treated as a safe, effective, and legal product as the findings of the Arizona Medical Marijuana Act require, certainly not treated with more stringency than is currently required for the dispensing of drugs, prescription or otherwise, from Arizona's pharmacies and physician offices, The safety, efficacy, and legality of medical marijuana warrant the spread, not the suppression, of its use. For these reasons and in view of the Arizona Medical Marijuana Act, medical marijuana services must be readily available to the qualifying patients and dispensary licensing must not be available only to an elite and wealthy group. Partial listing of defects ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be â€œwithout imposing an undue burden on nonprofit medical marijuana dispensariesâ€¦.â€ In no way do the MPP/AZDHS draft regulations respect that requirement. Quite the contrary, the regulations impose unacceptable burdens not only on dispensaries, but on the suffering, dying, and good citizens of Arizona. ARS 28.1 Section 2 â€œFindingsâ€ of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel,

arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 6 to 8 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require â€œongoingâ€ care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patientâ€™s care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The departmentâ€™s regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patientsâ€™ rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patientsâ€™ parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(4) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily life. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii and R9-17-202.F.5(h) are cruel, arbitrary, unreasonable, and usurp patientsâ€™ rights to choose other providers or sources of information. R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly

provided substantive misinformation. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physicianâ€™s professional practice. Arizona's pharmacies dispense drugs that are very toxic, yet are not required to have medical directors on-site or on-call. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse.

Delete Â§R9-17-307(C) from the rules completely.Â This section has many implications, none of which are good for the industry, DHS, patients, or the State as a whole. Â Requiring every dispensary to have its own cultivation operation is a security risk.Â Essentially this rule necessitates more variables in an equation that already has inherent dangers.Â The more cultivation facilities, the more difficult they will be to monitor and keep secure. Â Additionally, by requiring each dispensary to grow its own marijuana you create a quality control issue.Â How can a patient rely on the consistency of the product when it is grown by different operations under varying conditions? How will DHS manage to analyze that multitude of plants?Â Logistically it would be much easier to ensure a high quality product reaches the end user by permitting the market to establish fewer high production cultivation operations that supply multiple dispensaries.Â Unfortunately, as written now, Â§R9-17-307(C) does not allow for this. Â Realistically, Â§R9-17-307(C) closes the door on the possibility for

central grow operations can establish themselves.Â This creates a heavy burden on DHS and other authorities not just for security and quality reasons, but also in terms of monitoring and tracking inventory.Â If a dispensary needs to grow 70% of what it sells, can only import 30% of what it sells, and may not export more than 30% of what it grows to other dispensaries, there will be a book keeping nightmare. Â Not only will the rules will be greatly simplified by deleting Â§R9-17-307(C), but it is in the Stateâ€™s best interest to do so.Â It will reduce the burden on an already underfunded government to monitor and secure over one hundred and twenty cultivation operations, and ensure that pure and safe medicine reaches those who are in need of it.

I believe the doctor-patient relationship portion can be improved. It is too restrictive as proposed. I would suggest 2 visits rather than 4 is appropriate. I would also clarify the provision that the number of visits could be waived if the doctor accepts responsibility for treatment by specifying that that the doctor may still refer to other specialists as appropriate for treatment of the subject condition without abrogating the requirement for primary responsibility. Often times primary doctors refer to specialists, and this ability should be should be included as a provision in the rules.

Delete requirement for a Licensed Medical Doctor for dispensaries. Maybe a Registered Nurse but any employee can be trained for this procedure. Delete the requirement for dispensaries to grow and purchase in any ratio! Fees for patients to get a medical marijuana cards should be waived for those using state health care. $5000.00 non-refundable... make a process that the state only keeps a processing fee if applicant does not get granted the dispensary license. Delete the requirement for patients to get authorization from the state to cultivate. Delete the requirement for caregivers to get authorization to cultivate.

Please consider the legal definition of a physician patient relationship as defined by the courts in your final definition; "The physician-patient relationship is regarded as a fiduciary relationship, in which mutual trust and confidence are essential. A physician is held to a standard of medical care defined by the accepted standards of practice in his or her area of practice. Some of the obligations of a physician's duty of due care include the obligation to fully inform the patient of his or her condition, to continue to provide for medical care once the physician-patient relationship has been established, to refer the patient to a specialist, if necessary, and to obtain the patient's informed consent to the medical treatment or operation." Numerous court decisions have held that: "Once the physician-patient has been established, it continues until it is ended by the consent of the parties or revoked by the dismissal of the physician, or until the physician's services are no longer needed. Without proper notice of withdrawal, affording the patient ample opportunity to seek alternative care, the physician's termination of services to the patient could be held to be an abandonment, subjecting the physician to the charge of negligence and liability to the patient for any damages proximately caused by such negligence." Please ensure that the ongoing part of the definition is established in the final rule.

Draft Rule R9-17-311 should be expanded to include a requirement that when verifying the qualifying patient's identity, dispensaries must employ a biometric identity verification system, such as a thumb print scan. DHS is mandated by the Initiative to ensure that dispensaries are only releasing medical marijuana to qualifying patients who hold a validly issued registration card. If DHS required biometric verification in the rules, it would ensure that counterfeiting, identity theft, or other forgeries resulting in medical marijuana falling into the wrong hands would be prevented. This requirement will have the best chance of preventing the type of abuse we see, for example, with underage persons purchasing alcohol using fake identification. By requiring biometric identity

verification, it would be nearly impossible for a dispensary employee to dispense marijuana illegally. While it is certainly expected that dispensaries will self-police their agents, under the current Rules it would be very easy for a disreputable agent to collude with a non-patient to dispense MM under somebody else's registry number. In this scenario it would be extremely difficult for a dispensary owner to discover illegal transactions as the record would appear legitimate. However if that transaction must be accompanied by a cardholder's thumbprint illegal transactions would be impossible. The proposed rules require a dispensary agent to verify information from the State's medical marijuana electronic verification system and enter additional information into the system relating to the transaction. The technology is available to allow this process to be automated so that the dispensary computer directly communicates with the medical marijuana electronic verification system without a human user being required to enter the information. This automatic communication from computer-to-computer would reduce the chances of human error while reviewing or inputting information, and thus better prevent fraud and improper dispensing of medical marijuana. It would also mean that human users could not alter or enter fraudulent information, again reducing the chances for fraud or abuse of the medical marijuana system. The rules should explicitly allow such electronic transactions by making the existing R9-17-311 part A and adding as part B: B. A dispensary may use an automated electronic system of hardware and software to verify the information required in Section A before dispensing medical marijuana to a qualifying patient or designated caregiver and to submit the required information to the medical marijuana electronic verification system.

1. Medical Director Definition: Should change to include any Doctor who is permitted under Title 36 to recommend Medical Marijuana. 2. Ongoing Definition: AZDHS should rely on the recommendation of a Arizona licensed Physician, regardless of the relationship period, so long as the recommending physician complies with the provisions of Title 36, or until such time as there is evidence of fraud. 3. ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rule making be implemented â€œwithout imposing an undue burden on nonprofit medical marijuana dispensariesâ€¦.â€ 4. ARS 28.1 Section 2 â€œFindingsâ€ of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizonaâ€™s pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizonaâ€™s pharmacies and physician offices are not required to have on-site transmission of video surveillance or any of the unusually high security requirements. These requirements should be modified to reflect the same requirements imposed on compounding pharmacies. However, in your defense, dispensary owners would be foolish not to have high security for their own interest as that is the greatest issue faced by those I know in California and Colorado. 5. R 9-17-101.10 falls under this same category of being an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. 6. R 9-17-101.15 is reasonable at first glance but then I realized that the department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. 7. R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 seem to be . ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. 8. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) seem somewhat arbitrary. Though many qualifying patients, qualifying patientsâ€™ parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. 9. R9-17-205.C.2 and R9-17-

320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. 10. R9-17-310 seems a bit arbitrary but is a lot like Colorado. However, Prop 203 did not give the department the authority to require a medical director, much less to define or restrict a physicianâ€™s professional practice. 11. R9-17-313.B.3 is unrealistic as there is no language in Prop 203 that gives the department the authority to provide agricultural limitations. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. 12. R9-17-313.B.6 seems like it was written with the intent of using the initial draft as a negotiating tool. The department seems to have taken some liberties by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. 13. R9-17-314.B.2 would require the DHS to provide modern scientific evidence that medical marijuana provides a substantial health risk. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. 14. R9-17-315 seems arbitrary as dispensaries are in principle no different than pharmacies. The department has placed an undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. 15. R9-17-317.A.2 seems arbitrary and may violate the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse. Additional issues: SURETY BOND: Clarify the purpose, the type, the amount and the third party beneficiary, of the surety bond, or eliminate its reference from the rules. NON-PROFIT ENTITY: Clarify the need to establish a non-profit entity. Title 36 only requires an applicant to operate the dispensary under a non-profit â€œbasisâ€. Can an applicant establish a LLC or other entity so long as his/her bylaws comply with Title 36? 70% COOPERATIVE GROW: Clarify if a group of dispensaries can form a cooperative to grow their medical marijuana under one roof, so long as the facility is in compliance with Title 36 and the AZDHS rules. SEEDS: Please clarify where a dispensary owner can purchase his initial seeds. LANDLORD RIGHTS: Please clarify landlord rights with respect to entry and inspection of a dispensary/ cultivation facility. (Assuming the landlord is not a registered agent of the Dispensary). Additionally, please clarify access by a repair service to enter upon the restricted areas of a dispensary/cultivation to make necessary repairs.

Oh so now we finally learn that all the public comments will be published as a PDF, a full 3 weeks after you started the process. I like how you are citing the initiative as the final arbitor of the rules when it suits you (i.e. the 25 mile rule) but choose to ignore it when it doesn't suit your narrow minded view of marijuana as medicine. Please re-read the section 36-2803 Rulemaking: The Department shall adopt rules: (b) Minimum oversight requirements for nonprofit medical marijuana dispensaries. (c) minimum recordkeeping requirements for nonprofit medical marijuana dispensaries (d) Minimum security requirements for nonprofit medical marijuana dispensaries. So after reading this how do you justify the most draconian rules in the country in regards to establishing the medical marijuana program? You are a disservice to our state in putting together rules that even you admit will eliminate more than 80% of the eligible patients that are legally allowed to have medical marijuana. Thanks Mr. Humble you have shown your true colors by your actions and why aren't you being investigated for showing up at a paid event in Pinal County at a Casino (you're listed as a panelist) with Jordan Rose of the Rose Law Group talking to the well heeled folks about the dispensary application process on January 15, 2011. The rule making process is still ongoing and you're out there talking about this prior to the public hearing process? Is this fair? Are you just bought and paid for by the syndicates headed up by MPP (Marijuana Policy Project), Rose Law Group and Joe Yuhas. Please post all the communications from those three groups/individuals so all will be revealed. Please don't scrub

this because I'll be posting in the public comment forum which is now part of the public record. Enjoy your days now because you'll be locked our state up in litigation if you don't revise the rules and eliminate those high fees for patients, surveillance cameras on our citizens, 41 medical directors (what idiot came up with this) and the 70/30 rule (are you guys on Oxycontin or something).
remove them
Article 3 subsection B. Your description of an enclosed, locked facility does not make it very greenhouse friendly. Citizenship of the US is required in many areas of draft. Should legal resident alien status also be included in the wording. Afterall, this is not a matter of national security.
Medical Director - Needs to be removed. The patient already has a physician. This will only add to the cost of the patient's product Patient Requirements - A patient should not have to see a dr 4 times before getting a medical marijuana license. Once again you are adding to the cost of the patient. The 70% - 30% removes the being able to provide to other locations or buy from other locations if a dispensary is unable to grow enough. The cost of setting up a dispensary and growing facility become prohibitive, since the money has to be spent up front and you may not get a license. This rule will make it only the very "wealthy" or conglomerates can set up a dispensary. How can you know when you will be approved for a license? At this point it is only after the inspection and after you have invested a lot of money and prepared a site that may not be able to be used. Most of these rules will add to the cost of the product and make it cheaper for the patient to look for their product elsewhere.
Nothing should be done until there has been a public discussion with U.S. Hemp about the implementation of medical marijuana in Arizona. It is clear that Will Humble or the ADHS take an adverserial stance toword the will of the voters and this is the first thing that must be dealt with. It is time for Mr. Humble and the ADHS to admit that marijuana does have medical uses and it is time for them to admit to what they knew about marijauan as a cancer treatment and when they knew it. The studies about marijuana killing cancer cells and tumors has been supressed by the ADHS before the vote on prop 203 and that needs to be addressed before any of these people get an oportunity to do more sabatage to prop 203
The rules regarding the "working day" may prove to be ineffective and problematic. Not all Arizonans work from 8 to 5 Mon through Friday. The language needs to be modified to show that the 'working day' is established by business needs of the employer. This might help cover situations where employees perform shift and/or weekend work. A definition of 'under the influence' needs to be included in the rules. Based on scientific evidence, perhaps a period of time might be used...say, smoking two hours prior to starting work, or something of that nature. And two hours is probably too small a window. Maybe more like 4-6 depending on the person, and their tolerance to the drug. Also, the rules might want to include language that prohibits the use of marijuana at least 24-48 hours prior to working in safety sensitive positions like AIRPLANE PILOTS, etc. This is crucial!!
Medical marijuana should not be allowed to become a source of illicit marijuana; production should be limited to only what is necessary to supply legitimate demand and should be strictly tracked; medical need should be based on medical facts subject to objective review; employers should not be

forced to tolerate impaired employees or protect employees that are in violation of federal law; second hand smoke should not be tolerated (privacy of home should be where a person smokes this illegal drug)

Regulation of patient charges. You might consider some regulation covering the prices charged for the medicine. It may seem inappropriate to regulate charges for medical marijuana because we live in an open market society where demand drives cost, however there are factors involved here that don't apply to other medicines. 1. The number of suppliers is limited by law. Whereas normal pharmacies are not limited in number or in location, this new law does limit the number of dispensaries to a percentile of pharmacies. This narrows the choices of a very ill patient of whom to buy from and how close they might be. 2. There is precedent for ADHS setting prices for services; ambulance service. Not only does ADHS regulate the amount the ambulance service provider can charge, ADHS also regulates how many and who can provide that services through the Certificate of Necessity. This mirrors the agency's setting limits on where dispensaries can be and who is allowed to open them. Why not control how much charges can be? 3. Dispensaries are supposed to be non-profit. Recovery of cost of doing business with a marginal profit is reasonable, gouging the patients who need medical marijuana is not. By limiting charges for the product, not only would DHS be protecting the patient from being over-charged, it would also discourage â€˜investorsâ€™ who think that opening a dispensary is a â€˜gold-mineâ€™ opportunity. 4. Insurance does not cover marijuana. Whereas regular medicines qualify for minimal co-pays for those who have insurance coverage, medical marijuana is not going to be covered by any insurance company. By setting prices, DHS will help ensure those who need the product will have a fair chance of affording it. [redacted]

We can look at this two ways, one are we going to treat medical marijuana as pharmacy or as a bar? For one thing you donâ€™t charge your patients $150 to have the right to prescription medicine such as Codeine, Oxycodone, or Morphine for pain; or Norpramin, Azilect, or Abilify to help fight depression; or Lumigan, Betaxolol Hydrochloride Ophthalmic, or Diamox Sequels for Glaucoma; or Chemotherapy for Cancer patients do you? Than to top it off, charge them for the medication besides would get quite expensive for the patients. Another issue is to have to see a doctor 4 times a year. Is that before or after the patients are allowed their medicine? What about the people that need the medical marijuana right away to relieve symptoms caused by Chemotherapy, Multiple Sclerosis, Epilepsy, or Glaucoma? The idea of charging a dispensary for being there and/or having to move is really strange. Do we charge our pharmacies like that? Not that I am aware of. See the thing is, is that these laws being created are not treating this medicine like a medicine nor is it treating the patients like patients either. If you are going to tax dispensaries and charge the patients to have a license to possess medical marijuana than you ought to think about doing that to the pharmacies. Now if you are going to treat it like alcohol in a bar situation than go ahead and tax the dispensaries like you would a bar, but donâ€™t make patients buy a license. In fact you should legalize it like alcohol is and just put an age limit on it. Than have everyone show their identification card (driverâ€™s license) like you would have to at a bar to get served.

The draft rules must be discarded in their entirety and, in an open and honest process, new regulations should be drafted to the advantage of the suffering, dying, and good citizens of Arizona. Among the serious problems of the current proposals are the following: ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be

"without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h)

cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information. R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. Arizona's pharmacies dispense drugs that are very toxic, yet are not required to have medical directors on-site or on-call. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse.

As a full time provider of HIV services I want it to be very clear that not ALL HIV diagnosed persons are appropriate for the Certification Card. I would very much like to NOT have to have any part of this process and I wish there were Marijuana Clinics that gave the certifications. I have been asked daily when I would be able to give patients their "card". A Medical Director should be appointed for the distribution centers. I feel that as an HIV Provider I am being forced to be a part of a program that will force me to go against what I believe is the appropriate use of MJ, or be that mean provider that patients will loose confidence in my "empathy".

We could improve on some rule by just plain removing them. They are going to cause more harm than good. I believe that rules R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). â€¢ Any Arizona physician may in a single visit prescribe "speed," e.g., Adderall, to a kindergartner-without 4 visits spread out over 1 year any Arizona physician may prescribe to a kindergartner a drug that can kill that child by heart attack, stroke, seizures, or other "side effects." â€¢ Cancer, HIV, Hepatitis C, and ALS patients often do not have 1 year to live. â€¢ The patients that do live are cruelly being told to change doctors or suffer for 1 year. â€¢ Deadly and addictive drugs such as the opiates are prescribed in a single visit by Arizona physicians and, despite the best efforts of physicians, some of those deadly and addictive drugs are illegally diverted, but that does not cause the AzDHS to demand 4 visits, 1 year of visits, or that the pain specialist assume primary care of the patient. â€¢ Marijuana is 100% safe, gives patients good relief, and cures some conditions-Marijuana is not deadly and is not addictive. â€¢ The alternative offered by the AzDHS to avoid 1 year of suffering, the cannabis specialist takes over the primary care of the pt's qualifying condition, is done nowhere else in medicine-Nowhere else in medicine does a specialist take over a patient's primary care. â€¢ The AzDHS does not have the authority to define or re-define the patient-physician relationship or the number of doctors visits, or the length of time for those visits-that infringes on the patient's choice â€¢ The draft regulations are cruel and unreasonable. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine.

The first is the Physician/Patient relationship. To have a one year relationship with a physician before they can receive this medicine, is a very sensitive and serious matter. Some patients do not want to or feel comfortable taking their complete issues of ailments over to a completely "new" physician. This also is like telling the patient who has an oncologist for cancer related issues, to take their issue over

to a physician who is not an oncologist. One year of a relationship between physician/patient could also be an impossible task. Some patients may just learn that they have cancer and that they need to start treatment right away or that they may not have one full year of life left to live to be able to change over physicians to be able to receive medical marijuana. This would limit some patients from being able to receive the wonderful medicinal qualities of marijuana for any sorts of chemo or other issues that effect their appetite, chronic pain or nausea related issues etc. As I am learning, this is a ruling that is not required by other states with medicinal marijuana laws. Why have this here in Arizona? Next issue would be the 70/30 issue for dispensaries having to cultivate 70 percent of their own medicine and only be allowed to purchase 30 percent from other dispensaries. With some of the federal laws kept in mind on cultivation, as far as how many plants an individual can grow before the DEA could step in, this ruling you have made makes any dispensary flirt with the federal laws for cultivation and puts all dispensaries and growers for the dispensaries in risk of federal prison. How will you address this issue? Next issue is the build out on dispensaries to have to be already done and built out, before even knowing if they will get a dispensary license. This ruling puts potential dispensary owners in a high money bracket that stops small business free enterprise from happening...ie: a mom and pop owned dispensary that can supply enough marijuana medicine for patients. This ruling makes many people I have spoken with, feel that this ruling is making it possible for 'Only the wealthy' and not make it available for small business owners who Can make a business happen and work in this industry. Small mom and pop stores open all the time, they do and can work, and they do and can stay in business while being productive and putting money back into the community as well. What would we like to see? No build out mandatory before applying for a license. We would like to see that a well made business plan be shown at the time of applying for a license.
As a physician, I find your rules alarming. The POOR need to be considered. Do not make it hard for those patients in NEED to procure medical marijuana. In many cases it is more effective and less dangerous than pain pills. Make application fees low, make dispensary costs low. Make it easy for the patient to get a doctor. It is up to the doctor, not the patient, not the AZ Health Dept., to determine whether a patient should have medical marijuana.
More clarity on the limitations of cultivation.
Implementing a two stage application process in which AZDHS: 28. TWO STAGE APPLICATION PROCESS: R9-17-302 Applying for Dispensary Registration Certification - - Review the principals and legal entity first. - Perform whatever background checks AZDHS desires, including FBI and all the other requirements as set forth in the proposed rules relevant to the principals and legal entities. - Issue a conditional License to the 125 most qualified individuals subject to approval of the facilities. (dispensary and cultivation sites) - The conditional license would require that the applicant to complete the build-out and/or construction of the facilities within 90-120 days. - Thereafter, the conditionally approved applicant would submit the second half of his application (Facilities) for inspection and approval. - The second half of the application must meet all the requirements of the proposed rules relevant to the facilities. - Provided the applicant meets all the facility requirements he/she would then be issued a Dispensary Registration Certificate

R9-17-102- fees To be a caregiver is to help out a very ill patient out of their goodwill. I would not expect the caregiver to pay any money just to help out their patient in obtaining the medication that they need. Registry Id card should cost 100 and the renewing fee should be 50. Most patients are lower income families that just don't have the money year after year to pay . These debilitating mediical conditions make if very difficult for them to work full time to even afford the medication for themselves. I fully agree on the Dispensary agent for 200, would be another tax for state's economy. R9-17-107 Time-frames B. An address for where the dispensary is to be located and a written agreement with owner of building saying that once the license is issued on contiguity the dispensary will then start setting up shop within 30 days must be an inspection by AZDHS R9-17-202 B. A qualifying patient may have up to 3 care givers at any given time. Say if your caregiver becomes sick, or an emergency happens and the caregiver is gone for 2-3 weeks. A patient needs more then one caregiver to get their medication in a timely manner R9-17-202 F. 5 A physician's written certification in a Department-provided format dated within "30" calendar days before the submission of the qualifying patient's application that includes (undue wait time, the severity of the patient's condition cannot wait 90 days in order to get a card to obtain their medication)..... R9-17-202 5a.v.Email address this should be omitted already have the doctor's license, telephone, and address R9-17-202 5e.i. Has a professional relationship with the qualifying patient that has existed for at least one month and the physician has seen or assessed the qualifying patient on at least 2 visits for the patient's debilitating medical condition during the course of the professional relationship (Living in Arizona 'the nation's melting pot' you constantly have people moving in from out of state. They should not have to wait for a year to get their medication R9-17-202 G. 13 Change 90 calendar days to 30, this would be an undue burden on waiting for 3 months to get your medication. R9-17-202 G 13 e.i.(1) Has a professional relationship with the qualifying patient that has existed for at least one month and the physician has seen or assessed the qualifying patient on at least 2 visits for the patient's debilitating medical condition during the course of the professional relationship (Living in Arizona 'the nation's melting pot' you constantly have people moving in from out of state. They should not have to wait for a year to get their medication R9-17-202 C. change 30 calender days into 7 days for renewing, there is no need for the extra waiting time. R9-17-307 A. 3. Employ or contract with a medical doctor. I believe this should be completely removed from the rules. I believe it could create a conflict of interest. If the doctor is getting financed through a Dispensary, it create a lack of judgement in the doctors favor. R9-17-307 A.4. Provide volunteer services at or on behalf of the dispensary. I have a major issue with this, as a potential dispensary owner, I plan on donating 55% of revenue into local charities and volunteer for local charities. This definitely cannot be in the rules R9-17-307 C.1. A dispensary shall cultivate at least 25% of the medical marijuana the dispensary provides to qualifying patients or designated caregivers: (the reason for such a low % is if something happens to the current grow, if it gets infected or something else goes wrong then the dispensary would be shut down because it wouldn't have enough inventory to make it by. R9-17-307 C. 4.May acquire up to 75% of the medical marijuana the dispensary provides to qualifying patients and designated caregivers from another dispensary in Arizona. a qualifying patient, or a designated caregiver. The reason for this is that the Dispensary needs inventory, if the Dispensary doesn't have the inventory for a week or 2 weeks, they can very well go bankrupt and have to close their doors. R9-17-307 C. 5. Shall not provide more than 30% of the medical marijuana cultivated by the dispensary to other dispensaries. (this omission should just be deleted. For the safety and financial security of the dispensary R9-17-315 Security C v. this should be omitted just for the reason that the grow house will already have enough security with the large walls with barbed wire on top.

#1 R9-17-102. Fees 5. For a registry identification card for a: a. Qualifying patient; $150; b.

Designated caregiver, $200; and c. Dispensary agent, $200; 6. For renewing a registry identification card for a a. Qualifying patient, $150; b. Designated caregiver, $200; and c. Dispensary agent, $200; This is outrageous! I, for one, cannot afford to pay this. Nor could I afford the extremely high prices of medical marijuana that is being charged in other states. Medical marijuana is supposed to be an option to patients who have tried other drugs and procedures that haven't worked, or which have unwanted side effects. How is anyone supposed to afford this? What if you pay all this money and it doesn't work for you? For my family of 3, our total gross income for last year was $39,000. This puts me out of the poverty range to get any kind of state help. My individual insurance premium alone, is $400 per month, and my monthly co-pays for doctor visits and prescriptions run $200+ per month. These fees need to be reduced by at least 75%, or better yet, 90%. This is not supposed to be about fees to generate revenue for an ailing state budget. It's about giving patients the freedom to try an alternative medicine that has been used for centuries and grows wild in nature. #2- I see no exceptions for patients living within the 25 mile range of a dispensary, to cultivate their own plants. This forces patients to pay whatever the dispensaries are asking. Additionally, many patients would prefer to cultivate the plants themselves, thereby allowing them to cultivate the plants without the use of pesticides, inorganic fertilizers, etc... As an avid gardener, personally, I would not trust the medicine I was getting if not cultivated by myself, or someone whom I know personally.

While the proposed fees for dispensaries and patients are generally reasonable, there should be a sliding scale or low cost card for low income patients that may be on Supplemental Social Security, Social Security Disability Insurance or Medicaid. (R9-17-102) While it is reasonable to require there be a legitimate physician-patient relationship, the language requiring four office visits in one year or physician certification of primary responsibility, a comprehensive exam, reviews of medications, medical records and continued assessment is overly restrictive. (R9-17-202) Certification by the physician that the patient has one of the listed diseases and may be able to benefit by the use of marijuana should be sufficient. The draft requires principal officers or board members of dispensaries to have been Arizona residents for at least two years. (R9-17-302) This provision may too narrowly limit the pool of dispensary principals and board members and prevent dispensaries from benefiting from the expertise of successful dispensaries in other states. The draft requires that 70% of a dispensaryâ€™s cultivated marijuana be provided to patients or caregivers while the remaining 30% may be provided to other dispensaries. (R9-17-307) This provision should be rejected and replaced by an open wholesale relationship between dispensaries that does not restrict how much of a dispensaryâ€™s medical marijuana supply must be self-produced and how much may be acquired from other dispensaries. The draft regulation requires dispensaries to have a medical director, either a medical doctor or osteopathic doctor with an active license. (R9-17-101) The medical director position should be widened to include nurse practitioners, public health professionals, toxicologists and medical and osteopathic physicians with inactive (but not invalid) licenses. There may not be 45 medical doctors or osteopaths with active licenses in Arizona willing to work so closely with marijuana dispensaries.

Allow open conversation and input from the parties who are interested in participating in the patient screening, certification, cultivation, supply, and their patients. Turning a deaf ear to their needs, while imposing regulations against them will only result in failure. If this is makes it off of the ground, I'm sure that you would prefer these participants to work with you in a cooperative manner. Apart from the medicinal aspects of marijuana, please consider the following facts: * over 50 years of regulations, incarceration, and negative propaganda has done little to curtail the use of marijuana. However, these same laws and drug screening have reduced otherwise respectable citizens into

unemployable losers (and then blame it on the 'drugs'). Existing laws are more harmful to a person's well-being than marijuana usage itself. *Existing laws force existing marijuana users to buy from violent drug cartels. What could be better than reducing the flow of assult weapons to Mexican villans, while redirecting that money to legitimate local farmers and tax revenue? Legalizing the use of marijuana among responsible adults instantly turns 'criminals' into productive tax payers. Why should that be discouraged? There appears to be a presumption that a dispensary and a grower is one unit. Why can't registered growers be independant suppliers to dispensaries? That would be a more reasonable business model.

I have lived on Arizona my whole life. I currently work in a laboratory researching Alzheimerâ€™s disease, at [redacted] in Sun City. This makes me very familiar with pathology of diseases that affect the elderly. I am involved with both clinical and molecular aspects of research. I have a unique understand of disease, because my experience in the lab, as well as my work with patients, doctors, and scientists. My familiarity with the mechanisms of how drugs interact with patients, makes me a credible source of information. After many long talks with my father and several of his friends, I have decided to work part time as their caregiver. This letter is long, because it greatly affects the health of people I care about. I have put a lot of time and thought into it and hope you will consider my opinion while writing future drafts. My number one concern is the restricting placed on both doctors and patients, which prevent individuals with qualifying conditions from obtaining a recommendation. All of my potential patients receive their medical services through Veterans Affairs medical hospital. These patients have all requested a recommendation from the VA doctors, but have been told that writing a recommendation is against VA policy. My patients should not have to pay hundreds of dollars to see a doctor that is not covered by the VA. This puts patients in a difficult position if they need medical marijuana. Either change their doctor to one that is not covered by insurance or continue buying from illegal sources. I agree that rules need to be put in place, which prevents individuals from gaining a recommendation with a fraudulent condition. However I feel that the best way to address this problem is through diagnosis requirements. HIV, cancer, glaucoma, ALS, Alzheimerâ€™s disease, Cohnâ€™s disease, hepatitis C, and multiple sclerosis have diagnoses that are not easily faked. Any patient suffering from one of these conditions should require no more than a recommendation, after positive diagnostic results. Requiring 4 visits, a year long relationship, or a doctor to assume primary care (R9-17-202-F-5-e) is an unnecessary restriction on patients. While none of my patients have cancer, this measure specifically excludes cancer patients. When cancer is diagnosed, chemotherapy often starts right away. There is no 1 year between diagnosis and treatment. Alternatively the patient would need their oncologist to prescribe the medicinal marijuana. Selecting an oncologist that specializes in the patientâ€™s specific form of cancer is already a challenge. Adding the additional requirement of finding a doctor that is comfortable writing marijuana recommendations only hurts patient care. Prohibiting real patients from obtaining medicinal marijuana, despite a clear diagnosis, does nothing to prevent individuals from obtaining a patient card with an illegitimate condition. Chronic pain is the only prevision that should require additional precautions to prevent fraudulent conditions. Chronic pain can usually be confirmed through results from lab tests that confirm a disease or disorder with chronic pain as one of the symptoms. If the pain is a result of an injury, x-rays or MRIs should be utilized in confirming diagnosis. If the cause of pain is determined through reasonable diagnostics, no additional visits should be required. My patient [redacted] is missing his right leg from the knee down. The cause of his pain is indisputable and should not require additional visits. Fraudulent claims only become a factor when doctors are not able to confirm a cause of the chronic pain through traditional diagnostics. If the cause of pain diagnostic tests come back negative, only then should additional appointments be

required. Doctors would be prevented from setting up shop and writing out prescriptions to anyone with a back ache. At the same time individuals legitimately suffering from severe and chronic pain would not be denied medical marijuana. With proper regulation we should be able to ensure that only patients with legitimate severe and chronic pain are able to obtain a medical marijuana card. Medical marijuana provides a significant reduction in the amounts of opiates required to relive pain. When I first met Bill on Christmas, he was very quiet, barely ate, and had to be assisted by his wife throughout the night. When I saw him on new years he looked like a changed man. He was very engaging, telling jokes, and had regained his apatite. When I remarked at how good he looked, Bill explained that he was having a bad back pain on Christmas and had to increase his dose of oxycodone. This past New Years Eve, Bill was able to take less than half the dose of oxycodone he took on Christmas, because of medical marijuana. Being able to cut Billâ€™s opiate prescription in half will add years to his life, and ensure that he is coherent enough to enjoy them. In my opinion, sustained use of opiates to relieve pain is a terrible treatment. Patients slowly build up a tolerance, leading to higher and higher doses of opiates. This continues until the dosage is so high, it causes repertory depression, which can lead to infections, respiratory arrest, or circulatory collapse. Delaying this opiate tolerance will dramatically improve the lives of many elderly citizens suffering from chronic pain. My second major concern is in regards to requiring dispensaries to grow a 70% of their own marijuana. Colorado has this requirement to minimize the number of unregulated cultivation sights. Arizonaâ€™s law ensures that all medical marijuana comes from a regulated source. By preventing dispensaries from trading merchandise, you are restricting patientsâ€™ choices. I donâ€™t want to be forced into driving half way across the state to get the most effective strain for my patient. Free trade among dispensaries will also hasten the time it takes dispensaries to be up and running. This benefits the state by reducing the number of patient and caregiver cultivators. In the beginning there will be no dispensaries, and all patients and caregivers will have the right to cultivate. The sooner dispensaries become operational, the sooner patients stop qualifying to cultivate. I do not want tens of thousands of people cultivating medical marijuana with dangerous, high voltage, equipment throughout the state. I am not looking forward to cultivating for the first few months, and hope dispensaries are open ASAP, so I can obtain the medicinal marijuana cultivated by others. Allowing dispensaries to trade freely, will decrease patient cultivation, encourage specialization, and ensure that the most effective varieties of medical marijuana are available to all patients. The free market is an excellent way to ensure that the best dispensaries are able to operate in Arizona. Keeping the cost of medical marijuana down is a deep concern for me and my patients. This is why I would encourage the removal of several provisions that increase the cost of marijuana. I am concerned with dispensaries obligations to have a medical director and pharmacist on staff. This easily adds $300,000 to the annual cost of running a dispensary, while providing no benefit to the patient. It also requires the doctor to give up their practice, in a state already in desperate need of more doctors. I fail to see how requiring these two superfluous positions provide any benefit to the patients. I understand that it is a good idea to provide information to patients, but MDs are there to treat patients not write pamphlets. Distributing health information could be taken care of by anyone with hospital, or medical research experience at a far lower cost. Requiring patients to pay 37.5 million a year to support unneeded doctors in 125 dispensaries will only drive prices up and lead patients back to the black market. Inspection of dispensary facilities is another area that I felt needed improvement in efficiency. I like that ADHS require internet accessible cameras. Internet cameras ensure safety of dispensary agents, offers protection from theft, and ensure that the marijuana is obtained from a legal source. If cameras only record 100 plants being harvested, but the dispensary reports obtaining 500 plants worth of marijuana, the dispensary can be reported to the police. I also believe ADHS needs to address why it is inspecting. ADHS should be preventing patients from receiving diseased or

unhealthy plants, and ensuring the marijuana is obtained from a legal source. I think the once a month inspection is far too often for most dispensaries. Many of these cultivation sites are planned in remote places in Northern Arizona. It would be unpractical for ADHS agents spending a several hour long drive to inspect each facility every month. A well run dispensary and cultivation site should be inspected 2-3 times a year at most. Only when sanitation or inventory problems arrive should ADHS increase inspections. ADHS could require the destruction of all diseased plants, and require an additional inspection within one month. If the problem is solved, there is no need for further inspection. If a dispensary is suspected of obtaining illegal marijuana, or making illegal sales the police should become involved. Due to the location of the dispensary and cultivation sights being known, police can easily run surveillance and incarcerate any individuals involved in illegal sales. All ADHS needs to do is ensure sanitation and reporting of inventory discrepancies to the police. Inventory was a portion of the law that ADHS did a very well job regulating. I like that the source of each marijuana purchase is recorded. This ensures that any illegal trading is caught quickly. Verifying the marijuana strain is a provision that will prevent medical marijuana from being combined with illegal pot. I think the inventory section was well written and is need of only minor changes. My only two concerns regarding inventory involves weighing procedures and details of what ADHS is doing with the medical marijuana samples. I feel that weighing unusable marijuana seems unneeded. While keeping track of the number of plants and the amount of usable marijuana seems reasonable, requiring a dispensary to weigh something that would otherwise be trash is just increasing the cost of production. I also think ADHS needs to define its goals for sampling the marijuana. A statement that ADHS wants to ensure there crops are disease free, or not from illegal sources would be enough.

Starting with ARTICLE 3. DISPENSARIES R9-17-302 APPLYING FOR A DISPENSARY REGISTRATION CERTIFICATE B. 1. Is asking for names of board members and name of the person applying for this business as well as the personal info of who is applying. When this is suppose to be about the Dispersary the actual facility the non profit business. It shouldn't be asking if this Non Profit business has any of the following in Section R9-17-302 APPLYING FOR A DISPENSARY REGISTRATION CERTIFICATE B. 1. f i-iv. If this has to be asked about the principal officers and board members what should it matter if people have a judgement,default on student loans or failed to pay child support. When a pharmacy apply for a license the pharmacist doesn't have to disclose this. It is the agents that is owed this or the person that owes this to make arraigement to pay this. How can you determine by this to allow a business to have a license. For Section R9-17-302 APPLYING FOR A DISPENSARY REGISTRATION CERTIFICATE B. 2. If you are applying through this process with the 5,000 fee. Why shoould you be applying again as a agent and paying an additional 200.00 dollars. Section R9-17-302 APPLYING FOR A DISPENSARY REGISTRATION CERTIFICATE B. 3. c i. I see this everywhere throughout the draft saying fingerprints in a Department provided format. Please clarify if you only want a fingerprint card or if you are cleared already with a clearance will that be acceptable. I'm hoping that everywhere that has Department provided format that these items we will have access to this before that application is given out to the public so that the people that are applying for a dispensary will be able to have everything in place to turn in the application. Section R9-17-302 APPLYING FOR A DISPENSARY REGISTRATION CERTIFICATE 4 Policies and procedures I feel that the State law has asked the minimum of the Health Department for its record keeping, security, and inventory that should get turned in every year to the legislature stated in the Prop 203 36-2809 Annual report 1-7. It should be the same the Health Department should ask the same from dispensaries. The law states in 36-2803 4. (a) (b) (c) (d) MINIMUM. Please keep it to that. Hours of operation should be what the business wants them to be it shouldn't be that dispensary should have the same hours of governmental jobs. Dispensaries operate normally on the weekend and later hours. Medical Director how can a non

profit pay a medical director salary. In the Draft R9-17-202 5. e-k shows all about the relationship between a patient and a physician. The physician has an on-going relationship with the patient and should explain to the patient everything and there needs and should continue a relationship with the patient. Inspections: There should be security measure that all facilities take for precautions but the Health Department having authorized remote access to the dispensary's electronic monitoring system and cultivation site is a violation of peoples privacy rights. There is quite a bit of things that you are over stepping the law by what power you want over dispensaries. It shouldn't be that everytime a patient comes in we document what educational support they are given all this educational material should be placed if your facility so patients can review it with comfort and not forced to take it. Inventory control system there is no need to have to disclose to anyone your harvest dates soil watering schedule all this is a cultivators personal information on how they grow. Labeling its understandable to put the strain,amount, if its a sativa or indica dispensary name but everything else is personal information. The samething goes for edibles we should put on the label what medical marijuana is in it and that information that the Health Department wants posted on all labels but nothing more If you want the dispensary to keep patients records for five years what good is it to have the database to enter everything in for the Health Department isn't that what we are keeping such good track of having this database to keep track of things. Clean and sanitation how can you say if someone has to have there nails trimmed short no polish no false nails this is over doing your boundaries.

The first draft of the rules and regulations were beyond the scope of authority that the AMMA law provided for ADHS. While I realize it is a tactic to make the rules very restrictive and then back off some, I think that ADHS has set an adversarial position with patients, caregivers, dispensary agents,and medical professionals. Only the lawyers, who are lining up as we speak, waiting with bated breath to pounce on ADHS, are excited about the first draft. No state has had the regulations and control of growth as AZ Prop 203 provided, it gave you the opportunity to set a model program and a standard for the rest of the nation. Many professionals work their whole lives to have the opportunity Prop 203 has given you. Many would love to have the job of setting up a new industry that could help our state with jobs, income, taxes, and turn this state around. You can make this a win/win for the state of AZ, create a system that will be adopted by other states, and create a legacy for yourself, yet you are approaching this opportunity the wrong way. Follow the law, which calls for minimal regulations, and approach this with the spirit you that you have been given a job and will do it to the best of your ability, regardless of your personal feelings.

Governor Brewer's statement at her Inauguration, "We intend to leave Arizona with a budget that is balanced, fueled by private enterprise, UNENMCUMBERED BY HEAVY REGULATION AND UNNCESSARY RULES." The Prop 203 draft is burdened with heavy regulations making most of this draft arbitrary for patients, not to mention that ARS 36-2803.4 of the Arizona Medical Act (that the people voted in) requires that the ADHS rulemaking be, "without imposing an undue burden on medical marijuana dispensaries...." In addition: ARS 28.1 Section 2 â€œFindingsâ€ of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. This is absolutely outrageous and discriminating and against what the people of Arizona voted in. R 9-17-101.10 is an undue and

unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require â€œongoingâ€ care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patientâ€™s care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous, arbitrary and ABSURD for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The departmentâ€™s regulations are an unreasonable and cruel usurpation of authority and denial of patientsâ€™ rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patientsâ€™ parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. Also, wheelchair and handicapped accessibility must be provided for. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows the qualified patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. This needs to be ongoing as prognoses and patient needs change. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patientsâ€™ rights to choose other providers or sources of information R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. Over regulation. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors.

Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. Over regulation, additional anxiety and inconvenience for patients, also creating additional burden and expense on the system, caregivers and patients. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. The department does not have the authority to establish any of these regulations! R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physicianâ€™s professional practice. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. Over regulation, burdon and additional expense on the system resulting in extra cost to the patient. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse.

Hi Mr. William Humble. My name is [redacted], I am involved with and I have been working dillengently with all members of the [redacted] I have also been working with hopeful dispensary owners, [redacted] as well as many other individuals who are hoping to help this medicinal marijuana movement work correctly in our state. I am a native of Arizona and I have been working hard at putting most Arizona Marijuana Associations together in one room to put our heads together to make this a great state for this new law. There are a few issues that I would like to address. Actually, there are many, but I will start with just a few and come back and drop more on as I get more feedback from the [redacted] group and others. This is because we run all thoughts and possible changes that we would like you to address, through each other first, before just posting them to you. The first is the Physician/Patient relationship. To have a one year relationship

with a physician before they can receive this medicine, is a very sensitive and serious matter. Some patients do not want to or feel comfortable taking their complete issues of ailments over to a completely "new" physician. This also is like telling the patient who has an oncologist for cancer related issues, to take their issue over to a physician who is not an oncologist. One year of a relationship between physician/patient could also be an impossible task. Some patients may just learn that they have cancer and that they need to start treatment right away or that they may not have one full year of life left to live to be able to change over physicians to be able to receive medical marijuana. This would limit some patients from being able to receive the wonderful medicinal qualities of marijuana for any sorts of chemo or other issues that effect their appetite, chronic pain or nausea related issues etc. As I am learning, this is a ruling that is not required by other states with medicinal marijuana laws. Why have this here in Arizona? What we propose, is that this ruling be pulled out completely or revised to address the issue I posted above. What would be fair? Well, any qualifying patient would have the choice of using medicinal marijuana, regardless of how long their relationship with their primary physician. They should be allowed to go to a physician that specializes in knowing the qualities of this medicine, without the patient being required to completely change primary physicians for wanting to use medicinal marijuana as an alternative medicine. Next issue would be the 70/30 issue for dispensaries having to cultivate 70 percent of their own medicine and only be allowed to purchase 30 percent from other dispensaries. With some of the federal laws kept in mind on cultivation, as far as how many plants an individual can grow before the DEA could step in, this ruling you have made makes any dispensary flirt with the federal laws for cultivation and puts all dispensaries and growers for the dispensaries in risk of federal prison. How will you address this issue? Does Arizona have our backs to be able to do a huge grow room to grow enough medicine to supply 70 percent of our own medicine? This is a scary subject that I have heard many many times from potential dispensary owners/growers. How would we like to see this subject worked? Open up the percentage to not having a percentage at all. This would open up dispensaries to work together to keep each other stocked with enough medicinal marijuana for all patients who qualify. Next issue is the build out on dispensaries to have to be already done and built out, before even knowing if they will get a dispensary license. This ruling puts potential dispensary owners in a high money bracket that stops small business free enterprise from happening...ie: a mom and pop owned dispensary that can supply enough marijuana medicine for patients. This ruling makes many people I have spoken with, feel that this ruling is making it possible for 'Only the wealthy' and not make it available for small business owners who Can make a business happen and work in this industry. Small mom and pop stores open all the time, they do and can work, and they do and can stay in business while being productive and putting money back into the community as well. What would we like to see? No build out mandatory before applying for a license. We would like to see that a well made business plan be shown at the time of applying for a license. Showing that they have plans of their build out for their dispensary, have a hold on property or own or already lease property for their location, and also show they have the investors or capital to make this happen. Dispensary owners shouldn't have to be millionaires or even close to millionaires, it does not take millions to build a dispensary, that is proven in many states around our country who have passed the law for medicinal marijuana use. Please do not make it necessary for a possible dispensary owner to have millions of dollars to be able to open up a dispensary. This is really not fair to small business owners. We do hope you understand where we are coming from when we say this. Small businesses have been what have kept free enterprise alive and helped many causes like this in our country. And this medicinal marijuana industry, shouldn't be treated any differently. Please Mr. Humble, keep us little guys who know how to run a business in mind when revising the second draft. I truly thank you for your time and we do hope to see a standard in medicinal marijuana that is unmatched in this industry. [redacted]

[redacted]

Regarding R9-17-314 Product Labeling and Analysis I would propose a bar code identification data collection system was required for cultivatation sites and items sold at a dispensary. Colorado is pursuing a strategy of enforcement of "Think seeds to cash" traceability with automation requirements with 24/7 access with local, state and federal access similar to video Surveillance. Regarding R9-17-312. Qualifying Patient Records This is a healthcare application and the state should be considering how this becomes Electronic Health Records System which could give the state access to the American Reinvestment and Recovery funds. I believe the cards issued to patients should leverage the states investment in the Motor Vehicles system card based system to aid in the data collection process. Governance, Risk and Compliance (GRC) are the primary drivers to solve with a complete archiving solution. You can achieve this with a solution that increases your end-usersâ€™ operating efficiency, solves their regulatory compliance concerns and decreases their costs of electronic disclosure. I would propose the consideration of complaince with Federal Rules of Civil Procedure to Electronic Stored Information to show good faith toward the Federal Mandates. The term has become a legally defined phrase as the U.S. government determined for the purposes of the FRCP rules of 2006 that promulgating procedures for maintenance and discovery for electronically stored information. Electronically stored information, for the purpose of the Federal Rules of Civil Procedure (FRCP) is information created, manipulated, communicated, stored, and best utilized in digital form, requiring the use of computer hardware and software. R9-17-310. Medical Director I would propose the Medical Director also be required to ensure all prescribing physicians be required to have access to a centralized database portal with 24/7 user authorized access requiring all prescriptions are entered into the system specifying the dispensary of choice in order to regulate patient usage. Verizon Wireless Health Information Exchange is an example. As part of the registration fees all medical personal could include a subscription fee to the exchange. Again potentially another step towards State access to Federal ARRA funds for Electronic Health Records.

Include Naturopathic doctors as able to be medical directors of dispensaries. OR explain why the only doctors truly trained in herbal medicine are being excluded.

The draft rules can be improved by ensuring the smaller communities have their voice to allow or/and not allow "democratically" these despenseries into our towns, for the only reason being that it lossens a grip the public hopefully has on the illegal distribution and use of all drugs amongst the citizens. ILLIGAL DRUG DISTRIBUTION AND USE IS NOT ONLY A GOVERMENTS PROBLEM AS WELL AS THE CITIZENS OF THE COMMUNITIES PROBLEM!!!!

I feel there are many areas that need to be approved upon and I am sure many will develop over time. Unfortunately many people are greedy and think of new ways to circumvent the law. -R9-17-302 goes into great detail to ensure the individuals, members, partners, company,...etc are looked at thoroughly. However, investors are not taken into account. Colorado put into their rules and regulations a statement on any investor of 5% or more would need their background checked. I think this is huge to ensure we don't have investors from other states coming in and creating the toxic environment they have developed. I also think this takes into account unlawful characters and drug

cartels. -I believe the point mention above also goes for the two year residency requirement in section R9-17-302.B.3.b -R9-17-302.B.15.a asks whether a pharmacist is on-site or on-call. Is this relevant if there is truly no prescriptions being made? Also is this a requirement? If not why is this question in here? -R9-17-302.B.15.b talks about relaying information on the "importance of physical activity and nutrition onsite." I feel this is good information the dispensaries should provide. However, I don't believe this will always pertain to every patient. Some patients will not be able to perform physical activity or have extreme dietary problems. This is a horrible reflection to put upon the patient. -R9-17-302.B.15.d states "Whether the dispensary has a surety bond and, if so, how much." What is the reason for this question? Is a surety bond a requirement? Will the Department of Health Services be following up on the surety bond to make sure its not from a questionable source. *Also I have been informed of Marijuana Policy Project and Arizona Medical Marijuana Association involvement with the Department of Health Services in creating rules and regulations on the Application Review Board. Due to their involvement it should be mandated per R9-17-319.a.2.g that any member of Marijuana Policy Project or Arizona Medical Marijuana Association should be denied a registration certificate due to the large conflict in interest.

Infusion of marijuana into food products.

The allowable enclosure for a cultivation facility should include walls with barbed wire protection instead of stictly a full enclosure covering. A more patient freindly approach pertaining to registration fees and requirements for sometimes already financially challenged patients creates an undue burden upon them. Requiring a patient to keep track of their designated caregivers information creates an undue burden. The Department has no authority to regulate the Doctor Patient relationship. The 70% cultivation rule will cause shortages of medicine for patients. If a problem occurs in a dispensaries cultivation facility and they loose their inventory the business could be a complete loss due to regulations imposed by the Department. A two stage dispensary application proccess should be implimented to avoid an unjust burden on dispensary owners. The first stage being the provisional approval of the organizations application for dispensary certification pending approval from the second stage where approval of the dispensaries certificate of occupancy and inspection of such location(s). R9-17-106. Adding a Debilitating Medical Condition Item 7 requiring the citations of peer reviewed scientific journals is outside of the Departments authority. R9-17-307. Administration 4.D. This section requires that persons working at contracted food service facilities not have access to medical marijuana. We may want to suggest that persons contracted to process the marijuana from plant to edibles must be supervised by a registered dispensary agent, thus not requiring all persons involved to be registered agents. Cultivation documentaion to include soil types is excessive to the growers; this provision becomes invalid with the uses of hydroponic gardening, does this constitute a non-compliance? The requirement for a medical director needs to be better defined. Medical professionals are just going to cost the dispensary more money, in the end its the patient who pays; there is no insurance for MMJ. The patient shouldnt have to apply for the designated caregiver to provide services, these charges for application fees will only be passed on to the patients causing even further burden.

R9-17-101 (15) There is no need to have a medical Director at the Dispensary, or any at all. The â€œPhysician-patient relationshipâ€ R9-17-101(17) takes care of the complete medical oversight for the patient marijuana use. The â€œDispensaryâ€ R9-17-101(8) should not be required to have a Doctor involved to allow the marijuana purchasing transaction. -- The same argument supersedes the needs listed in R9-17-310(C.2.) All this Medical Director requirement and these inflated fees R9-17-

102(5.) is going to do is drive costs up so high people have to buy their pot on the street. You are requiring the patient R9-17-202(F.2.e.) and caregiver R9-17-202(F.6.i.v.) to be US citizens. That is wrong. My wife was born in Canada but has lived and worked in Arizona for the last 38 years. She is an employee of the [redacted]. She has every right to be my caretaker or, if qualified under R9-17-201 Debilitating Medical Conditions, a patient. --The same change is needed at R9-17-203(2.i.e.) also at R9-17-204(A.5.f.v.) R9-17-101(16) â€œOngoingâ€ Please change the one year physician-patient relationship to six months. I see my chronic pain Dr. every month. Six months gives the Dr. plenty of time to get to know the needs of the patient. One year is excessive. Also a lot of us will be needing to find a marijuana friendly Doctor, my current one is not. Six months will give the â€œphysician-patient relationship time to develop.

The requirement for a Medical Director should be eliminated from the proposed regulations. This will impose additional cost to the patient when most can least afford additional cost is this economic crisis. What if a Medical director can't be found? The requirement for a one year doctor patient relation is an undo burden on the patient as well as 4 visits. This should be deleted. R9-17-102 Fees : A nonrefundable fee is uncalled for burden on a small business person,change it to $1,0 00 of the 5,000 is nonrefundable. Qualifying patient fee should be $50 and renewing $50. to change a location fee should not exceed $500. After all you already paid $5000. The time frames for adding a Debilitating Medical Conditions should be cut in half. R9-17-107 B The registration packet for a dispensary needs to be included in the next draft. F 1. a. add vii. the address of the facility. F. c.formats need to be included in the next draft. R9-17-302 A. I STRONGLY AGREE WITH THIS REQUIREMENT. PLEASE DON'T CHANGE. B. 1. b.delete need a 2 part process this being in the second phase. B.1.g. delete B. 1. f. iii no surety bond site planes, floor plans should be left up to the cities. 15.a. no pharmacist should be required, possible conflict of interest, unneeded expense. 15.d. no surety bond R9-17-306 Item B. The electronic monitoring system access by DHS creates a security risk for the dispensary due to the possibility of transmissions being intercepted or hacked. Also sound like big brother. .R9-17-307 Administration. A. 1. a Your dictating how to run a business 3. delete,4. b. delete C.1.change 70% to 50% way to restrictive. 4. change 30% to 50% same in 5 R9-17-310 entire thing should be deleted R9-17-313 3. a. change soil to type of grow method.

â€¢ The definition of â€˜ongoingâ€™ on page 4 is concerning in that cancer patients may not have a one year relationship with ANY doctor. Is there any other medicine available today where a patient must have such a relationship established? If that long-term relationship is not established, the patient falls under clause b of the definition, which requires that this doctor assume primary responsibility for the patientâ€™s care. At Cancer Treatment Centers of America, care management is provided by a registered nurse with oncology expertise. Radiologists, surgeons and other specialized doctors perform procedures and develop strategies, but do not manage care. According to the draft rules, a nurse would not be able to recommend medical marijuana and neither would any of the specialized doctors because none of them â€œassume primary responsibility for providing management and routine careâ€. It is worth noting that ALL of the doctors and nurse practitioners for these cancer patients are able to prescribe prescription drugs. (See diagram http://www.cancercenter.com/landing-pages/cancer/options.aspx). â€¢ Please consider including Alzheimer's disease to your list of Debilitating Medical Conditions on page 12. Please see the following online summary with referenced scientific papers in this subject: http://norml.org/index.cfm?Group_ID=7003 â€¢ The need for regulation is understandable, but the requirement on page 17 (#11) to have a second physician review the recommendation seems severe. Such secondary review is not a requirement for any other medicine, including those that are

highly toxic and addictive. â€¢ When available, please provide some transparency in the area of selection criteria used to evaluate a dispensary applicant for licensure. To do otherwise invites undue speculation, conspiracy theories and generally negative outcomes. â€¢ A surety bond is a guarantee, in which the surety guarantees that the contractor, or â€œprincipalâ€ in the bond, will perform the â€œobligationâ€ stated in the bond. It is difficult to understand the purpose of a surety bond in Dispensary operations. Please consider giving some rational and specifics on the surety bond that is required, specifically: o A single bond for the dispensary entity, one for each Director or one per agent? o Who is the beneficiary of this bond and under what circumstances? o What amount would be sufficient to protect the interest of the beneficiary? â€¢ It seems very extremely redundant (intended) to require that a Medical Doctor (Medical Director) be tasked with authoring procedures and educational materials and being â€œon callâ€ when qualified patients have already gone through a primary and, sometimes, secondary physician before getting a multi-page written recommendation, and the AZDHS has already approved their patient application. Perhaps a compromise solution would be to have AZ DHS, in conjunction with state doctors, develop standardized educational materials. Similar to HIPPA, perhaps patients need to review these materials and sign a form indicating that they have read / understand the content. Also, producing a video for required viewing might not be a horrible idea. At least this way, the patients would get standardized information without having to pay the costs associated with an on call Medical Director. â€¢ Should AZ DHS persist in requiring a Medical Director, consider that Nurse Practitioners and Advanced Nurse Practitioners can prescribe medications and act as primary care providers. It is incongruent to require that a Medical Director have M.D. or D.O. credentials. â€¢ The requirement for a certificate of occupancy is, arguably, controversial, but needed, where available, to avoid long delays for Dispensaries. Note the situation in Maine, in which Dispensaries were delayed by their municipalities for months following their state approval. â€¢ On one hand it seems to make sense to distribute growing operations and require that a dispensary grow at least 70% of the marijuana it sells. On the other hand, it does not. Walgreens, CVS, Wal-Mart and Costco are not required to produce the pills they sell. Please consider providing some rational in this area or reducing the percentage required.

This draft contains many, many pages of restrictions on medical marijuana that do not be implemented. The cost of meeting all the rules imposed as a patient will allow med marijuana to be restricted to just wealthy patients as insurance will not cover any of the costs. And if your PMD does not chose to prescribe marijuana, then you have to wait A YEAR before you can use it AND pay for 4 medical visits. It would be interesting if there was a state law that spelled out these exact same conditions that Humble proposes for marijuana but was aimed at prescription narcotics. The pharmaceutical companies would be in an uproar and Humble would be job hunting like so many other Americans are now. Pain medication and narcotics are the number one drug prescribed in the USA now. People die from legal prescription narcotics, yet there is no regulations on them similar to what Humble proposes. How many people have died from a marijuana overdose? Yet he wants to regulate it like it's deadlier than prescription narcotics? It is obvious Humble is against medical marijuana, and is trying to impose his negative views on the people that voted this in. Humble, the people have spoken. The statute outlines the how's, and it's up to the individual cities on how they want to regulate it without interfering with the statute. Time to hire a new State Health Director. There are many unemployed people that would be qualified and willing to take this job, and who would be willing to uphold the right of the people to enact laws.

Add as R9-17-312(E): â€œNot less than annually and prior to recertification under R9-17-305, a

dispensary shall submit to the Department a report covering the period from the last certificate was issued to that dispensary that contains the following information: (1) the total number of sales of marijuana products, detailing each kind of product sold; (2) the total amount of usable marijuana sold; (3) the total amount of usable marijuana produced or otherwise procured; (4) the total amount of marijuana on hand; (5) the total amount of cash or other reimbursement realized for the sale of marijuana; (6) the total amount of cash or other reimbursements paid for producing or acquiring marijuana.â€ Modify R9-17-102(5)(b) and (6)(b) as follows: â€œDesignated Caregiver, $200 per patient for which caregiving services are provided.â€ Create Article 4 for the Medical Marijuana Program in DHS Rules that governs medical professionals wishing to issue medical marijuana certifications in Arizona. Medical professionals must meet the following requirements: (a) DHS must create and administer a medical professional certification registry. (b) Qualified medical professionals that wish to issue certificates under the initiative must register annually with DHS and pay a reasonable annual fee to offset the cost of registry administration. (a) Medical professionals must be Arizona licensed in and primarily practice in Arizona. (b) No more than 30 active patient registry cards may be issued based on the certification of an individual medical professional at any one time. (c) Medical professionals must see their certified patient at least once every 6 months, face to face, and document they have done so in annual certifications. (d) Medical professionals may not issue certificates to themselves or immediate family. (e) Medical professionals undergoing discipline or substance abuse problems must not be authorized to issue certifications. 19 (f) Medical professionals recommending the patient be dispensed a smokeable form of marijuana, must provide a statement detailing at least 3 efforts of the medical professional and patient to administer infused marijuana, a statement detailing why such attempts were unsuccessful, and a declaration from the medical professional why only smokeable marijuana will alleviate the patientâ€™s condition. (a) Add to new Article 4 a requirement that the medical professional must notify the Department within 3 business days if the patient no longer qualifies for certification for medical marijuana, or if the medical professional has not had a face to face contact with the patient for more than 180 days. (b) Add R9-17-205(I) to require the Department to revoke a Qualifying Patientâ€™s Registry Identification Card upon notification by the certifying medical professional that the patient no longer qualifies for certification or that the medical professional has not had a face to face contact with the patient for more than 180 days. (c) Add to R9-17-202, 203, and 204 a section that requires certification from two medical professionals for any person applying for a registry identification card after having had a previous one revoked under R9-17-205(I), and require both certifications state that the medical professional is aware of the grounds for prior de-certification.

A medical director should be allowed to prescribe medical marijuana to his/her patients in the separate setting of his/her office; although it should be inappropriate to prescribe it under the role of dispensary medical director. The private practice setting and the individual doctor patient relationship shouled tsuffer just because a doctor happens also to serve as a director in an entirely different setting/role.

Personal cultivation should not be restricted to people living 25 or more miles away from a dispensary.

How long must the records be retained? If records are lost/stolen, what types of notifications must be sent out? Do these rules follow HIPAA? R9-17-312. Qualifying Patient Records A. A dispensary

shall ensure that: 1. A qualifying patient record is established and maintained for each qualifying patient who obtains medical marijuana from the dispensary; 2. An entry in a qualifying patient record: a. Is recorded only by a dispensary agent authorized by dispensary policies and procedures to make an entry, b. Is dated and signed by the dispensary agent, c. Includes the dispensary agent's registry identification number, and c. Is not changed to make the initial entry illegible; 3. If an electronic signature is used to sign an entry, the individual whose signature the electronic code represents is accountable for the use of the electronic signature; 4. A qualifying patient record is only accessed by a dispensary agent authorized by dispensary policies and procedures to access the qualifying patient record; DRAFT 12/17/10 40 12/17/10 5. A qualifying patient record is provided to the Department for review upon request; 6. A qualifying patient record is protected from loss, damage, or unauthorized use; and 7. A qualifying patient record is maintained for five years from the date of the qualifying patient's or, if applicable, the qualifying patient's designated caregiver's last request for medical marijuana from the dispensary. B. If a dispensary maintains qualifying patient records electronically, the dispensary shall ensure that: 1. There are safeguards to prevent unauthorized access, and 2. The date and time of an entry in a qualifying patient record is recorded electronically by an internal clock. C. A dispensary shall ensure that a qualifying patient's record for a qualifying patient who requests medical marijuana from the dispensary contains: 1. Qualifying patient information that includes: a. The patient's name; b. The patient's date of birth; and c. The name of the qualifying patient's designated caregiver, if applicable; 2. Documentation of any patient education and support materials provided to the qualifying patient or the qualifying patient's designated caregiver, including a description of the materials and the date the materials were provided; 3. For each time the qualifying patient requests and does not obtain medical marijuana or, if applicable, the designated caregiver requests and does not obtain medical marijuana on behalf of the qualifying patient from the dispensary the following: a. The date, b. The name and registry identification number of the individual who requested the medical marijuana, and c. The dispensary's reason for refusing to provide the medical marijuana. D. A dispensary shall provide qualifying patient record to the Department for review upon request.

1. I wouldn't rule out partial out of state ownership of dispensarys. Make it 50% Arizona resident or 100% Arizona property owners. 2. Let a physician recommend marijuana - period. Time restrictions are wrong. They don't do it with any other medicine. 3. No time limit with physician. What if you are new to the city. What if it is a specialist. 4. Allow delivery. Some sick people are home bound or can't drive. 5. Make the liscense affordable. $50 is fair. 6. Let a dispensary buy marijuana from other sources. You don't limit a Walgreens type store of where they get their products. 7. Allow smoking or eating on premisis based on zoning.

Are the following Security Rules the same for all pharmacies? The Security rules for the dispensaries should not be more stringent than a typical pharmacy. This set of rules may inadvertantly raise the cost of establishing a dispensary. These additional costs will be passed along to patients already incurring high medical expenses. R9-17-315. Security C. To prevent unauthorized access to medical marijuana at the dispensary and, if applicable, the dispensary's cultivation site, the dispensary shall have the following: include: a. Devices or a series of devices to detect unauthorized intrusion, which may include a signal system interconnected with a radio frequency method, such as cellular, private radio signals, or other mechanical or electronic device; b. Exterior lighting to facilitate surveillance; c. Electronic monitoring including: i. At least one 19 inch or greater call-up monitor; ii. A video printer capable of immediately producing a clear still photo from any video camera image; iii. Video cameras: (1) Providing coverage of all entrances to and exits from limited access areas and all

entrances to and exits from the building, capable of identifying any activity occurring in or adjacent to the building; and (2) Have a recording resolution of least at 704 x 480 or the equivalent; iv. A video camera at each point of sale location allowing for the identification of any qualifying patient or designated caregiver purchasing medical marijuana; v. A video camera in each grow room capable of identifying any activity occurring within the grow room in low light conditions; vi. Storage of video recordings from the video cameras for at least 30 calendar days; vii. A failure notification system that provides an audible and visual notification of any failure in the electronic monitoring system; viii. Video cameras and recording equipment with sufficient battery backup to support at least five minutes of recording in the event of a power outage; and ix. The capability of providing authorized remote viewing of live and recorded video with: (1) Internet connectivity of at least 384 kbps upstream; and (2) A static IP address to allow for remote connection; d. Panic buttons in the interior of each building; and
16. "Ongoing" when used in connection with a physician-patient relationship means: a. The physician-patient relationship has existed for at least one year and the physician has seen or assessed the patient on at least four visits for the patient's debilitating medical condition during the course of the physician-patient relationship; The definition of "Ongoing" is too stringent. Too many medical conditions progress at a rate too rapid to develop an ongoing relationship of at least one year. In addition, it seems burdensome and cost prohibitive for a patient to visit a physician at least four visits.
see above info
It is confusing on what operating procedures the department is requiring to obtain dispensary license. The term operating procedure pops up in many sections but it is not clear if those are at time of submission or in place for operation and on hand for when the department requests. Also the request for business records is in unclear. Are these for personal records or for the dispensary non profit records kept once dispensary is up and running. The request for business plan is strange for a state agency. It needs to clarify a couple points. It seems that the guidelines are asking for how the dispensary's profit will be put to use. Due to the dispensary being non-profit, it leads one to believe that the state is asking for wording explaining where the profits from medical marijuana will be put into action in the community, more than a business plan that a banker will be looking for in this case. Plus, the difficulty of developing a business plan in the first year for a system that will depend on the state processing patients leaves much to the imagination.
The time and duration of the Dr. patient relationship seem to be unnecessarily onerous and lengthy. This could prevent needed care for a patient. The 70-30 requirement for growing seems unnecessary and would lead to difficulty in proper regulation and quality control.
See Matforce recommendations
The draft laws appear to have fiscal and political motivations that do not serve the citizens of AZ. Homeopathic and Naturopathic Physicians have been unjustly eliminated from the distribution of effective and cost effective health care to AZ residents. The greed and self serving interests of MD's

and DO's has cost the residents of AZ millions due to their own self interest. When are we going to stop the self serving motivations of this group that destroys the health and economy of AZ? The state of AZ has declared that ND's and HMD's are licensed care physicians in our progressive state.

R9-17-101: 16 â€“ â€œOngoingâ€ â€“ The definition for ongoing is facially discriminatory in that it discriminates against low-income patients, veterans, and uninsured potential medical marijuana patients. The definition does not follow the purpose of the proposition as voted on by the citizens of Arizona because it serves to deny medical marijuana to those patients who discover shortly before death that they have a qualifying condition. These are some of the people that most need access to medical marijuana, and denying them based on lack of a one-year doctor patient relationship will only serve to frustrate the purpose of the statute. A doctor can adequately assess a patientâ€™s need for medical marijuana in a single visit. 16(b) provides for the important ongoing monitoring of the patientâ€™s progress, and is good for monitoring after the fact instead of a year before the fact when the patient needs medicine. R9-17-307 â€“ C(1) â€“ The 70/30 rule will create shortages for patients in rural areas and increase prices across the state because facilities better suited to cultivation will not be able to adequately supply those better suited to dispensing. Please reject this rule in favor of a open relationship that does not impose supply restrictions. R9-17-310 â€“ Other health professionals are capable of serving in the role of medical director. As written this is too restrictive because of the continued illegality of medical marijuana on the federal level and many doctorsâ€™ hesitance to embrace â€œnewâ€ medicines soon after they are made available. R9-17-311,12 â€“ Maintaining dispensary records for five years is excessive, and records should be kept by patient and caregiver ID, not name.

Delete: R9-17-310 There is no need for a medical Director to be onsite. The pt has already established a relationship with their personal DR. who can provide the appropriate information and monitor the patients usage and health. Having another Doctor provide more and possibly conflicting information,can be detrimental to pt. health and care. Lower pt. fee for medical card. Lower 5k dispensary application fee, comes across as enabling the wealthy and limiting others. $2500 address change is excessive esp. after a 5k dispensary app fee. Should allow a one time free change

The draft rules would make the legal prescription, distribution and use of medical marijuana impossible to achieve in a clinically or humanely effective way. It completely usurps medical judgment and universally accepted notions of physicain-patient relationship. Nowhere else in medicine is a doctor required to wait a year before initiating treatment whose need can be clinically determined in one visit. Nowhere else in medicine must a patient wait a year, or even the time it takes for 4 doctor visits, before she "qualifies" for relief of suffering. Nowhere else in medicine must a physician specialist unethically assume primary care of a patient in order to treat the condition for which he is exclusively qualified. This would constitute medical malpractice. Nowhere else in medicine is a patient compelled to surrender her right to qualified primary care in order to be treated by a specialist. Perhaps the rule drafters would like to turn their primary care over to their opthamalogist? No other pharmacy is required to operate from within the confines of walled, patrolled fortress. It is quite obvious that the proposed rules are intended to circumvent any and all legal avenues by which the medical marijuana law can be implemented. The proposed rules are a cruel, shameless and fundamentally illegal attempt to treat as criminal the humane treatment of human suffering. The draft rules must be consistent with every other medical treatment norm. I direct your attention to the comments of valley physician Dr. Sutar for a detailed critque of the rules. I concur with Dr. Sutar's comments in their specifics and in their entirety. regards, [redacted]

I feel the patient and doctors relationships are being overly scrutinized. Why a patient would need to have a 1 year relationship with 4 visits to qualify for marijuana is unknown to me. A doctor can currently write prescriptions for medications far more lethal than marijuana without such scrutiny. Not every Arizona resident has the means or insurance to maintain a primary care physician. Additionally anyone currently working with a federal doctor such as veterans will not be immediately able to obtain a doctors recommendation. Requiring a dispensary to have a medical director shows how the AZDHS views the use of medical marijuana. The fears of the AZDHS should not impede the ability of the dispensary to operate. If the a patient has questions they should consult the physician who gave them the recommendation. It could prove difficult for a dispensary to contract such a physician and what liability would the medical director absorb in this role? As for the educational material, I understand the need and the importance of such material. But for the sake of a consistent and dependable information, I think it would be more beneficial if the state developed material dispensary's should administer during new patient registration or even with each sale. From what I see in the draft, at the time of application the dispensary must already have a sight location for the dispensary and cultivation sight being that dispensary's must grow at least 70% of their own medical marijuana. I feel this is a little difficult to mandate as that requires significant investment with no guarantee. This leads me into additional questions about the application review process. From what I understand cities are going to be designated a certain amount of dispensaries that can open up. What concerns me is that even if I am one of the strongest applicants but am looking to serve patients in an area that is popular among applicants, will I miss out on the opportunity to operate a dispensary over possibly a less qualified applicant who applied for a more rural area and is the only applicant for that area? I feel the only way to safely address would be with a lottery system. While this scares me as very qualified applicant, I feel this approach should ensure there is no political favors being offered to any applicants and address the concerns I mentioned. An example will be provided below. An example of the lottery system could give each applicant 3 tickets that were numbered 1 through 3 based on their preference. The applicant could choose to put all their eggs in one basket or divide them out over various cities. If an applicant was fortunate enough to get selected in more than one city, they would be defaulted to the city with the higher preference ticket. Then after the dispensaries were selected they could get to work developing their site and set an appointment with the AZDHS for inspection prior to opening.

#l. The licensing application should be a two step process. First the approval of the application and its applicants, then the final licensing approval within 90days after the inpection of the facitly. This will allow the applicant to first aquire a conditional license before they sign a lease and aquire a facility. It would be poor business practice and financially irresponsible to sign a lease and build a facitly on a gamble that one would qualify for a license. #2 The information provided in the application should be kept confidential to protect against identity theft and to prevent possible law suits against the State should this occur. #3. A waiting list approval could be implemented if a company does not meet their deadline or if another company goes out of business then the next in line could be selected. #4. Business should not have to be Non Profit, this adds to the expense of the Corporation. Physician office as well as Pharmacys are not Non Profit.

R9-17-101. Definitions 16. "Ongoing" when used in connection with a physician-patient relationship means: a. The physician-patient relationship where the debilitating medical has been assessed

Naturopathic Medical Doctors (NMD) were excluded from the ability to be medical directors of medical marijuana clinics. NMD's are clinically trained experts in herbal therapy and have studied the

benefits, mechinism, phytochemistry and side effects of hundreds of herbs. NMD's are the most trained and experienced physicians in herbal therapy and should therefore have the privilage of being medical directors.

R9-17-101. Definitions 15. "Medical director" means a person or persons who will oversee the policies and practices on patient information and who has been designated by a dispensary to provide medical oversight at the dispensary. This person does NOT need to have a medical degree, but must assist in the development, review and maintenance of records as determined by by a State sponsored Medical Research Panel from the University of Arizona and Arizona State

I feel that a major part of the draft rules that can be improved is the area in which the department's proposal specifies that the patient must have severe and chronic pain as a result of a chronic or debilitating disease or its treatment. In my case, I do not have a disease. However, I do have chronic debilitating pain and muscle spasms that were onset by a traumatic head on collision car accident in 1999 which I was ejected through the windshield and suffered lacerations to the face, a severe concussion, and started the beginning of severe chronic back and nerve pain. I have been successful in using treatment with other narcotic pain medications but these treatments begin to stop working after long term use/tollerance and leave one with little options. I would greatly benefit from the use of Medical Marijuana and would feel much better knowing that these treatments could be utilized correctly under my doctors supervision, rather than having to self medicate Illegally. Thank you for your time and consideration, [redacted]

PLEASE CLARIFY YOUR ASSOCIATION WITH MPP AND AMMA specifically Andrew Myers and his "round table" that has recently come to light. If these allegations are true in any sense then this process is tainted and people need to go to jail!

Please see below.

start over and don't regulate to the least common denominator...think about the sick people this medicine will help and write rules to facilitate their healing.

R9-17-307. Administration should be rewritten as shown below. A. A dispensary shall: 1. Develop, document, and implement policies and procedures regarding: a. Job descriptions and employment contracts, including personnel duties, authority, responsibilities, and qualifications; personnel supervision; training in and adherence to confidentiality requirements; periodic performance evaluations; and disciplinary actions; b. Business records, including manual or computerized records of assets and liabilities, monetary transactions, journals, ledgers, and supporting documents, including agreements, checks, invoices, and vouchers; c. Inventory control, including tracking, packaging, accepting marijuana from qualifying patients and designated caregivers, and disposing of unusable marijuana; d. Qualifying patient records, including purchases, denial of sale, delivery options, if any, confidentiality, and retention; e. Patient education and support. Information collection will be handled by the Department of Health by a survey. Questions to be determined by a State sponsored Medical Research Panel from the University of Arizona and Arizona State 2. Maintain copies of the policies and procedures at the dispensary and provide copies to the Department for review upon request; 3. Not allow an individual who does not possess a dispensary agent registry identification card issued under the dispensary registration certificate to: a. Serve as a principal officer or board member for the dispensary, b. Be employed by the dispensary, c. Have access to medical marijuana

at a food establishment contracted to infuse medical marijuana into edible food products for the dispensary; or d. Provide volunteer services at or on behalf of the dispensary; and 4. Provide written notice to the Department, including the date of the event within ten days after the date, when a dispensary agent no longer: a. Serves as a principal officer or board member for the dispensary, b. Is employed by the dispensary, c. Has access to medical marijuana at a food establishment contracted to infuse medical marijuana into edible food products for the dispensary, or d. Provides volunteer services at or on behalf of the dispensary. B. Except as provided in subsection (C), a dispensary shall cultivate the medical marijuana dispensed by the dispensary in an enclosed, locked facility. C. A dispensary: 1. Shall cultivate at least 70% of the medical marijuana the dispensary provides to qualifying patients or designated caregivers; 2. Shall only provide medical marijuana cultivated or acquired by the dispensary to another dispensary in Arizona, a qualifying patient, or a designated caregiver authorized by A.R.S. Title 36, Chapter 28.1 and this Chapter to acquire medical marijuana; 3. May only acquire medical marijuana from another dispensary in Arizona, a qualifying patient, or a designated caregiver; 4. May acquire up to 30% of the medical marijuana the dispensary provides to qualifying patients and designated caregivers from another dispensary in Arizona, a qualifying patient, or a designated caregiver; and 5. Shall not provide more than 30% of the medical marijuana cultivated by the dispensary to other dispensaries.

The disabled veterans that do not have medical health insurance need to be considered as to the draft rule that the patient needs to have seen a private doctor for over a year or four medical office visits. I have been to both the Phoenix VA hospital as well as the Williams Field VA Clinic dozens of times for different problems. I don't think that any of the federal government employed Doctors would be willing or allowed to provide a prescription for medical marijuana. I do not have heath insurance other than the VA and have not been to a private Doctor in several years. I have been provided from the VA with copies of my medical records which is 3-4 inches thick. Will a private medical Doctor be able to form a opinion and provide a prescription, if warrented, from these records? So how is a disabled low income veteran suppose to aquire a prescription? Could this problem be addressed on behalf of the thousands of Arizona disabled veterans who might benefit from the new medical marijuana program? Thank You

R9-17-311 Medical Director 1. a. Omit the requirement for the medical director to give alternative medical options for the condition. The medical director does not have a physician-patient relationship with the patient. That is something the qualifying physician should be providing to the patient not the medical director. In addition it is undermining to the recommendations of the qualifying physician who is responsible for the patient's care. Add this as a requirement for the qualifying physician! R9-17-306 Inspection B. Requiring the dispensary to provide authorities authorized remote access to the dispensary's electronic monitoring system. This is concerning on several levels: a. On an inspection side it may seem reasonable, but overall security of the dispensary is compromised if an outside entity can get into the electronic monitoring system. It is one more level that can be breached lthat leaves the dispensary more vulneriable to theft. It is reasonable that the authorities have access to all tapes/recordings but access to real time remote monitoring is not reasonable or practical on the security side b. There are concerns about HIPPA HITECH privacy violations of the patients privacy rights. c. It's an over intrusion of the Dept of Health and an expression of lack of trust that the dispensary and the agents will follow the regulations set forth. R9-17-315 Security B. Transport between dispensory and: There should be added an additional transport site of: 5. laboratory contracted with dispensary to conduct analysis of the medical marijuana.

I feel that a major part of the draft rules that can be improved is the area in which the department's proposal specifies that the patient must have severe and chronic pain as a result of a chronic or debilitating disease or its treatment. In my case, I do not have a disease. However, I do have chronic debilitating pain and muscle spasms that were onset by a traumatic head on collision car accident in 1999 which I was ejected through the windshield and suffered lacerations to the face, a severe concussion, and started the beginning of severe chronic back and nerve pain. I have been successful in using treatment with other narcotic pain medications but these treatments begin to stop working after long term use/tollerance and leave one with little options. I would greatly benefit from the use of Medical Marijuana and would feel much better knowing that these treatments could be utilized correctly under my doctors supervision, rather than having to self medicate Illegally. Thank you for your time and consideration, [redacted]

I think its unfair to put an undo burden to charge a terminally ill patient $150 for a medical card and make people jump thru hoops to just to try a medicine that is much less harmful than narcotics doctors are providing.

1. Certified doctors must answer to AZDHS, and only be AZ Doctors. Doctors to be certified. 2. Patient and Doctor must meet in person. 3. Limit number of marijuana patients per doctor to 30. 4. Patients provide medical history to doctors for their chief complaint including workers comp claims 5. Database tracking doctors that write certifications and patients they are written for including the medical condition 6. Add requirement for a psychological evaluations for minors 7. Legislation authorizing lawsuits against doctors that are negligent, including where it causes injury 8. Stronger penalties for forged/fake cards 9. Card to have doctor name, office address and phone number 10. Caregivers must be trained, earn a certification (statewide standardized) that must be renewed annually. This includes those who transport MM. 11. Training, licensing, certification process for caregivers to include: legal requirements, handling, safety, security, transportation requirements (sealed container) and penalties. 12. Active duty certified public safety officers cannot be medical marijuana holders. 13. Transportation must be in a sealed, tamper proof container and have a chain of custody. 14. It is illegal for cardholders to smoke MM in the presence of minors. 15. Cardholders must keep supply of THC locked in a secure area, just as they have to lock growing plants. 16. Establish strict standards including photo ID, DL or other state issued ID. 17. Cardholder must be an AZ resident according to AZ residency requirements 18. DHS should have a Review Panel to review the case of anyone who gets a marijuana recommendation for more than one year. 19. Doctors must report all data. We need a list of what data must be collected and kept Â¬ age, diagnosis, number of prescriptions per doctor per month, how long patients are kept on pot. Records we need from dispensaries: how often patients go to dispensaries, times of day and week that marijuana is sold by dispensaries. 20. Requirements for trials of standard medications first, including marinol. 21. Managed care does this. It should be a requirement with most illnesses to prove that. Penalties for doctors abusing dispensing. 22. Special review of doctors prescribing more than 30 cards per year. 23. Doctors canÂ¹t prescribe to family, friends or self. 24. Doctors must be Arizona licensed physicians and live in Arizona. 25. Make special requirements about how they come up with the need for medical marijuana. 26. Doctors must see patients every 2 months. (like Adderall) 27. Make it clear what doctors can be disciplined for. 28. Doctors with substance abuse issues and legal problems canÂ¹t be approved to write marijuana recommendations. 29. Define doctorÂ¹s liability for prescribing marijuana. 30. Require insurance & bonding for prescribers. 31. Get the licensing board

to define improper prescribing. 32. Exclude internet docs, out of state docs and patients. 33. No doctor can have more than 25 active marijuana patients at one time (like suboxone) 34. Second opinions required for: patients given a marijuana recommendation on their first visit to a doctor, patients with a diagnosis of pain or muscle spasms. 35. Requirement that patients try two standard medications first, especially marinol. Anti-nausea drugs for HIV/AIDS 36. Glaucoma only by ophthalmologist. 37. Cancer only with cytological or radio logic evidence. 38. Zoning ordinances to require dispensaries and home grows in specified zoning districts 39. Home and commercial grown facilities, once licensed, must be included on DHS website. Database accuracy must be a priority. 40. DHS to delegate authority for inspection to local authorities through IGAâ€™s. 41. Home grow to require training and a fee.
Clarification on R9-17-107. Time Frames B. Need clarification on if the dispensary must be ready to open when applying for the dispensary application.
1. I believe the 25 mile rule should be specified as DRIVING DISTANCE to dispensary. 2. I do not believe the patient should need to have an established (one year) relationship with any doctor for a recommendation. No other prescription requires this including many much stronger pain medications. 3. Patients make good caregivers due to the better understanding of the medicine and how it helps with different conditions, what strains help with pain, what strains help with spasms or siezures. Let anyone who is actually sick with debilitating condtions be caretakers as well. 4. The structures you describe with 12 foot high walls and cage tops (outdoor grow structures) are basically ovens. This is something that really needs more thought. I understand the need for security, but the structure described, unless you were growing a landrace strain found growing in the Sahara desert, is an oven.
The Original Prop 203 that passed by the majority of Arizona residents, stated the definition of Physicians to include MD's, DO's, Naturopathic Doctors and Homeopathic Doctors, your draft has changed the legal definition to "Medical Director" and has excluded Naturopathic and Homeopathic Physicians. These two excluded licensed physicians in the proposed draft are the most highly qualified to recommend medical cannabis. I'm greatly concerned this exclusion of Alternative Medicine licensed primary care physicians in OUR wonderful state is politically motivated by self serving interests.
The Original Prop 203 that passed by the majority of Arizona residents, stated the definition of Physicians to include MD's, DO's, Naturopathic Doctors and Homeopathic Doctors, your draft has changed the legal definition to "Medical Director" and has excluded Naturopathic and Homeopathic Physicians. These two excluded licensed physicians in the proposed draft are the most highly qualified to recommend medical cannabis. I'm greatly concerned this exclusion of Alternative Medicine licensed primary care physicians in OUR wonderful state is politically motivated by self serving interests.
1. Eliminate the "Ongoing" definition 2.Do not exempt AzDHS from A>R>S> 4-1001
include NDs (Naturopathic Doctors) in the group of doctors allowed to operate in this new arena
1. Eliminate the requirement for a medical director. This greatly increases operational costs that will be passed on to the patients. It's not in Prop 203 and is unreasonable. Is there any other retail business in Arizona that must have a medical director? My understanding is that no other state that

legalized medical marijuana requires dispensaries to have a doctor as a medical director. Do you know if a doctor's malpractice insurance would cover services to the dispensary? The doctor may not be covered by malpractice insurance because the insurance company may say that being a medical director for a marijuana dispensary involves an industry that violates federal law and/or does not involve the practice of medicine. 2. If you retain the medical director, allow licensed pharmacists to be a medical director. 3. Do not require dispensaries to get a certificate of occupancy. Many cities (Mesa for example) do not provide a CO,. It was only a few years ago the Phoenix started issuing them. 4. Do not require Arizona residency. It's not is Prop 203 and is unreasonable. I don't believe there is any other type of business in Arizona that must be owned by an Arizona resident. 5. Give dispensaries guidance on what criteria you will use to select licensees. 6. Create a preliminary approval so dispensaries can determine they will be able to get a license before spending a large amount of money without any assurance they will actually get a license. Dispensaries could then build tenant improvements, purchase equipment and hire personnel knowing that they have a good chance of getting the license. Applicants that are rejected and that do not get preliminary approval, will be spared wasting their money. 7. Ease up on the requirements for a patient to get a recommendation from a doctor. As one local doctor wrote recently, doctors can see a patient once and prescribe any number of drugs that are potentially much more harmful than marijuana. 8. Eliminate or greatly reduce the requirement that a dispensary grow at least 70% of the marijuana it sells. This growing requirements causes dispensaries to fund and operate a retail business and a farm, both of which are time-consuming and expensive. Let dispensaries that want to grow more than the sell do so. It would reduce the capital required by other dispensaries.

R9-17-101: 16 â€“ â€œOngoingâ€ â€“ The definition for ongoing is facially discriminatory in that it discriminates against low-income patients, veterans, and uninsured potential medical marijuana patients. The definition does not follow the purpose of the proposition as voted on by the citizens of Arizona because it serves to deny medical marijuana to those patients who discover shortly before death that they have a qualifying condition. These are some of the people that most need access to medical marijuana, and denying them based on lack of a one-year doctor patient relationship will only serve to frustrate the purpose of the statute. A doctor can adequately assess a patientâ€™s need for medical marijuana in a single visit. 16(b) provides for the important ongoing monitoring of the patientâ€™s progress, and is good for monitoring after the fact instead of a year before the fact when the patient needs medicine. R9-17-307 â€“ C(1) â€“ The 70/30 rule will create shortages for patients in rural areas and increase prices across the state because facilities better suited to cultivation will not be able to adequately supply those better suited to dispensing. Please reject this rule in favor of an open relationship that does not impose supply restrictions. R9-17-310 â€“ Other health professionals are capable of serving in the role of medical director. As written this is too restrictive because of the continued illegality of medical marijuana on the federal level and many doctorsâ€™ hesitance to embrace â€œnewâ€ medicines soon after they are made available. R9-17-311,12 â€“ Maintaining dispensary records for five years is excessive, and records should be kept by patient and caregiver ID, not name.

Notwithstanding the â€œloopholeâ€ for chronic pain, eliminate the concept of â€œongoingâ€ and â€œ physician-patient relationshipâ€ from the draft rules at LEAST for glaucoma.

Definitions of the following need to be added: Inventory What is an inventory audit? Audit

I have many criticisms of the proposal, but I will defer to Dr. Edgar A. Suter, who has already said

everything I thought of more eloquently than I could have dreamed of. "ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." ARS 28.1 Section 2 "Findings" of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 9 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require "ongoing" care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patient's care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis specialist may not have the requisite training or experience to do so. The department's regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patients' rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patients' parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(2) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily living. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every

year. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h) cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physician's professional practice. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse."

They could be improved by cutting the fat: getting rid of say 90% of the proposed regs.

R9-17-315. Security It is recomended to enhance the security of the facilities that the following voluntary video security measures be enacted. Recomendations to remain the same with the omisison of 2.iv 2.v. ix. 1 ix. 2 Which must be legal and unconstitutional as requirement.

1. Medical directors should not be required for each dispensary, 2. The cost for medical directors would put undue burden on small business. 3. Dispensaryâ€™s should be able to serve any patients with a valid medical use card issued by any state where similar laws for medical use have been approved by popular vote. 3. Remember that patients are not criminals the law was voted in by popular vote to help sick persons. 4. My doctor gives me a prescription for 5 different drugs for a 1 year period and I can even have the pharmacy call and get another few months supply in a pinch but I have to make an appointment to see the doctor. When I see the doctor he reminds me that I need to see him every 6 months and he refills my 1 year prescription. Why is the AZ Dept of Heath services treat these patience differently than another medical patient could that be discrimination. 5. Delete the 70-30 rule, they should be allow to purchase and not have to grow the marijuana cost are significant to start up and you are making it that way. 6. The very restrictive rules and regulations will make the cost of the medicine inflated.

As stated above, I think the draft rules can be improved to really consider abuse by qualified patients and caregivers. Not that I assume these people are necessarily out to break the rules, but I think a whole can of worms will be open if neighbors and criminals discover someone is growing on their property. I am concerned with the crime element having access to innocent civilians. I think the best way to about implementing medical marijuana is to only allow AZDH approved cultivation sites to grow marijuana. These sites can be monitored electronically and information about where the seeds used to grow the plants originated, growing time, quantity, THC levels, etc.. can be controlled. Then distribution records to dispensaries can be maintained and the public is safe from "tainted" product or black market product, too. I think that dispensaries should only be a place where product is sold and information and merchandise, including edibles, are sold. They should have safe and secure access and video monitoring for everyone's protection. I also believe that the cultivation sites should be away from the dispensaries at an undisclosed location to the public. This way criminals, drug lords, and even fanatics who are totally against medical marijuana are not tempted to vandalize, destroy, or injure the property or employees of the dispensary. The culivation sites are heavily guarded and monitored and the inventory of a dispensary is limited by the amount of qualified patients it serves. If a dispensary only serves a handful of people, it's inventory should reflect the number of patients x the legal amount (I think it's 2.5 oz every other week). So if the dispensary serves 100 people, then it's inventory is limited to 250 oz. every other week. As the number of patients grow, the inventory can grow with it. This is a great way to control abuse in the system. All qualified patients are logged and documented and all inventory is manageable. Then, when a dispensary needs more product it places a P.O. with the off-site cultivation center and a paper trail is generated from receipt of the P.O. to it's delivery to the dispensary. I would say that a cultivation site could supply more than one dispensary as it must grow product in anticipation for demand. Then different strains could be monitored and developed for "sale" back to it's approved dispensary. Now you can control and regulate product, supply, demand with a tracking system from seed to patient. If a patient should ever get sick from a particular product the products are able to be traced..just like what happened with e-coli and spinach. Each bag had a production date, a batch number, and facility attached to it's UPC code. That's my advice. A grocery store doesn't grow it's own spinach. It gets it from quality controlled suppliers. Likewise, a qualified patient, caregiver, or dispensary should not be able to grow its own product, but can order it from an AZDH approved cultivation site. For those living too far away, or don't have transportation there needs to be a mechanism to get the medical marijuana to the people who need it such as a Medical Marijuana Transport Company that is licensed, insured, and specializes in delivery. We must protect the public from the harm from others and/or the criminal element that might seek to harm individual dispensaries, caregivers, or patients if they knew where they were growing their

product. Keeping the cultivation sites separate from the dispensary will solve that serious dilemma. It allows control, inventory, record keeping and security. An added thought: neighboring commercial businesses might also object to a dispensary growing medical marijuana in a place near where they operate. Consider the fire hazard that might occur with grow lights and electrical appliances used to grow. That is a disaster waiting to happen. A cultivation site should maybe only be a stand alone building or a secure industrial building away from commerce. The dispensaries can then just feature the finished product without endangering the public. I know I've said alot, but I think what I offer makes complete sense. Good luck and God speed! Hope this helps!

Create esaier access so that the spirit of the law is upheld

I feel that Neurofibromatosis should be included as a condition. There are three different types my mom and I have Schwannomatosis it causes tumors to grow on nerve endings and is very painful. I have read that THC can slow or stop the growth of some tumors and for that reason and to help with sleep and pain it should be added to the list. I have been to several specialists to see if I can get some of my tumors removed and have just been referred to pain management and was told that I will just have to live with it. I don't like the meds that I have tried and I have tried more that I count. the only thing that helps at all is Hydrocodone and I take 6 10/660 pills a day along with some other pills just to get through a day. I don't like narcotics and may not like marijuana but I am willing to try anything to feel better. I also feel that to have to be with a doctor for a year or more is tough. I have been with my PCP for five years but they say that a specialists needs to make that recomendation even though they feel that medical Marijuana could help me . I have only seen most of the specialist once and was told that I will just need to live with it.

â€œIf people let the government decide what foods they eat and what medicines they take, their bodies will soon be in as sorry a state as are the souls of those who live under tyranny.â€ ~Thomas Jefferson, 1781 Any Arizona physician may in a single visit prescribe "speed," e.g., Adderall, to a kindergartener-without 4 visits spread out over 1 year any Arizona physician may prescribe to a kindergartener a drug that can kill that child by heart attack, stroke, seizures, or other "side effects." â€¢ Cancer, HIV, Hepatitis C, and ALS patients often do not have 1 year to live. â€¢ The patients that do live are cruelly being told to change doctors or suffer for 1 year. â€¢ Deadly and addictive drugs such as the opiates are prescribed in a single visit by Arizona physicians and, despite the best efforts of physicians, some of those deadly and addictive drugs are illegally diverted, but that does not cause the AzDHS to demand 4 visits, 1 year of visits, or that the pain specialist assume primary care of the patient. â€¢ Marijuana is 100% safe, gives patients good relief, and cures some conditions-Marijuana is not deadly and is not addictive. â€¢ The alternative offered by the AzDHS to avoid 1 year of suffering, the cannabis specialist takes over the primary care of the pt's qualifying condition, is done nowhere else in medicine-Nowhere else in medicine does a specialist take over a patient's primary care. â€¢ The AzDHS does not have the authority to define or re-define the patient-physician relationship or the number of doctors visits, or the length of time for those visits-that infringes on the patient's choice â€¢ The draft regulations are cruel and unreasonable.

It should also include employees of Manufacturing products to require back ground checks. I also think that people that cannot afford the Renewal fee, should be allowed a Renewal fee based on their income. That is of course if they paid the Initial Patient fee at least up front. The surety bond

requirement did not state who would be required to have it. Doesn't a surety bond insure an individual and not a Company? If a Dispensary is not entering into a contract with the patient, why would they have to have a Surety Bond? Isn't a bond required when there could be a potential loss and the bond would insure that loss? Doesn't a Doctor have malpractice Insurance?
However, I see no duty for card holders to report convictions of excluded offenses. Applicants should be required to disclose any offenses reported in their criminal history, so records can be obtain to rule out they are not excluded offenses. Need to make specific requirements for all applicants to provide official records showing proof they do not have excluded offenses when they disclose a criminal offense. The Administrative Review completeness having a 5-day time-frame seems way too short when the DHS may have thousands of applicants coming in during the first few months after April 1st??? The same goes for the Substansive Review time-frames, time-frame seems way too short? How long is it going to take to get fingerprint records back? What if the fingerprints were not cleared and the applicant has to roll them again to determine if they have a criminal record? What about getting the criminal records to prove that any offenses reported in their fingerprints are not excluded offenses?
#NAME?
R9-17-102 Fees $5000 Registration Fee is setting to monopolize industry for the wealthy only $2500 to change location of Dispensary is excessive,maybe one free charge,considering $5000 registration fee. Qualifying Pt. $50 fee and not $150 $25 to renew R9-17-102 Cultivation site definition-The one additional location besides the dispensary where Marijuana will also be cultivated by and for the dispensary. Delete 10-b Delete 15. The patient already has supplied adequate information and relationship with a DR. That relationship proves that their personal DR. can provide medical oversight. 16-a Change Physician-Pt. relationship to 3 months not 1 year. 2 visits not 4 R9-17-106B 3-Not 90 days change to 45 4-Strike 150 days change to 75 5-Strike 180 Days change to 100
The [redacted] appreciates the opportunity to make some initial comments on the informal draft of the Medical Marijuana Rules: 1. Regarding R9-17-101 (18), a citation within this section is needed to confirm that a hospital is a public place. The existing statute ARS. 36-2814 A.2 clearly includes hospitals. 2. Please confirm that hospitals may prohibit the possession of marijuana on their property by anyone.
The inreasonable burdens placed upon dispensaries. 12 ft walls and constant video surveillance? Why wouldn't medical marijuana be treated like any other medicine? It seems extremely unreasonable to require 4 visits to a doctor over 12 months in order to get a doctor's recommendation. If a patient is suffering why would the State of Arizona take the position that the patient needs to wait ONE YEAR to get medicine? They don't need to for any other type medicines. If a doctor can't make a recommendation to their patient after one visit, then they shouldn't be licensed to practice. Why would they need to see the same suffering FOUR times and allow the patient to suffer for a year before they can make a recommendation? Who comes up with this stuff? You have a NON LETHAL drug recommendation as compared to a possibly lethal prescription medicine, but you can get the

lethal one after one visit, but the State of Arizona will make you wait a year, suffer for a year, until you can get the non lethal medicine????? What sense does that make?
THE LAW GIVES YOU ABSOLUTELY NO AUTHORITY TO PLACE THESE RESTRICTIONS ON DISPENSARIES: 36-2803 36-2804 36-2804.01 Where is the authority to deny someone a dispensary app if he is in default on a student loan?
the way it is written potential for wide abuse with recreational users and not medical need
i cant believe you have to have a physician for a year or more what about the people that cant afford that i no that especially in these hard times i cant in fact i should have went to a doctor a long time ago i thought maybe this medical marijuana would be a good option for me and now i have no hope because of the fact that i dont have enough money u need to seriously rethink this i cant believe u would do this
R9-17-101 17. Proposed rules state: "Physician-patient relationship" means interaction between a physician and an individual in which the physician has ongoing responsibility for the assessment, care, and treatment of the patient's debilitating medical condition. A physician may be treating one aspect of the patient's care which would be eased by the use of medical marijuana but may not have the ongoing responsibility for treatment. In the case of a cancer patient, the chemotherapy treatment may be eased by using marijuana during the treatment period. As with any prescription it is inherent that the prescribing physician monitor the patient and discontinue prescribing the treatment when no longer necessary. An radiation oncologist may prescribe the use of medical marijuana during the radiation but not to continue beyond. This is a relatively short term relationship between the doctor and patient. R9-17-102. Fees An applicant submitting an application to the Department shall submit the following nonrefundable fees: a. Qualifying patient; $150; I feel that this fee could be prohibitive to some patients who are already struggling with medical bills. The amount seems extraordinarily high. In fact this is higher than a driver's license which many would consider to be a lethal weapon. R9-17-103. Electronic Submission An applicant submitting an application for a registry identification card or to amend, change, or replace a registry identification card for a qualifying patient, designated caregiver, or dispensary agent shall submit the application electronically using a Department-provided format. Amazing as it may seem there are people who do not have access to electronically submit a form. Applicants should be permitted to submit forms in paper or to submit at Dept of Health in person via a terminal. F. If the Department determines that an initial application for a dispensary registration is in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall provide a written notice of preliminary approval of the dispensary registration certificate that contains the dispensary's registry identification number. d. A copy the principal officer's or board member's: i Arizona driver's license issued after October 1, 1996; ii. Arizona identification card issued after October 1, 1996; iii. Arizona registry identification card; iv. Photograph page in the principal officer's or board member's U.S. passport; or v. An Arizona driver's license or identification card issued before October 1, 1996 and one of the following: (1) Birth certificate verifying U.S. citizenship, (2) U. S. Certificate of Naturalization, or (3) U. S. Certificate of Citizenship. The above section is not clear as to whether one of each is required for items i, ii, iii, iv. This should be clarified to indicate that a valid AZ driver's license or registry identification card or passport R9-17-302. Applying for a Dispensary Registration Certificate 1. An application in a

Department-provided format that includes: a. The legal name of the dispensary; b. The physical address of the dispensary; It is beyond comprehension that an organization applying for a dispensary license would already have a physical address. This should be clarified to state that the physical address is proposed and/or based on preliminary application acceptance. f. Whether a principal officer or board member ii. Is a physician currently making qualifying patient recommendations; iii. Has not provided a surety bond or filed any tax return with a taxing agency; Two objections to the above wording: ii - Is a physician precluded from being involved in a dispensary and also making patient recommendations? This is unclear by the wording. iii - Why would a surety bond be required to ensure performance? What other Arizona businesses must post a surety bond in order to be licensed? This seemed like a discriminatory practice. 4. Policies and procedures that comply with the requirements in this Chapter for: a. Inventory control, b. Qualifying patient recordkeeping, c. Security, and d. Patient education and support I did not see where the above reference "requirements" were specified. 5. A copy of the certificate of occupancy or other documentation issued by the local jurisdiction to the applicant authorizing occupancy of the building as a dispensary and, if applicable, as the dispensary's cultivation site; 6. A sworn statement signed and dated by the individual or individuals in R9-17-301 certifying that the dispensary is in compliance with local zoning restrictions; As previously noted, I am not clear on how a business can establish a certificate of occupancy and a sworn statement that it is in compliance with local governing authorities without actually have a license. These terms should be conditionally required based on receiving a preliminary approval. 15. Whether: a. A registered pharmacist will be onsite or on-call during regular business hours; b. The dispensary will provide information about the importance of physical activity and nutrition onsite; c. Whether the dispensary has or has not incorporated; and d. Whether the dispensary has a surety bond and, if so, how much; and The above section is not clear as to whether a through d are requirements for licensing. This should be clearly stated and if required, justification provided. C. A dispensary: 1. Shall cultivate at least 70% of the medical marijuana the dispensary provides to qualifying patients or designated caregivers; The proposed regulation does not address how the dispensary shall acquire the initial seeds or inventory to commence growth of the product.
Instead of AZ resident being able to own the dispensery- how about anyone who owns and pays property taxes in state of AZ.
Ensure that the rules are strict, clear, and restrictive. Try to eliminate any and all loop holes.
The draft can LIMIT the number of dispensaries to a group and/or individual. The Patient/physician relationship (4 times in the last year) is hard for those of us on fixed incomes with no health insurance. I do like the fact that a Physician/Medical Doctor cannot issue a presrciption for Medical Marijuana. It does not address employees of Manufactures into brownies or creams. The draft can address how much of the INITITIVE it is going to approve as I thought the Dept of Health could amend the inititive.
Google [URL=http://google.com]google[/URL]
Add Migraine Headaches to the list of approved debilitating conditions. I have suffered from these

headaches for years and have seen multiple doctors, most of them long term, and have tried many different drugs and diet recomendations. No medication has worked to reduce the frequency of my headaches. Iâ€™ve seen that other states have approved marijuana for this use and Iâ€™m desperate to find some relief!

It seems stupid to apply for licenses when the 5000.00 is a non-refundable application fee and retail space for dispensary/grow- op are needed before knowing if a person will be granted the licenses? And still non-refundable..... Also limiting the dispensary/grow-op space will stop the dispensary from having enough medicine to supply the patients. Seems that growers and cooks will be tied to dispensaries, giving them all the control of prices and products. It is not clear about the caregivers needing to pay 200.00, is that per patient they are caring for? Or is that just a onetime yearly fee that will cover the 5 patients they will care for?

My concern with the rules is that the patient and State of Arizona are not fully protected. The following are my concerns: Medical marijuana is by definition a medicine. Therefore, it needs the quality control through manufacture, dispensing and use by patients as all medicines require. The State needs to insure that the same protections and requirements developed for medicines by the Federal Food and Drug Administration are adopted for this medicine. Otherwise the State is opening itself for class action legal liability from the patients. Therefore, dispenraries need to meet all of the Federal standards. It makes no sense to allow patients to produce their own medicine (medical marijuana) without the same requirements as the dispensaries. The State needs to inspect all patient's cultivation and medicine production and dosage they use. Patients do not have keep accurate records to prevent unauthorized sales of medicine to other users. Just saying (by affidavit) they will not sell on the street is not good enough. Also, there is no specification as to where and what variety of seed or plant a patient is required to use. The State should disallow the sale of patient medicine (medical marijuana) to anyone. There are no requirements for laboratory testing by dispensaries on medicine (medical marijuana). Therefore, the state has no idea what quality of medicine the patients are using from a dispensary. Random laboratory testing should be mandated by dispensaries and records kept. What determines a usable or unusable medicine (medical marijuana)? The State labeling requirement for dispensaries to state that "marijuana is added to food without oversite" is actually stating the State is liable because it has not provided the necessary oversight. This would be a class action attorney's dream in a law suit.

My concern as a lifelong citizen of Arizona is the abuse and corruption that will follow through the processes of obtaining and administrating the medicinal marijuana, and to insure its kept available only to those that are truly the persons intended for it. As I prepare and propose these new considerations and measures, I do have to say I am in support of Arizona legalizing medicinal marijuana, I think it would be beneficial to the intended users and also to the State of Arizona, but I also have a grave concern for the dispensing. I want to see that the dispensing to be administered by proven professionals, ideal citizens, and business owners and their partners in Arizona. As I propose to change the fee schedule, I would like to make the point that the new "medicinal marijuana industry" is and should be treated as big business for the State of Arizona, and shall therefore be considered as such. Changing the fee schedule I also feel it would: 1.) deter the average person, business, or entity with a few thousand dollars to be able to apply as dispensary. I would rather have and see reputable pharmacists (CVS, Walgreens, Wal-marts,) that have been in business in Arizona or as a whole, for a minimum of 10 years and without any violations or lawsuits against them- whether business, state, federal, personal, and also including applicants,owners, assigns, partners, board

members. (this reassures me personally that the business and owner are truly interested in the process and running a respectable program, as opposed to having tons of "pop-up" smokeshops, or business's flood the streets like Circle K's, control measures must be implemented through financial means and process. I would also recommend that the "License" or "certificate" be only obtainable to a dispensary if a "Certified Licensed trained Pharmacist by the State of Arizona" is employed at the location, (again control measures.) 2.) Be able to implement, support, and possibly create new state jobs to enforce "control measures" for the dispensing and monitoring of the applicants, process, business's, owner's, partners, and assigns. 3.) The employed dispensing agent must be certified and licensed as a "Pharmacist", and that they are the only ones allowed to handle and fulfill orders. there must be at least 1 "certified and licensed pharmacist" on site during business hours. (not sure where this fits in) My main proposals are to reconsider changing: R9-17-102 Fees, which affects- R9-17-301. Dispensaries, R9-17-302. Applying for a Dispensary Registration Certificate. R9-17-102. FEES An applicant submitting an application to the Department shall submit the following nonrefundable fees: 1. For registration of a dispensary, $8,000 1.5 Once registration is approved,a "Medical Marijuana Dispensary License" fee of $35,000.00- $45,000.00 due within 30 days of approval by the state. (after considering what a liquor license costs) 1.6 Fee if the business is not already registered as a "Licensed Pharmaceutical Dispensary " through the State of Arizona- $50,000 (control measures, after all its for medical purposes) 2. To renew the YEARLY registration of a dispensary, $10,000; (control measures) a. additional fees if not renewed within 2 weeks of expiration $20,000 or even loss of License. 3. To change the location of a dispensary, $4,500; (control measures) a. additional fees if not reported within 2 weeks $20,000 4. To change the location of a dispensary's cultivation site, $10,000; (control measures) a. additional fees if not reported within 2 weeks $20,000 5. For a registry identification card for a: a. Qualifying patient; $150; b. Designated caregiver, $800; c. Dispensary agent, $800; 6. For YEARLY renewing of a registry identification card for a a. Qualifying patient, $150; b. Designated caregiver, $200; and c. Dispensary agent, $200; 7. For amending or changing a registry identification card, $75; and 8. For requesting a replacement registry identification card, $1500. (control measures so that they are not abused) Thank you for reading and strongly considering my views and requests for changes-[redacted]

[redacted] 6 January 2011 Mr. Will Humble Director Arizona Department of Health Services 150 North 18th Avenue Phoenix, Arizona 85007 Re: Draft Regulations, Arizona Medical Marijuana Act Dear Mr. Humble, Our Association voices strenuous objection to the seriously defective content of the draft regulations. In aggregate, the draft regulations inform Arizonaâ€™s suffering, dying, and good citizens that they are chattel. If the State says â€œSuffer!â€ we must suffer. If the State says â€œWait and die! We must wait and die. Indisputably too, the proposed dispensary regulations benefit only the elite super-wealthy, only those who can gamble millions of dollars to build fortresses that may never be licensed, fortresses that indulge police state spy-cam fantasies, but are unreasonable and unnecessary to the task. Such blatant favoritism in your proposed regulations only buttresses the allegations of collusion between the Arizona Department of Health Services (hereinafter, "the department") and a favored wealthy few [cf. 1/4/2011 [redacted] Professionals letter, exhibits, and news release]. The current rulemaking process is damaged beyond repair. We demand that the department rescind the draft regulations immediately and begin the process anew. In a transparent public process, promulgate draft regulations that are moral, legal, compassionate, and to the advantage of Arizona's suffering, dying, and good citizens. Repugnant assumptions in the draft regulations The unstated but evident fundamental assumptions of the regulations are immoral, lawless, pathological, elitist, and demagogic, utterly incompatible with moral imperatives of a free nation. These repugnant

assumptions are: 1) the lives of Arizona's citizens belong to the State; the State, not the patient, will decide if, when, and what care patients will receive; 2) the department of Health Services is, as its spokesperson has indicated, above the law and may disregard the 1998 Arizona Voter Protection Act; and 3) the department may patronize the wealthy and elite to their advantage and to the disadvantage of the suffering, dying, and good citizens at large. In your introduction of the draft regulations you even opined that you drafted the regulations for the â€œgoodâ€ of the opponents of the Arizona Medical Marijuana Act, a bizarre concept akin to â€œSegregation is no longer the law, but the department is obliged draft rules to satisfy segregationists.â€ Reminders Patients, not the State, own their own lives, so have the right to choose if, who, when, and what kind of medical care they will seek. Marijuana is completely safe in itself, cannot be lethal, and so should be treated as a safe, effective, and legal product as the findings of the Arizona Medical Marijuana Act require, certainly not treated with more stringency than is currently required for the dispensing of drugs, prescription or otherwise, from Arizona's pharmacies and physician offices, The safety, efficacy, and legality of medical marijuana warrant the spread, not the suppression, of its use. For these reasons and in view of the Arizona Medical Marijuana Act, medical marijuana services must be readily available to the qualifying patients and dispensary licensing must not be available only to an elite and wealthy group. Partial listing of defects ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services rulemaking be â€œwithout imposing an undue burden on nonprofit medical marijuana dispensariesâ€¦.â€ In no way do the MPP/AZDHS draft regulations respect that requirement. Quite the contrary, the regulations impose unacceptable burdens not only on dispensaries, but on the suffering, dying, and good citizens of Arizona. ARS 28.1 Section 2 â€œFindingsâ€ of the Arizona Medical Marijuana Act requires the department to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. Arizona's pharmacies and physician offices dispense addictive, dangerous, and toxic drugs that, unlike marijuana, are potentially deadly, yet Arizona's pharmacies and physician offices are not required to have 12 foot walls, constant on-site transmission of video surveillance, residency requirements for principals, or any of the other cruel, arbitrary, and unreasonable regulations proposed by the department. R 9-17-101.10 is an undue and unreasonable burden. 6 to 8 foot high chain link fencing, open above, constitutes reasonable security for outdoor cultivation. R 9-17-101.15 is unreasonable and usurps authority denied to the department. It violates the 1998 Arizona Voter Protection Act. The department does not have the authority to deny the involvement of naturopathic and homeopathic physicians as defined by ARS 36-2806.12. R 9-17-101.16, R 9-17-101.17, R9-17-202.F.5(e)i-ii , R9-17-202.F.5(h), R9-17-202.G.13(e)I , R9-17-202.G.13(e)iii , R9-17-204.A.4(e)i-ii, R9-17-204.A.4(h), R9-17-204.B , R9-17-204.B.4(f)I, and R9-17-204.B.4(f)Iii are cruel, arbitrary, unreasonable, and usurp authority denied to the department. Those sections violate the 1998 Arizona Voter Protection Act. ARS 36-2801. 18(b) defines an assessment, singular, as sufficient. The Arizona Medical Marijuana Act does not give the department authority and the 1998 Arizona Voter Protection Act denies the department authority to require multiple assessments, require â€œongoingâ€ care, or redefine the patient-physician in any way, much less to promulgate a relationship among patient, physician, and specialist that is found nowhere in the practice of medicine. Nowhere in medicine is a specialist required to assume primary responsibility for a patientâ€™s care. Nowhere else in the practice of medicine does Arizona require a one-year relationship or multiple visits for the prescription or recommendation of any therapy, including therapies with potentially deadly outcomes. Marijuana is not lethal, but the department usurps authority to treat it with cruel and unreasonable stringency far beyond the stringency imposed upon drugs that are deadly. Plainly, it is dangerous and arbitrary for the department to suggest that a cannabis specialist assume primary care of cancer, HIV/AIDS, ALS, multiple sclerosis, Hepatitis C, and other potentially terminal qualifying conditions when the cannabis

specialist may not have the requisite training or experience to do so. The departmentâ€™s regulations are a cruel, unreasonable, and arbitrary usurpation of authority and denial of patientsâ€™ rights of choice, including their rights to choose other medical providers, other sources of care or information, or even to choose not to seek (or cannot afford to seek) other medical care at all (whether prior or subsequent to application). R9-17-102.3, R9-17-102.4, R9-17-102.7, R9-17-102.8, R9-17-104.5 , R9-17-105.4, R9-17-203.A.3, R9-17-203.B.8, R9-17-203.C.5, R9-17-304.A.11 usurp authority denied to the department. ARS 36-2803.5 only gives authority to the department for application and renewal fees, not for changes of location or amending or replacing cards. R9-17-103, R9-17-202.F.1(h), R9-17-202.G.1(i), and R9-17-204.B.1(m) are cruel, arbitrary, and unreasonable. Though many qualifying patients, qualifying patientsâ€™ parents, and their caregivers suffer financial and medical hardship, the sections make little or no provision for patients, parents, and caregivers without internet skills or internet access. R9-17-106.A(4) is cruel, arbitrary, and unreasonable. The regulation does not allow for addition of medical conditions that cause suffering, but do not impair the ability of suffering patients to accomplish their activities of daily living. For example, conditions such as Post-Traumatic Stress Disorder (PTSD), Anxiety, Depression, and other conditions may cause considerable suffering, yet still allow patients to accomplish their activities of daily life. R9-17-106.C is cruel, arbitrary, and unreasonable. The regulation only allows suffering patients of Arizona to submit requests for the addition of medical conditions to the list of qualifying medical conditions during two months of every year. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. R9-17-202.F.5(e)i-ii and R9-17-202.F.5(h) are cruel, arbitrary, unreasonable, and usurp patientsâ€™ rights to choose other providers or sources of information. R9-17-202.F.6(k)ii, R9-17-204.A.5(k)ii , R9-17-204.C.1(j)ii , R9-17-302.B.3(c)ii, R9-17-308.7(b), R9-17-308.7(b), and R9-17-309.5(b), are arbitrary and unreasonable. If a caregiver already has a valid caregiver or dispensary agent registry card, no additional fingerprints need to be submitted. R9-17-205.C.2 and R9-17-320.A.3 are arbitrary and unreasonable. A registry card should not be revoked for trivial or unknowing errors. Revocation of a card should not be allowed unless the applicant knowingly provided substantive misinformation. R9-17-302.A, R9-17-302.B.1(f)ii, R9-17-302.B.1(g), R9-17-302.B.3(b) , R9-17-302.B.3(d)i-ix, R9-17-302.B.4(c), R9-17-302.B.4(d), R9-17-302.B.15(a), R9-17-302.B.15(b), R9-17-302.B.15(d), R9-17-306.B, R9-17-307.A.1(e), R9-17-307.A.3, R9-17-307.C, R9-17-308.5, R9-17-319.A.2.(a), R9-17-319.B are arbitrary, unreasonable and usurp authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department does not have the authority to establish residency requirements, control the occupation of the principal officers or board members, require surety bonds, require a medical director, require security measures that are an undue burden (security measures for non-toxic marijuana that exceed security measures required for toxic potentially lethal medications stored at and dispensed from Arizona pharmacies and physician offices), require educational materials beyond what the law requires, require an on-site pharmacist, require constant, intrusive, or warrantless surveillance, or regulate the portion of medicine cultivated, legally acquired by a dispensary, or transferred to another dispensary or caregivers. R9-17-310 is arbitrary, unreasonable and usurps authority denied to the department. These sections violate the 1998 Arizona Voter Protection Act. The department has no authority to require a medical director, much less to define or restrict a physicianâ€™s professional practice. Arizona's pharmacies dispense drugs that are very toxic, yet are not required to have medical directors on-site or on-call. R9-17-313.B.3 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping for cultivation or to require the use of soil, rather than hydroponics or aeroponics, in cultivation of medicine. R9-17-313.B.6 is arbitrary, unreasonable and usurps authority denied to the department.

This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an undue burden on recordkeeping by requiring the recording of weight of each cookie, beverage, or other bite or swallow of infused food. R9-17-314.B.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. Especially in the absence of peer-reviewed evidence, the department has no authority to require a statement that a product may represent a health risk. R9-17-315 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to place an unreasonable or undue burden by requiring security practices to monitor a safe product, medical marijuana, that is not required for toxic, even lethal, products. R9-17-317.A.2 is arbitrary, unreasonable and usurps authority denied to the department. This section violates the 1998 Arizona Voter Protection Act. The department has no authority to require the daily removal of non-toxic refuse. Summary The department has a duty to facilitateâ€"not subvertâ€"the law. Consistent with the Arizona Medical Marijuana Act, the department must acknowledge that patients have rights to choose their care and their providers. The department has a duty to ensure that compassionate and talented providers who do not have millions of dollars to gamble are awarded licenses. The current rulemaking process has been irreparably contaminated, mostly by the maliciousness of your own proposed regulations. The process must begin anew. If malefactors are identified, they must be excluded. The new process must be open, a matter of transparent public record, and reflect the passage of the Arizona Medical Marijuana Act, not opposition to that law. To do otherwise demands immediate injunctive relief. Sincerely, [redacted]

Requiring a fee of up to $150 could cause a major economic strain on many AIDS and Cancer patients who are already struggling with medical bills. The terminology which states the requester is unable to "accomplish daily living" is very subject to interpretation. R9-17-204 4-e Requiring a patient to have a one year relationship with the prescribing physcian doesn't make any sense when a cancer patient may have just begun a relationship with an oncologist who prescribes the marijuana to help alleviate the effects of chemotherapy. When I was diagnosed with breast cancer I had 4 different physician's treating me at different times in the process, none of which I had seen for a year prior to my diagnosis. R9-17-302 - Requiring as part of the dispensary application process to have a site built-out and ready to open for business prior to the license approval is beyond comprehension. I question why any logical businessperson would invest the time and funds before even a preliminary license approval is received. R9-17-302 B-f-iii - The definition of a surety bond is to protect an obligee against failure to perform by a principal. This proposed rule would seem to preclude individuals from meeting license requirements. It would also seem that failure to comply with the regulations once a license had been issued would result in revocation of the license rather than revocation of a surety bond. What other businesses in Arizona are required to post a surety bond in order to open for business?

I have issues with the stipulation requiring a year's treatment with a doctor prior to being able to obtain a medical card. As a nurse, I feel that this violates doctor/patient confidentiality. Since there will most likely be doctors reluctant to recommend medical marijuana out of fear of the Feds, people with qualifying medical conditions may have to find another doctor willing to make the recommendation. Forcing them to wait a year could be viewed as inhumane and cruel. This stipulation does not apply when a physician prescribes Oxycontin, which is far more dangerous than medical marijuana. How about we apply a little reason here?

No where did I read that medical marijuana is to be used specifically for the terminally ill. The illnesses are extremely vague. 98% of California marijuana "cardholders" are not the terminally ill, or cancer patient Use a bar code so the Dept. can track the dispensaries, designated caregiver & patient use/disperse. Overall, medical marijuana is a total joke. The Federal laws should supersede any state laws...it's an illegal drug. period.

One major issue I see is the 70%/30%. This means that there will be potentially over one hundred cultivation facilitates around town, it seems safer to have less cultivation and have a zero rule on cultivation, so dispensaries can purchase 100% of product from outside sources

The language on qualifying patients doesn't seem to make sense. There are two parts to this section. The first says there must be a 1 year relationship and at least 4 visits regarding the health issue. The FAQ on the web site has incorrect information. It says that it's either a 1 year relationship or 4 visits covering the health issue. But the draft says you need both. The second parts says "or" which seems to suggest, "if the patient doesn't meet the first criteria the following criteria must be met." Here the draft says the recommending doctor has assumed primary responsibility and routine care for the medical condition AND that they have also conducted a comprehensive medical history and physical exam. Wouldn't a comprehensive medical history and physical exam always be indicated? Does that mean if you've seen a doctor at least 4 times for at least a year for a debilitating medical condition that it's not necessary to have taken a complete medical history or done any physical exams? If the second section is meant to cover patients that need immediate care and can not wait a year and 4 visits for treatment, it would be helpful to be clear in the language.

The definition of â€œMedical Directorâ€ must be expanded to include Naturopathic Physicians.
As the definition is written now in the draft rules, â€œMedical Directorâ€ means â€œa doctor of medicine who holds a valid and existing license to practice medicine pursuant to A.R.S. Title 32, Chapter 13 or its successor or a doctor of osteopathic medicine pursuant to A.R.S. Title 32, Chapter 17 or its successor and who has been designated by a dispensary to provide medical oversight at a dispensary.â€ This definition has wrongly omitted a licensed Naturopathic Physician. Naturopathic Physicians are certainly no less capable of performing the duties of a Medical Director, and in fact may be in a better position to guide the alternative care required for medical marijuana patients. According to the Association of Accredited Naturopathic Medical Colleges â€œnaturopathy is a traditional approach to health that is holistic, meaning that it encompasses the whole being. It is based on natural and preventative care. Naturopathic medicine combines many methodologies, such as acupuncture, massage, chiropractic adjustment, homeopathy and herbal cures, along with sensible concepts such as good nutrition, exercise and relaxation techniques. The exclusion of Naturopathic Physicians is not only illogical but is also unfounded based on the language of existing statutes and the language of Prop 203. For example the education and licensure requirements for Naturopaths are no less stringent than those for M.D. and both are afforded nearly identical authority to treat patients (See A.R.S. Title 32, Chapter 14). Further, Naturopaths have specialized education in botany and herbal therapies, making them uniquely qualified to serve as Medical Directors for a dispensary. Excluding them from serving as Medical Directors does a severe disservice to patients. Finally Naturopaths qualify as a â€œPhysicianâ€ as defined in Proposition 203 Â§36-2801(12). Thus, Naturopathic Doctors will be permitted to recommend MM to patients under State Law. How then can they be excluded from serving as Medical Directors? This seems contrary to the intent of the law at best and discriminatory and potentially illegal at worst. Naturopathy is a legitimate and widely accepted field that focuses on natural and primarily non-invasive therapies to treat disease, stimulate

healing, and promote overall health. Naturopaths are trained to understand the way herbs and homeopathic remedies affect the body. Since, licensed Naturopathic Physicians can and likely will legally recommend the use of MM to patients according to State Law, it seems axiomatic that the same credentials should entitle a person to work as a Medical Director at a MM Dispensary. Further, Naturopathic doctors above other professionals included in the definition of â€œPhysicianâ€ set out in Proposition 203 Â§36-2801(12), are uniquely qualified to understand and oversee the use of MM by registered users, because they understand how natural remedies effect the body.

1. I believe the 12 foot wall requirement for "enclosed" should be eased for those who are cultivating within their own residence because they are not within 25 miles of a dispensary. Not all homes have 12 foot walls. 2. The $150 registry identification card for patients may be too much for less fortunate people and may exclude lower income patients. I believe a sliding scale or reduced cost card is appropriate under certain circumstances. 3. In my opinion the written certification from an Arizona physician unduly discriminates against Veterans as veteran physicians cannot generally prescribe marijuana because of Federal laws. I believe the taking primary responsibility for the care of the qualifying patient may be too strict a requirement for the veterans who cannot afford private medical care for outside physicians and those outside physicians are required to take over medical treatment and may thus refuse if the Veteran cannot afford the private physician. I would recommend excluding Veterans from this language. 4. I really like the Arizona residency requirement of two years however do so may exclude the "expertise" of out-of-state people running dispensaries from helping set up and run the new dispensaries and being compensated for such. Allowing these members to provide services would allow their input without necessarily allowing them to "own" the company. I believe clarification in this respect is appropriate. I like the two year requirement though. 5. The dispensary application is very cumbersome but appropriate. I believe it will be necessary for many dispensaries to have the assistance of legal counsel for the application and ongoing compliance issues relating to procedures, policies, contracts etc. As you know there is an issue as to whether attorneys can assist these clients under the Arizona ethical rules. I would recommend providing your input to permit legal assistance to the Arizona State Bar. 6. I do not believe the cultivating marijuana requirement of only 30% being able to be provided to other registered dispensaries is appropriate as it will limit supplies to the smaller (likely rural) dispensaries. The rule is too preclusive and is not in the best interests of the patients. Instead, a market-based/wholesale relationship between dispensaries that does not limit how much it can produce and/or supply would be more effective and help the economic viability of dispensaries and assure rural communites can be supplied adequately. I also believe there needs to be clarification regarding cultivation in that a dispensary can acquire its marijuana from a wholesaler who cultivates for more than one dispensary. In other words, a large cultivator should be able to supply multiple dispensaries simultaneously, from one location, and not be inhibited by the 30% rule. 7. The requirement of each dispensary having a medical director with a current license will likely preclude many small dispensaries from sustaining its operations or even beginning operation. With 125 dispensaries and physicians only being able to serve three dispensaries, there will be a need for a minimum of 42 licensed physicians. Because of the illegality of medical marijuana on the federal level, it may be difficult to find 42 physicians willing to serve in this capacity and work so closely with the dispensary while they also have to keep their own practice going. i would recommend you also allow RN, Nurse Practitioners, Public Health PhDs, AZ physicians and osteopaths with inactive (not invalid) licenses serve the dispensaries as well. 8. Keeping records for five years is ok, but the provision should be

clarified to better protect privacy and state all records should be kept according to qualifying patient id number and caregiver ID number--not the individual's name. 9. The inventory system requirements is very complex but workable after working through the problems that will arise initially. The DHS may want to provide inventory sheets that can be filled out and will be easily inspected as needed. 10. The amount of electronic surveillance and other electronic requirements are going to be very expensive for the average dispensary and will probably keep many smaller entrepreneurs out of the business. This in turn may affect the more rural personnel wherre dispensaries will be unable to open because of the amount of capital needed to meet the requirements and the small number of qualifying patients that will move through the dispensary. The requirements are good ideas may may have the opposite effect on dispensaries opening up because of lack of funding. 11. 9.
Listen to the people
keep pricing down on medications. card cost are to high. smoking areas need to be open. its not like every person here will have it and smoking.
open the smoking areas. hotels and outdoors need to be included. pricing for the cards and for the product. theres nothing to protect the patientfrom high cost including your fees. this is medicine and yet anybody can open a dispensary. the state should own and operate the dispensaries. but no matter who owns them there should be a flat monthly fee of $100-200 for 5oz of medicine. protect the patients remember people who really need this will get it and those are on limited incomes like social security disability. and any law can be amended and change the growing part of it let us grow our own if we want.
Section R9-17-307 needs to be expanded to handle more HR issues that can be sensitive to this industry. If this industry is going to be accepted by the main stream business community, then it needs to subject itself to more scrutiny and hold itself to a higher standard. With that being stated, I have listed below the changes and or addtions to be made to the above referenced section: