

**How can the draft rules be improved?**

Open-Ended Response

A recommending physician should not have to assume responsibility and routine care for a patient's qualifying condition if another physician is already providing routine care and responsibility. Would it be right for a doctor that isn't an oncologist to assume responsibility and routine care for a cancer patient? Doctors that aren't specialists may feel VERY UNCOMFORTABLE about providing care, as currently defined in the draft rules, for a patient that would require a specialist. A recommending physician should certify, though, that another doctor is assuming responsibility of the patient's routine care, if applicable. Also, the rules should clarify what will happen once patients are issued cards and dispensaries are built but not functioning due to growers not having completed growing marijuana plants. Also, persons in rural parts of Arizona will face a similar dilemma if a dispensary opens that was not present when their cards and approval to grow were issued. Any person that grows plants when no FUNCTIONING dispensary is within 25 miles should be allowed to continue to grow that plant, for however long it takes, even if a dispensary within 25 miles has begun to sell marijuana. It can take numerous months, lots of money, and effort to grow a plant. Don't waste the time and effort of patients during this gray period of time. The law does not allow for taking away this right! Also, what if a potential patient has no medical record within the last 12 months? Could older than 12 month records be used? This should be clarified and there should be a way to allow patients without 12 months of previous medical records a way to get a recommendation.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

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The draft rules can be improved through the removal of R9-17-306(A). The reason that I feel this way is that there are a number of legitimate reasons for a business to relocate, including, but not limited to natural disasters, changing market trends, issues with the landlord, and etc.

Add PTSD and ensure no taxation as it was the original law we voted for!

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R9-17-302 sections B2, D1, and D2 should be changed to allow a merit-based process. Issue 1: Well-

intentioned applicants looking to open a legitimate health-based dispensary are put on equal footing with someone looking to open a head shop so long as they both have completed the application. Issue 2: Applicants with a well-thought-out business plan are put on equal footing with ones that have barely a business plan at all. According to Don Herrington from the Tempe Chamber of Commerce's Business Luncheon on February 17, 2011, AZDHS's main motivation behind the current system of choosing a lottery system was to ensure an equal opportunity a license award for those individuals who have money and those who do not have money. It would be wholly inappropriate for completeness to be solely judged on physical location preparation. It would be a more prudent route to contrast each application against criteria which is beneficial to the State of Arizona. Is the business going to be around for 5 years or more? Is the business structured to meet patient demands in an accountable fashion? Does the business have the appropriate medical staff to avoid ethically questionable dispensing? Does the business have a plan to operate on start-up or investment capital in the first year? Does the business have a plan in place to guarantee quality and reduce the threat to consumers associated with large scale cultivation (i.e. viruses, mold and fungi)? A merit-based criteria would be significantly more beneficial for the State of Arizona economically by spawning businesses prepared to do business for 5 or more years and bring revenue to the State. Additionally, the benefit to the patient would be equally as preferable. A dispensary that practices safe cultivation and dispensing is a help to the patient community instead of a threat to their health.

R9-17-302 B-2b Random selection from the pool that meets the "minimum" qualifications is not a very good idea. This lottery type system will favor the deep-pocket investors that will treat it just like a lottery with good odds. The more applications, the better their chances. We've already seen the money from other states as evidenced in the community forum meetings that you held. Half the room are marijuana advocates, the other half are lawyers and investors. Please develop some sort of criteria to choose the applicants fairly. Please take into account the business plans that show an active interest and partnership with their communities, not just profits with an end-of-year donation to an anonymous charity in order to comply with the not-for-profit character. R9-17-303 #5 - You should require more than a sworn statement that the dispensary location is in compliance with local zoning restrictions. Individuals can easily download the information from a county assessors website and include the specific municipalities zoning guidelines in the application. Folks that are winging it with "commercial retail" properties are going to waste a lot of time and money. R9-17-306 There should be exceptions to changing dispensary locations during the first 3 years (i.e. building destroyed by fire, flood, or anything that would condemn the building and cause undue hardship to dispensary owner) R9-17-302 I am not apposed to to cities or towns having the opportunity to comment on redistributing dispensaries in their jurisdiction. However, there is no indication of when they will be allowed to do so. Furthermore, there are no provisions for providing that information to dispensary applicants. R9-17-302 CHAA distribution of dispensaries has a lot of flaws. Utilizing zones is a great idea, but the zones should match the population density and distribution of pharmacies, for which the law is based. Several CHAA's are not zoned for dispensaries. Are those to be reallocated to the population dense areas to allow more than one dispensary per zone??

Regarding the matter of issuing a dispensary certificate: Create a panel of individuals to grade each applicants submission based on a standard. I used the word "submission" instead of "application" because there is additional information attached to the application such as a detailed business plan, proof of solvency, dispensary lease and it goes on and on.... If you have problems finding the manpower to create an application grading panel let us know. There are many individuals that may not have supported this initiative but would certainly volunteer their time to ensure that the entities

issued a certificate were the qualified based on specific criteria that is best summed up in Will Humble's letter dated February 14, 2011.

Please refer to the previous comment above. There are many things that can and should be changed. Please consider the following ideas as starting points and make revisions before the 'final' guidelines are issued. There has got to be a way to have questions and answers on the program before it is finalized. So far AZDHS has overcomplicated a seemingly simple law. Medical Marijuana is now legal. Let the entrepreneurs get started doing business and the rules can be adjusted as it goes along. Remove the stigma and start dealing with it as any legal business. Regulations will surely follow. There is no need to delay patients receiving affordable, compassionate care now. DHS has not become experts in treatment and are not a regulatory body. We need to see the application before it becomes final. As the draft rules are being reviewed by the public, it is equally important to have the application be available for public review as well. The application is the initial step in reviewing the criteria AZDHS will be using in their due diligence. It is important to get public comments on the content of the application as it is just as critical as the rules used to create it. There is no reason for a monetization requirement that has been suggested in the application. It is arbitrary and the law makes no reference to it. As with most other business ventures, it is the responsibility of the certificate owner to obtain the funding needed. While there is no question some financial assets will be needed, requiring inordinate amounts, in the tens or hundreds of thousands of dollars is unreasonable and financially discriminatory. Entities and individuals having extraordinary financial backing does not make them better qualified to provide needed services to the community, it only makes them wealthier. Some have begun introducing scare tactics including raising the possibility of 'Mexican drug cartels' being enticed if a significant financial floor is not instituted. This is ignorant at best. Precisely how and why would any respectable citizen choose to attach themselves to the dangers and risks of "cartel" association? If there is evidence to support these alarmist claims, it is imperative that the evidence be provided immediately and publicly and thoroughly reviewed for accuracy prior to accepting it as fact and designing guidelines to quell it. I understand there are costs associated with performing due diligence, but the \$5000 application fee is exorbitant. It reeks of a bureaucracy bending entrepreneurs over a barrel for no other reason than that they can. Even more insulting is the 80% (\$4000) loss if you don't get chosen for a certificate. This is another glaring attempt to limit the pool of potential dispensary operators with no logical basis for it. A more reasonable fee and administrative loss directly associated to actual due diligence costs, provided by the AZDHS for transparency, would be appropriate, fair and in your constituent's best interest. Overall, it would be good to start over with common sense, market-driven rules based upon realistic economics and historical lessons. The rules in current form are unnecessary, over bearing, controlling, economically ignorant, and most likely illegal and unconstitutional.

The rules do not specify where the marijuana is supplied from, that the marijuana is consistent in quality, who the growers are that supply it, and how the state will over see the growers, the amounts regulated, and identify all contributors in the system.

Improvement comes from listening to feedback. The AZDHS should address grievances that were presented at the meetings and act on them. After all this, the community congress, is the way in which our country was founded and governed in its beginning. I give the AZDHS serious credit for taking on the task. Following are some of the issues that were brought up; in no particular order

except as the multiple attendees spoke their pieces. I picked these out as they had interest to me. 1. Medical Director- many of the audience did not know that the Medical Director's limitation to only 3 dispensaries and the audience was not advised of the specific change, only changed. The question of extending the duties of the Medical Director beyond those of "Doctor" status to those who are professional Nurses. It seems to make sense as many if not all of the tasks listed in the "Draft Rules" are routinely covered by nurses throughout the Medical profession. Most of us who have been in a doctor's office or a hospital recently will recall that the Nurse's are far more visible in the examination and treating of patients than are the doctors. This is not a negative comment about the doctors, just an observation of today's medical practice. 2. Cultivation and seeds/clones " nothing that I can recall from the Rules and the meeting addressed this topic. In fact it was verbally admitted by one of the AZDHS staff that this has not been addressed. How does one grow marijuana of any type unless these are available? In reality, one can't pull them out of the air unless AZDHS come up with something extremely new; no seeds, no clones, no marijuana. 3. In Prop 203, Chapter 28.1 Arizona Medical Marijuana Act, Section 36-2801 give the caregiver the ability to grow up to 12 marijuana plants. Why was the rule changed and the 25 mile barrier added into the rules? I have heard most of the reasons offered by AZDHS, but most of the answers given relate to politics and greed on the part of the dispensaries. I, as a potential dispensary owner, would not argue leaving that task to the caregiver. There are too many patients who do not have the ability to hand over \$350.00 an ounce for marijuana. This change was not well thought and is tainted by greed and ignorant politicians. 4. Limits on prescriptions for MM (Medical Marijuana) " this issue was raised by several nurses. Nurses have the same code of behavior and much of the knowledge of doctors. In today's medical practices nurses write many of the prescriptions. Why should they not be able to write prescriptions? 5. CHAA chart for Dispensary locations " this was brought under serious criticism by virtually every person in the room, once the wide differential in population was explained by several of attendees. The AZDHS did point out the CHAA's breakouts of the state and the point that it was an easy tool to use. Given an example by one of the attendees of a population range from 20,000 to 200,000 there was an immediate negative shadow thrown on the use of the chart. Many brought up the seeming favoritism of AZDHS to certain entities that would be trying to obtain a Certificate. I would observe that there were more than a few people that were using strong voices to emphasize their negative feelings to the idea of the CHAA's chart, HERE IS A THOUGHT- USE VOTING PRECINCTS. 6. The Dispensary Lottery " Balderdash, whimsy, twaddle, rubbish, drivel, rubbish, etc.. a uniform rejection of a concept. This business will address and serve those who are very ill, in great pain and/or are nearing death. And the AZDHS is going to make a lottery of who gets a Certificate to serve them? No, finding the right people will not be an easy task. Looking potential death in the face is not either. You need to choose those who carry out that task. What are you going to do about it? The skills of running a business are needed as are those who know and care about their clients. This is the reality that you face. Set up that business plan and/or find a skilled personnel firm to do it. Then give the potential applicants the opportunity to tell you what they will do and how they can do it. If you are not aware of the reality of the tenure of small businesses, allow me to enlighten you; 2 out of 3 (that's 83 out of 125) are out of business by the third year.

Legalize marijuana to over 21 year-old people. Keep DUI in place.

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By reinforcing drug laws, not getting rid of them.

Dear Mr. Will Humble so far I am disappointed by the some of the draft rules concerning the dispensaries. I believe we have gotten off course on what was supposed to be a law concerning the compassionate use of Medical Marijauna by qualified MM patients. I understand that the dispensaries are supposed to be set up as nonprofit organizations. I have read up on some of the people whom are interested in opening a dispensary. How can a nonprofit organization with little or nothing to lose come up with the monies required to open a dispensary? Do you think for one minute that these people or individuals are doing this out of the goodness of their hearts or do you think its possible that they could be in it for the money? Do you think anyone willing to put up huge investment startup costs would do it at a loss? Do you think maybe that they are in it for a reason? Arizona was suppose to do this differently than the other states that have enacted this law, but so far I have seen you adopt many rules from other states largely Colorado and California. It seems there has been a huge problem in those other states because there was lack of foresight and planning. Our great state of Arizona was supposed to do this the right way but so far the draft rules favors big business. So far these nonprofit organizations from what I see want to make money not lose it. Do you think anyone or entity in their right mind would put up large up front costs and investments on a business that isn't secured and a gamble at best. I know in todays economy nobody can afford to lose money. It is important to be open and honest when discussing issues especially when you have an interest in peoples health overall and aren't blinded by the sight of money. Of course people want to make money who wouldn't. I also have an interest to help people with this special medicine that has been long overdue. I believe it can be done in a safe and effective manner when oversight is clear, apparent and at hand. So far again I think the current rules have made it apparent and clear that most people who have an interest in being a part of this business will not be able to afford to. I have watched your interviews on TV and you even said since you didnt know enough about this business that you were learning from other states and their draft rules. How can this be a fair and just process when you are adopting rules developed and implemented from other states. There has been some presure I am sure from people who say they know how to do this. This is from people who have these types of businesses in other states. You cannot learn from them. This is our state and our law and we the people adopted, voted for and passed this law. We understand there will be a learning curve and thats okay. You must take a firm stance on how this will be or we will see our state turn into a state that uses marijauna recreational. Think for a minute, how can a qualified medical marijauna patient possible afford this medicine at 400 dollars an ounce. That amounts to 2,000.00 a month. On average a MM patient will be older and with a legitimate medical condition and more than likely a fixed income. Common sense says that in order to keep a dispensary running there will need to be a lot of patients that can afford this medicine. Logistics alone can reasonably spell out that this will not be affordable and in order for the dispensary to continue it will need many more patients that are within the categories suggested at this time. Honestly how can a dispensary with the proposed startup costs afford to stay open.

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- New draft rules struck the qualifications of the Medical Director. If this is going to be a requirement for dispensary owners, it will be necessary to clearly define these qualifications. I'm very concerned

about this requirement as many doctors will

The following is an addendum to the letter submitted by the [REDACTED]. The intent of this online submission is to ensure that the Department has all of the [REDACTED] comments and suggestions. In order to avoid awarding certifications to less qualified applicants, the [REDACTED] proposes three options (listed below in order of preference) that would allow the Department to weigh the quality of the applications without engaging in an extensive and complicated review process. First, the [REDACTED] proposes that the Department create a scoring system like that used in Maine and Rhode Island where the various provisions of the application are broken down and assigned a possible score (including the possibility of no score) based on the importance of the criterion. The Department would then assign a score to each subpart of the application, and then add up each subpart for an overall total score. Based on the total score, the Department would provide certifications to the highest-scoring applications. Second, if the Department is not amenable to the first option, which the [REDACTED] considers to be the best way to provide quality dispensaries with minimal burden on the Department, the Department would create two tiers of scoring. The first tier is a baseline for which every successful application must be 100% compliant. If any application does not meet the baseline criteria, then it is not considered. Then, after narrowing the number of applications based on their compliance with the baseline score, the Department would review the remaining information required in the application and establish a scoring system for remainder of the subparts. The Department would assign a score to the remaining subparts and rank the applications according to their scores. Based on the total score, the Department would provide certifications to the highest-scoring applications. Finally, if the Department chooses not to follow either of the first two options, the [REDACTED] proposes that the Department use the attached checklist, which was created by the [REDACTED] and give one point to each checkbox. After adding up the points obtained from the checkboxes, based on the total score, the Department would provide certifications to the highest-scoring applications.

The ambiguous nature of some of the rules has made planning for and selecting a location for a medical marijuana dispensary very difficult. We also understand that the Rules require one point of access for the public, and that some argue that is what the initiative called for. However, clarification is necessary, as a single entrance/exit of any kind is simply not practicable and would make it impossible to operate a safe and secure business. For example, if I were to acquire a dispensary license I would want to ensure I have the ability to install a secure emergency exit for the safety of my patrons and employees. The initiative drafters were clearly concerned with the security of medical marijuana inventories, and I share that concern. However, in order to operate safely in the regular course of business, as others in the same industry operating in other states can attest, the facility will require an additional doorway that is exclusively for employee use to enable the secure transfer of the product. This additional access point will allow dispensary employees to do their job responsibly, away from the distractions that can occur in the storefront of this or any retail use, especially one catering to patients with ailments that may diminish mobility. More than one entrance/exit should be allowed. To address this, please add language to the rules that explicitly allows dispensaries to have a second point of access exclusively for employees where they can process medical marijuana transfers, as well alarmed emergency exits as needed. Airports, where security is paramount, operate this way. To get to their gate passengers must go through a single screening point of entry. However, there are exits beyond the gate that are alarmed and only for use in an emergency. If airports can do

this, a medical marijuana dispensary should be able to do it too. Allow natural lighting at grow facilities. Second, I agree with the rules' prohibition of outside growing facilities because growing must be done in a secure facility. However, DHS should adopt language permitting roofing materials that allow light to pass through at cultivation facilities. First, medical marijuana is an organic remedy that should be cultivated in a manner that allows the product to grow in harmony with the natural world so that cultivators can provide a medicine that is pure and natural, with minimal use of chemicals or artificial resources. Second, a grow facility that uses 100% artificial lighting is much more costly and has a greater negative impact on the environment because of extra energy required for heat and lighting that could be accomplished by the sun. Allowing roofing materials that allow natural sunlight to permeate will drastically reduce environmental impact by capitalizing on one of our states most abundant natural resources. The rules should permit this common-sense, pro-environment approach.

**Proof of Capitalization** The most recent draft rules lowered the application requirements and evened the playing field in a number of ways. While it's great to give people access to this new industry, I also believe DHS needs to remember it has a responsibility to the people of Arizona and citizens who will reside around these dispensaries and cultivation facilities. Individuals who do not have adequate funding for starting and operating a dispensary in a secure and above board manner are a threat to those who reside in that community. The temptation if funds are scarce will be to cut corners wherever the dispensary owners feel it is possible and this could be in security, product quality control and safety. DHS needs to raise the standards and require applicants to provide proof that not only they have a great plan in place for operating a dispensary, but that they have adequate funding. I believe by requiring applicants show proof of a funds reasonable to support the start up and operations of a large amount of money in a bank account. Based on the extensive amount of research I have done regarding the start-up and operating costs required to establish a successful medical marijuana dispensary, I believe requiring \$750,000 is reasonable.

**Commitment to community** I think the requirement that owners and operators of dispensaries must have been an Arizona resident for at least three years is great. In keeping this new industry locally owned and operator, we assure the citizens of our state that dispensary owners have a commitment to operating upstanding, high quality and secure dispensaries. I believe DHS can further strengthen this commitment to the community by establishing a community "give-back" bench mark as a pre-requisite for a complete application for a dispensary license. Potential operators who are unwilling to give back to their local community are not the type of individuals we want operating dispensaries in our local communities. By requiring that applicants give back to a local charity, hospital or philanthropic organization, we're asking applicants to pay more than lip services towards their commitment to supporting the local community.

1. stop calling Hemp(English) Marijuana(Spanish) we need to educate our public as to the truth about this fabulous plant. Female plants denied the pollen of male plant create the sinsemia (spanish for without seeds) the strong medicinal. Pollinated plants produce seed and convert the THC into vibrant life force and essential fatty acids. Gruel, which is hemp seed mush, was the most abundant, complete food on the planet. Sails (canvas, the Dutch word for Hemp) rope, fine linen, "home spun, clothe" (Benjamin Franklin wore only home spun clothes as an statement to Europeans on the viability and prosperity of the America) fuel from the herd, and it is a nitrogen fixer for the soil and was the the stabilizer for the river banks because it is deep rooted. in fact the word Bank came from the fact that the "river bank" was the place where value was accumulated by nature in the form of non eroding root mass.

2. Stop all importation of Marijuana into Arizona.( then Joe █████ has a job to do that does not punish residence) Only Seeds should be allowed to be imported, in order to promote biodiversity. Let All the hemp products ,medicinal, fiber, fuel, food etc be PRODUCED BY

ARIZONIANS WITHOUT RESTRICTION. This way the money created by real productivity stays in Arizona! 3. Tax chemically grown Hemp. Organically grown hemp should be tax free for the growers. This is for the health of the planet. Distribution systems would generate all the revenue the state requires..

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An alternative to the lottery-style selection process for dispensary licenses, I feel that the department shall consider the merit, intent, and plan for positive impact of the individual or organization applying for the license. I feel that individuals or groups from the healthcare sector- such as physicians, pharmacists, or nurses - should be given priority over groups from a more financially driven background, since healthcare providers have experience in the delivery and use of medications. I also feel that since the dispensary is to be ran as a not-for-profit business, a plan for how the dispensary would make donations, if any and to whom, should be included for consideration by the department as a part of the application process.

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There is significant concern regarding the one entrance issue in regard to Dispensaries or Cultivation Buildings. There are strict rules under the Uniform Building Code adopted by most municipalities that state that NO building may be larger than 1,500SF if served by ONE entrance. There MUST be allowed by a definition in the rules that a building may have only ONE ENTRANCE DOOR except for EMERGENCY PANIC EQUIPPED ALARMED EXIT DOORS as required by applicable Municipal Building Codes for fire escape purposes.

Overall, I think the rules represent an improvement over the first draft. Please consider the following:

1. Random or lottery selection of applicants is unprofessional and without precedent. Selection should be based upon merit, experience and financially based evaluation. Barbers, Realtors, Contractors, even hamburger flippers are all required to demonstrate or prove merit and education. Lottery selection will have consequences that will add confusion and disrepute to DHS; and confusion, litigation and failure to the industry. Lots of folks would like to see that happen (failure), and DHS should take the "high road" and exercise good business and reasonable and educated defensible processes to select licensees. A professional protocol is called for - as it is in most businesses that require professionalism and regulation. DHS and the MM industry is dishonored if professional standards and practices are ignored. Lotteries are not, should not be the protocol of selection.
2. Application should be 4 step process – First, \$3,000 fee - make application with business plan and

model, demonstrate abilities to carry out the plan and comply with all state regulations. The applicant evaluation should be performed by an unbiased third party qualified to judge professional standards and business practices. Second, \$1,000 fee and grant conditional license and provide reasonable time for applicant to secure site, use permit, etc. Third, \$1000 fee - come back to DHS with approved site, security, zoning, use permit and operational plan and fixed time to get up and running. Fourth, \$2,000 fee - final inspection of plan, site, etc and applicant granted final license: to be renewed annually.

3. The CHAA design does nothing except to (hopefully) wall off the state in 25 mile circles to prevent home growers. It's not going to work. Dispensaries in some of the CHAAs cannot work based upon population. The numbers just don't add up. This together with the fact that in the outlying areas - it's still too easy and cheaper to grow your own or get it from a friend rather than go to a dispensary miles away and pay twice the price. The present CHAA approach does nothing to discourage or hinder recreational users. The dispensaries in sparsely populated CHAAs will go out of business and the home cultivators will proliferate. Question - if you lived remotely and grew your own or obtained on the street - would you patronize a dispensary miles way and pay twice the price? If it were me I would hardly be able to contain myself until that dispensary went out of business. Common sense. So - get rid of the CHAAs and develop grid or system based upon population - just like any other business. If the intent is to prepare for real businesses providing real services to folks that really need it - the present CHAA plan cannot and will not work - and there will be many folks later - telling you (DHS) "I told you so!" The lawyers will get rich with ensuing litigation.

4. Don't confuse the responsibility of dispensary licensing with law enforcement against those that are presently using marijuana for recreation. These are two separate and distinct challenges and one has nothing to do with the other. A combination of law enforcement (recreational use) and providing unique or alternative "medicines" are challenges addressed by their respective Arizona Revised Statutes and not only is it bad idea to combine them - but it's probably unconstitutional as well.

5. Patient - Physician relationships - I see some problems here but I'm not a medical professional and DHS would be well served to consult with medical professionals for the final rules.

6. Now, confusion abounds trying to figure out locations, obtain zoning and use permits, negotiate contingent leases - which may all be for naught if one is not awarded the license for a specific CHAA. Change the process - and announce THAT change immediately - bring a halt to the confusion and colossal waste of time and money by well intentioned folks trying to create a business using silly and unreasonable business practices. Thank you for your consideration. The comments I provide are based upon the input of many of my associates and partners in our endeavor to successfully secure a dispensary license or permit.

Thank you for allowing us to submit comments on the draft rules that have been set forth by the ADHS. This is a special time in a process that will shape our great state into a model of success and compassion, and I am glad that I am able to voice my opinion in this process. Shown below, are specific sections that are in the draft rules that either concern me, or that I applaud for your efforts. Thank you again for the opportunity and I hope that my comments are well received.

R9-17-101: The definition of enclosed is too restrictive. It is appreciated that the required wall height has been lowered from 12 to 10 feet and although this seems like an unnecessary inclusion in the rules it is an achievable requirement. However the inclusion of the required roof enclosure is too restrictive. With our ever limited resources of our economy as well as planet we need to take advantage of the renewable resources that are available before even considering an alternative. This becomes difficult for any large cultivation facility as not only will the wire mesh or metal wire grid cost an outrageous amount but the structure required to support such a requirement will create a hindrance to

operators, and even at times a possible safety hazard. This type of roof enclosure is bound to create more problems than it is meant to mitigate. A simple problem that might not have been considered is that of insects and birds creating habitats even defecating above what will be processed into medicine. A simple open roof design with proper security features such as razor wire and security cameras recording perimeter activity. It is appreciated that the definition and requirement for an ongoing physician patient relationship has been replaced with a more appropriate definition. However the requirement for a physician to be the only medical professional allowed to prescribe this life saving medicine is preposterous. It is well known that other medical professionals possess the education and experience to properly diagnose and prescribe dangerous drugs; why should a possibly healthy medicine be treated any differently? R9-17-102: The fee for registration of a dispensary is a fair amount and should remain. The fact that it is non-refundable is also a solid attempt to weed out applicants with insufficient capabilities and should remain as-is. However, the fee for registration of patient as well as Caregivers and their ID cards is excessive and should be reduced. We as voters and citizens of Arizona were not looking to impose more financial burdens on our sick when we passed the ARS 36-28.01. These amounts should be more in line with the cost of obtaining a driver's license from the DMV. R9-17-201: Hypertension, PTSD, Fibromyalgia, GI Disorders, Tourettes, and Rheumatoid Arthritis should be added to the list of Debilitating Medical Conditions. Dystonia and Parkinson's should be explicitly mentioned in R9-17-201.13. R9-17-202.F.7: The fee should not be as high in order to register as a Designated Caregiver. R9-17-302: The CHAA process for the distribution of dispensary registrations is not an effective way to distribute the registrations. The proper way to do it would be to divide the registration certificates across the state according to the population of pharmacies in each area. Random selection will only lead to problems with corruption; the process of allocating dispensary registrations should be determined based on a points system where points are earned based on standard criteria that should be publicly available. Each application should be reviewed by either the ADHS, a special panel of advisors, or an outside firm to impartially rating the applicants and awarding registration. R9-17-308.B: It is respected that the requirement was removed to have a remote access security camera system. R9-17-309.A.3: Please provide definition of what is meant by "contract with". Please provide guidance as to what type of contractual agreement would satisfy this requirement. This requirement does expose the medical marijuana program to risk of involvement with unethical physicians and therefore provides a risk to patients and should be dropped from the requirements. Instead, training by a medical professional should be performed at least once every 12 months. The same curriculum should be taught to all Agents of the dispensary, and if the employee is considered a "new hire" they should be required to complete the proper training before being allowed to conduct any transactions with patients. If this requirement is considered a "must have item", then a compromise could be made with the definition of who can qualify as a medical director by allowing other medical professionals to serve as such. R9-17-309.A: Thank you for removing the 70/30 requirement. This will allow for better patient relations among state dispensaries. We will also be able to experience benefits due to the establishment of the ability to collect valuable data from across a wide range of patients. R9-17-315: Inclusion of the "batch" system/Inventory Control System is a phenomenal way for ADHS as well as individuals conducting studies to be able to gather relevant data about different strains and uses of the same medical marijuana. This will allow us to be predisposed in Arizona to become a leader in medical marijuana research. R9-17-319.A: 1: This requirement does not allow for medical marijuana plants to be exposed to the outdoors. This lack of a proper definition for the protection required from pests and dust leaves little or no area that would be suitable for the cultivation of medical marijuana. Must it be grown in a class 8 clean room in order to meet the requirement for protection from dust and pests? Consequently that means that medical marijuana

cannot be grown in our most abundant natural resource of all, sunlight. Under a wire mesh roof with 10' high walls are the requirements set forth as a minimum by the ADHS, these are already too restrictive for safe and efficient operation. This must be removed in order to allow dispensaries the ability to operate in a normal business manner. \*Interesting fact: On average a solar panel that is 10% blocked from sunlight is only approximately 75% as efficient as one that is constantly exposed to full sun; what if plants are similar. 2: Please define what is meant by removed from the dispensary or cultivation site. Does removing the refuse or waste to an approved trash receptacle count as "removing it"? Or does this waste have to be disposed of "off-site" such as off the property limits? 3: This requirement is top vague to be considered a true concern of the ADHS. To require a business to unload their merchandise daily and clean all storage equipment is preposterous. Not only will it substantially increase patient costs due to the overhead involved in such tasks but it will degrade the quality of the end product as it is being constantly handled and exposed to such elements as are prohibited by R9-17-319.A.1. This section must be removed or highly modified to include reasonable requirements. It is not feasible for any company to wash its trucks daily, nor is it an ecologically friendly action in our arid desert. Thank you for taking the time to read my, as well as others input.

The draft can be improved by formalizing the above sentiment regarding what illnesses will qualify for a medical marijuana prescription. Also, any doctor of medicine should have the ability to prescribe the same as with any other medicine or prescription drug.

When more than one applicant for a dispensary is deemed qualified within a CHAA, then an auction should take place as opposed to a lottery. Bids should consist of percentages of excise tax the bidder will voluntarily pay to the State. I suggest bids in increments of 7%. Since this tax is voluntary it should survive a challenge under the Voter Protection Act. This system will have several collateral effects: 1. Make rural Chaas more attractive and competitive; 2. Raise substantial revenue for the State; 3. Tend to increase likelihood that altruistic applicants will receive dispensary licenses; 4. Discourage the Legislature from imposing a mandatory tax which will be found in violation of the Voter Protection Act since a tax does not, "further the purposes of such measure." Art. 4 part 1 section 1(6)c of the Arizona Const. We do not need this tied up in Court for months or years.

There needs to be more than a sworn statement that the dispensary is in compliance with local zoning restrictions. Although some towns do not provide use permits, many do provide them. Possession of a full use permit is probably not appropriate, but evidence of application for a use permit, where applicable, is appropriate.

make the organizations that want to run a dispensary disclose where they are getting their seeds, clones and other startup needs

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

Take out any language that discussed random issuing of permits

really concerned that the employee background checks and licensing has not been fully addressed.

Also think there should be something listed that indicates what the employee has to do to ensure they are issuing medical marijuana to the correct person

According to Prop 203 36-2801 ii) IF THE QUALIFYING PATIENT'S REGISTRY IDENTIFICATION CARD STATES THAT THE QUALIFYING PATIENT IS AUTHORIZED TO CULTIVATE MARIJUANA, TWELVE MARIJUANA PLANTS CONTAINED IN AN ENCLOSED, LOCKED FACILITY EXCEPT THAT THE PLANTS ARE NOT REQUIRED TO BE IN AN ENCLOSED, .... Yet, according to the Division of Public Health Services Medical Marijuana Program "FAQs" "Will there be people growing medical marijuana in my neighborhood? The Arizona Medical Marijuana Act allows a qualifying patient or the qualifying patient's designated caregiver to be approved by the Department to cultivate medical marijuana if the qualifying patient lives more than 25 miles from the nearest dispensary. A dispensary may cultivate marijuana at the dispensary or at a cultivation site, but the location of the dispensary and the cultivation site needs to be in compliance with local zoning restrictions. Anyone who grows medical marijuana must do so in an enclosed area. I see no evidence in the FAQs to allow patient cultivation when physician recommended. People need to be able to afford their medication and may not be able to afford potentially high dispensary prices. Please do not eliminate the doctors ability to recommend that a patient cultivate their own medicine.

Cultivation sites will have an impact on the environment, regardless of the restrictions placed on them by the Rules, however, requiring the use of ONLY artificial lighting and climate control will ensure those effects are devastating. The Rules should be amended to allow the roof barrier of cultivation sites to be made of translucent materials. Translucent roofing systems are designed to allow for the penetration of natural filtered daylight without maximum energy loss. Beneficial properties include excellent light transmission, superior UV resistance and impact strength. Most translucent roofing materials can be prepared with slight shading, which lets enough light through for strong plant growth, but is opaque enough to obscure vision from outside. This revision will allow dispensaries and cultivation facilities the opportunity to take advantage of clean solar heating, rather than acquiring heat from environmentally destructive coal-fired plants. DHS needs to review the stipulations set forth in ARS 36-2806(C) requiring a "single secure entrance" for a medical marijuana dispensary and clarify a dispensary must have a "single secure public entrance." It seems reckless and irresponsible to prohibit a dispensary from having a secure emergency entrance. It also seems negligent to require medical marijuana deliveries to occur through the same entrance as the public enters. Further clarification is most certainly needed to ensure dispensaries are operating in the most safe, secure and efficient manner possible. By refusing to clarify this requirement, dispensaries may endanger public safety by truly only have ONE entrance, exit and delivery door. I firmly believe DHS needs to also create additional barriers to entry which will ensure that applicants who do not have adequate funding to actually start and continue to operate a medical marijuana dispensary do not have the opportunity to enter the lottery system for a dispensary license. With the incredible level of competition in the most popular regions i.e. Phoenix, Scottsdale, Tempe etc., it seems important to ensure that those in the competition all actually qualify. The best example I can think of is the Boston Marathon; you can't simply wake up one morning and decide to join the race, there are precursor requirements in place to weed out unqualified runners. It is not until you have achieved a qualifying time in a comparable race, that you're allowed to submit a request to run in the Boston Marathon. Does it not make sense to have a similar system applicable to applications for a dispensary license? DHS should require that applicants to prove they have the funding necessary to operate a dispensary in reality prior to applying for a license. I suggest requiring applicants have at least \$750,000 in a bank account or similar account as a condition to submitting a complete

application. By doing so, DHS will assist in assuring experienced business owners applying for a dispensary license, that they aren't up against someone who has zero ability to financially start and operate a dispensary. This also assures the communities that the individuals who eventually receive a dispensary license were chosen from among the most qualified and capable applicants, even if they were chosen through a lottery system. Lastly I believe it's important that applicants be reminded that the medical marijuana industry in Arizona is a not-for-profit venture. It's important that in addition to requiring owners and operators to be Arizona residents for at least three years, they evidence their continued commitment to the communities in which they do business. I suggest requiring dispensary owners to donate a certain portion of their profits (or some other calculation etc.).

incorporate less regulation, forget the tax, forget the 150 for the card and the high cost of opening up a dispensary. after you add up all the cost only rich people will be able to afford the marijuana medication, and the majority of people that need the medication will still be buying their marijuana from Julio down at the school yard.

Lottery?! It's Ludicrous. Why would you consider this? Does this mean that anyone who applies would be eligible? We need an experienced managerial team or person who knows how to run a controlled substance business of this stature. Someone who has been successful at managing and controlling people and inventory.

The awarding of the Medical Marijuana Dispensary license should be based on merit, experience and quality of both product and services offered. The merit system should be based on the ability of each MMD applicant to develop their program based on demonstrated needs, individual community assets and issues, public perceptions, existing and potential resources, the interests of public health systems partnerships, and the unique cultural and geographic diversity of each county. Appropriate experience and expertise of key personnel in each of these areas will guarantee a successfully integrated dispensary. Random selection of MMD's is a disservice to the patients suffering from chronic and debilitating conditions, the voting constituency and our local communities.

The rules should be improved by allowing qualifying patients the choice to cultivate their own medical marijuana or to purchase their medical marijuana from a dispensary. Patients shouldn't be forced to pay for their medical marijuana when they can cultivate their own. This unfairly forces people in urban areas where dispensaries are more commonly located to be forced to buy. Qualifying patients living in a rural area will have an ability to cultivate their own medical marijuana or drive the 25 miles plus to purchase medical marijuana if they choose so. Qualifying patients should be allowed a choice in where they receive their medical marijuana.

It's clear that some criminals view a medical marijuana dispensary license as a get out jail free card. They think it will allow them to sell marijuana with impunity and some are lining up right now to apply for licenses. These individuals think Prop. 203 will allow them to take their drug dealing "mainstream," out of the back alleys and areas near schools, and into a commercial office space. Other than their location, these criminals don't plan on changing much about their

operation. They want to keep selling to anyone with money and they think theyâ€™ll now be selling a MUCH more potent version of their product, at a hefty MARK UP from street prices and increasing profits. To protect this new industry, these criminals MUST BE STOPPED. DHS, and the rules they adopt, are our best defense against these BOTTOM FEEDERS. Security Plan The current rules require filing security plan, but this plan is likely to sit in a filing cabinet collecting dust if the requirement is not strengthened. DHS should require applicants to submit a comprehensive security plan to local law enforcement for approval, prior to submitting it to DHS. In addition, applicants should be required to submit to regular inspections by DHS, in an effort to ensure ongoing compliance with the applicable Rules and law. Given the fact that budgetary constraints are a big concern, we propose that such required inspections be paid for and funded by implementing a fee on dispensary owners and operators. Discourage the use of cash: We also need to take measures to discourage the use of cash, which can easily be manipulated by the CRIMINAL ELEMENT. Discounts should be offered to patrons willing to utilize a credit or debit card. Of course, it would be unwise to banish the use of cash entirely, but by discouraging its use, perhaps those with less than altruistic intentions, will think twice before showing up with a hand full of cash. Insurance We require insurance for drivers, because there is always a risk that an irresponsible driver may cause an accident and injure or kill someone. An irresponsible dispensary owner and operator could injure or kill someone with a BAD BROWNIE â€™ insurance should be required. Legitimate dispensary owners and operators will have already taken the steps to acquire insurance, so by making this a requirement, it injures only the criminal element who had no intentions of operating in a safe and secure manner. Zoning The current Rules require an attestation that an applicantâ€™s site is in compliance with the local jurisdictionâ€™s zoning and land use requirements. The Rules should be strengthened to require certification that an applicantâ€™s site is in compliance with the local jurisdictionâ€™s zoning and land use requirements. This would create yet another barrier to entry, further eliminating those whose intent it is to pervert the industry and make a quick buck.

Is there a comprehensive security plan that makes sure the employees that are handling the medical marijuana are screened properly? I didn't see this anywhere in the rules

The rules should be improved by allowing qualifying patients the choice to cultivate their own medical marijuana or to purchase their medical marijuana from a dispensary. Patients shouldn't be forced to pay for their medical marijuana when they can cultivate their own. This unfairly forces people in urban areas where dispensaries are more commonly locate to be forced to buy. Qualifying patients living in a rural area will have an ability to cultivate their own medical marijuana or drive the 25 miles plus to purchase medical marijuana if they choose so. Qualifying patients should be allowed a choice in where they receive their medical marijuana.

The charge of \$160 to people who are already suffering from chronic diseases is inane and demonstrates the there is no real attempt to provide marijuana to those who need it. I have multiple myeloma cancer. I am on disability (about \$1000 a month). My monthly copays over what Medicare pays exceed my \$1000 so I must either find nonprofit foundations to assist me in my healthcare or sell my home and become homeless just to stay alive. Sometimes the pain is terrible. I have a choice. I can take pain medication which would leave me so dazed I am unable to function or use marijuana and be able to still think beyond the pain. The cost just to sign up for the program and the hoops I would be expected to jump through are awful. I can tell you that many of the people who truly would

benefit from this distribution of marijuana will not take part because it is so difficult. Since they do not know if it will work for them or not and as insurance will not cover it, they will not even try to get it this way. As the draft no where says that the dispensaries cannot gouge their customers by jacking up prices to levels exceeding the street price of marijuana, I most likely will not use the state's program. It is obvious that the state has no real desire to help those of us who would benefit from its use. While I do not want the California free-for-all distribution, I was hoping that Arizona would have some compassion. I can see that this is not the case. If someone is desparately ill, made poor because of the cost of their healthcare, it would be easier and cheaper to buy their marijuana from a illegal pusher than to buy it from a state dispensary. What police officer would arrest a person like me, with terminal cancer, who is just trying to live a while without pain, who possesses a small amount of marijuana to ease their pain? So why should I pay you \$160 just to see what a dispensary has that may help me?

add a section on how the medical marijuana will be issued

On one hand, the proposed rules prohibiting smoking marijuana in a "public place," On the other hand, the definition of "public place" does not currently include "planned community common areas." Condominium common areas, however, are included in definition of "public place."

make sure to add very detailed restrictions around signatures, identification checking and detailed log and record keeping for issuing patients their medical marijuana

1) Eliminate the requirement in R9-17-303, sub B.1.b, that an applicant for a Dispensary Registration Certificate provide the physical address of the proposed dispensary at the time of application. Though I suspect the intention is to ensure compliance with the density requirements of the statute, only the most wealthy will be able to secure a commercial space purely on the chance that their certificate will be granted. Instead, award the certificates at random from among otherwise qualified applicants, but make them provisional on their timely compliance with the density and zoning requirements. Further changes to sub B.5, and other related rules would need to be made as well.

If the Department of Health decides to go to a "Lottery" system, the candidates should be picked first before others needlessly spend thousands of dollars for nothing. After application fee, rent for several months without knowing, salaries, security, property drawn to scale are expenses that should not be spent unless someone knows they will qualify to get a license. I operated a business in a commercial building. It took four months for my Landlord to complete the tenant improvements. This was 60 days of a missed deal line on his part. Stress is a killer and I hope that the Dept of Health considers that it appears that [REDACTED] is wanting to monopolize the Arizona industry. Applicants should only be allowed to apply for ONE (1) DISPENSARY.

Ditch the CHAA, we need [REDACTED] dictating the Medical marijuana rules like we need the klukluxclan deciding immigration policy! Arizona has some of the highest unemployment rates in the nation and I would venture to assume that most people struggling to find work don't have \$15,000 to gamble and entirely risk losing to put their name in the hat for a dispensary?! I would also guess that dispensaries will be offering employees close to minimum wage so their not for profit ventures can net them huge profits. By placing the dispensaries willy nilly by finding a loophole to fool the voters, you are not going to affect the black market! Patients outside of halos and caregivers who have patients outside of a halo will have an opportunity to get in on a booming farming business. You are specifically attempting to thwart these middle class people from an opportunity to get into a business with a few thousand dollars that would help them provide for their families and pay taxes. I'm sure that because the [REDACTED] people think they are going to be obtaining the lions share of dispensary licenses, that they support this CHAA nonsense as it will cause the dispensaries to become a monopolized industry! Cutting any chance the little guys have to participate in a new multi-million dollar industry that has come to our state. Twelve year old kids can get marijuana any day of the week, and you are foolishly assuming that the black market is not already established and entrenched in our society. The black market for marijuana is going to continue to thrive until prohibition ceases and the value plummets! Placing the Chaa's all over to keep individuals from participating in this industry is only going to help the filthy rich that can afford to get in on the dispensaries to profit, while throwing the middle class people who desperately need any work they can find right now out under the bus. Two wrongs don't make a right! Thousands of valid patients will be forced to break the law due to your "as the crow flies" interpretation and the CHAA's. Most other states that have medical marijuana laws allow patients to grow their personal medicine! Rhetoric and baseless fears aside it's truly not a big deal! Keeping this as difficult and unreasonable as possible for patients will only guarantee that we will be voting to allow all valid patients to grow in 2012! Patients will still getting arrested because of these unintended consequences of your agency twisting the rules to suit this truly misguided agenda. These senseless restrictions will only remind people of why decriminalization is still necessary, so ultimately you will only be feeding that fire as well! We have voted for medical marijuana patients to have safe and affordable medicine, and not whatever you would call this mess you're trying to create is!

In so many ways! Allow people to cultivate their own, regardless of where they are in proximity to a dispensary. Drop the requirement for a doctor to be on staff at dispensary, the patient's doctor is responsible for their care and monitoring, so requiring an additional doctor is redundant. That goes for the requirement of 2 doctor's signatures in order to become a patient/caregiver as well. Mr. Humble ought to disregard his personal bias and agenda regarding this issue and stop trying to advocate from his position. It's not your job to determine who can and cannot have medical cannabis, it's your job to run the AZ dept of health in a way that the people of AZ want, and in this case it means making medical marijuana available to any and ALL those who need it. How should we define "need"? easy, leave that up to the Doctors.

more clarification around specific items as listed in our comments.

Can they add something into the rules to make sure that there are licensed and bonded employees distributing the marijuana? I have heard really negative things relating to security around the vending machines that have the marijuana

Attached is a listing of the rule changes and descriptions of why we would like the rules changed. Just so you understand who we are, our back ground in the industry is we do infusion (food, chap stick, salves, lotions and many more) in many other states, but both of us, the owners, live here in Arizona and we would like to move our production to Arizona. Thank you for your hard work and time that you have all put into the new rules. If you have any questions or need more information feel free to give me a call. Thank you, [REDACTED]

Put back in the part the required one year under a doctors care to be eligible. That is the only part that was good and made sense. It is also all the separates Arizona from the mess they have in California. What were you thinking!?!?! Sure they need a doctors permit (or whatever it is called), but so do they need it in California. It is a joke. Walk in to the office right next to the 'pharmacy', say 'I have terrible migraines that don't go away' and you get your permit. Why do you think it won't be the same way here?

eliminate the pot doc and allow AZ DHS to control this industry

regulate the method of providing the product to the patient. Do not allow any automated machines as there is not enough checks and balances on this method

A "doctor" should not be able to have more than 30 medical marijuana patients in a year and any increase in this rule must be approved by AZ DHS. Geographic dispersion of dispensaries to help minimize the less regulated home grower operations. Strong caregiver requirements against home growing and providing proper oversight and training. Careful monitoring of physicians by requiring a true doctor-patient relationship with legitimate certifications.

C. Proposed Fees Qualifying Patients in Arizona are required to visit their doctor to obtain a written certification, and then are required to obtain an ID through the Dept. While it is understandable that the implementation of the program costs money, \$160 for an ID (and for renewal) plus an additional \$200 for a designated caregiver ID is almost prohibitive. If at all possible, it would be preferable to lower the cost of the ID, perhaps by using the salary-based sliding scale provided for in Arizona Revised Statutes 36-2803(A)(5)(e). The reduced ID application fee is available to only the poorest citizens, and is still quite high at \$80. We appreciate the Department's willingness to recognize the need for reduced rates; perhaps another way to lower fees would be to broaden the qualifications for reduced fees. D. Quantity of Medicine Many patients throughout the U.S. have found that different routes of administration greatly affect the amount of medicine they may need. If a Qualified Patient is going to be preparing edibles with their medicine, it is important that they have access to as much medication as they need to prepare the food items they'll need. In addition, it should ultimately be up to the physician who has issued the Written Certification how much medication might be necessary for each patient. While the enacted language limits the quantity of medicine available per 14 days, it is possible to allow for an exemption based on the determination of the Certifying Physician. There may be additional qualifications, but it is best for patients and doctors to determine

the quantity needed during a particular period of time. E. Restriction of Caregivers with Felony Records While it is commendable that there is an exception within the Arizona Revised Statutes for those whose conduct would otherwise be protected under the Medical Marijuana Program for convictions pre-dating the Program, it is also important to recognize that people change. The Proposed Medical Marijuana Program should allow for rehabilitation and/or exemptions for family members. Many other states'™ programs have defined rehabilitation for the sake of Caregivers and Dispensary Agents. F. Restriction of Personal Cultivation We applaud the inclusion of a personal cultivation section within the Arizona Revised Statutes and Medical Marijuana Program; however, it has been found across the country that when the state is in charge of developing a system of access to medical cannabis, large gaps in access exist even absent geographical limitations. It is important to recognize that the implementation of the Medical Marijuana Program in Arizona will have some hiccups, and, unfortunately, Qualified Patients will be left in the lurch during these times. Allowing for exemptions for patients who are not only far from a Dispensary, but also those who have other issues with access would help provide stopgap measures ensuring access to the most Qualified Patients. Exemptions may include the time frame during which the licensing and opening of Dispensaries across the state is occurring, as well as for those who fall below a certain income level. Arizona officials need not look far to find a state that has struggled with this issue; New Mexico has had many troubles related to their state-run dispensary, though patients were protected, to some degree, by the fact that personal cultivation was allowed under New Mexico law. G. Privacy Concerns The privacy and confidentiality protections within the Arizona Revised Statutes and the Proposed Medical Marijuana Program go to great lengths to protect Qualified Patients'™ privacy. We ask that the Program go a bit further and remove the requirement that physicians examine patients'™ medical records covering the previous 12 months. While it is understandable that physicians have the most information available to them to make a diagnosis and determine a treatment plan, medical records are highly personal and are protected both at the state and federal level, and we hope that the Medical Marijuana Program is willing to recognize the privacy of patients and remove this onerous provision from the Program. In the same vein, requiring Dispensaries to maintain video camera surveillance puts Qualified Patients, Designated Caregivers, and Dispensary Agents at risk. Not only are health decisions highly personal, the decision to use medical cannabis is seen as even more personal and private. In addition, participants in the Medical Marijuana Program are operating in direct violation of federal law, and having easily subpoenaed surveillance footage puts everyone at risk. We understand the need for security, but have seen many successful Dispensaries operate with very little trouble without any video surveillance. H. Dispensaries Moving Requirements The vast majority of Dispensary requirements within the Proposed Medical Marijuana Program are reasonable. The main concern we have is with the prohibition on Dispensaries moving within the first three years of operation. It is unclear what the exact rationale is behind the prohibition, and we ask that, at the least, an exemption be made for unforeseen circumstances (i.e. landlord retribution, zoning changes, community concerns).

Why isn't there any information relating to the actual issuing of medical marijuana? Does it get signed for, who will be checking ids, etc?

The draft can be improved if you add that labs that provide testing can do that by getting a caregivers status or special permit to assist in the testing of strength levels. Also, there needs to be a strict license review to reward the applicants that have spent the time and effort making sure they have

done all the due diligence to ensure a successful dispensary/cultivation. There are too many negative ramifications to a lottery process. A patient should not have to deal with dispensaries that are picked randomly by chance.

February 18, 2011 Will Humble, Director Arizona Department of Health Services 150 N. 18th Avenue Phoenix, AZ 85007 Re: Comments to the Arizona Department of Health Services' Proposed Rules to be Promulgated Under Arizona Revised Statutes Section 36-2801, et. seq., Arizona's Medical Marijuana Laws Dear Mr. Humble: I am the creator of a website called [REDACTED] found on the internet at

The purpose of this website is to inform the public about the new law created by the voters' approval of Proposition 203. Although this new website is just shy of seven weeks old, it will have close to 20,000 visitors this month because it contains a treasure trove of information about this new law. I am an Arizona attorney who has been practicing business law in Arizona since 1980. Since I started counting in 2002, I have formed over 3,000 Arizona limited liability companies, for profit corporations and nonprofit corporations. As of the date of this letter, I have been hired by more than 30 groups that intend to apply for a dispensary registration certificate. What follows are my suggested changes and comments to the proposed Rules. 1. The Lottery. Eliminate the lottery and replace it with a selection system based on the quality of the application and the applicant. Our country has been a country where people succeeded on merit, not on government give-aways. DHS should pick the applicants that are best qualified and most likely to operate a successful business. The people of Arizona deserve the best dispensary owners, not a group of winners who are lucky to have their names drawn out of a hat. The application fee of \$5,000 is sufficient to pay for a review and analysis of each application. State in detail the criteria on which applications will be graded. Create a point system and say that dispensary registration certificates will be awarded to the top 124 scores. Provide in the Rules that if any of the 124 applicants selected for a license fails to actually obtain its dispensary license within one year, the dispensary registration certificate will be revoked and a new dispensary registration certificate be offered to the applicant whose total score was 125th and go down the list if other entities fail to open their dispensaries within the designated time period. I submit to you that selecting dispensary owners by a lottery is the surest way for DHS to get sued and to cost the State of Arizona a large amount of defense money it does not have. The current Rules are totally lacking in any guidance or requirements for conducting a lottery. Here are just a few of the almost unlimited problems with a lottery: ¶ There are no detailed Rules on exactly what applicants must do to be eligible for the lottery. Currently the Rules provide that the application must include a business plan. One applicant might submit a 50 detailed business plan that involved a great deal of thought and research. Another applicant might submit a one page business plan that has four bullet points and ten lines of text. If DHS discards and does not put into the lottery the application that contained the one page business plan because it is not sufficient, DHS will probably be sued and lose the lawsuit because the Rules do not contain any requirements or guidance on what must be in the business plan. Without any specific requirements for a business plan or policies and procedures on inventory control, the one page bare bones document should not be rejected. ¶ R7-17-303.B.5 says the application must be accompanied by: ¶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¶ What does that statement mean? One applicant obtains a lease for a dispensary site in Phoenix in an area that is properly zoned and gets a special use permit from Phoenix. Another applicant obtains a lease for a dispensary site in

Phoenix in an area that is properly zoned, but does not obtain a special use permit or even make any filings with Phoenix zoning. Will you reject the application of the second applicant? If so, DHS would once again invite a lawsuit because the second applicant can clearly affirm that the site complies with local zoning restrictions. The current Rules do not expressly state that an applicant must make any type of filing with a city to obtain zoning. It would be a mistake to require applicants to make any kind of filing with a city zoning department unless and until that applicant receives an initial dispensary registration certificate. Why waste the time and money of cities processing hundreds or thousands of zoning applications for entities that will never obtain a dispensary registration certificate. â€¢ DHS rejects one or more applications because the applications list the same location for the dispensary. It makes sense for a landlord who is willing to lease to a dispensary and whose property is properly zoned to be able to lease the site to multiple prospective tenants with a clause in each lease that the lease will not be effective unless the prospective tenant obtains a dispensary registration certificate. Maybe that landlord has the best facility/location in the CHAA, but the lottery winner has a site in a terrible neighborhood near strip clubs. DHS should want the free market to determine where the dispensaries will be located, not the luck of the draw. The current Rules do not prohibit multiple applications for the same site so if DHS were to reject one or more applications because the applications listed the same site, it would be inviting each of the rejected applicants to sue. Please modify the Rules to let one site be used by multiple applicants. â€¢ All the details of the lottery must be set out. For example, how will the lottery be conducted? Will numbers be thrown in a hat and selected by Rose Mofford? Will ping pong balls be put in a spinning basket? When will the lotteries be held? Will they be open to the public or televised? It should be open and televised. Any lottery details that are not stated in the Rules will create opportunities for lottery losers to sue DHS. The following is an article posted on [REDACTED] on February 3, 2011, by Anonymous: I believe that the proposed AZDHS Rule whereby the Department will allocate Medical Marijuana Dispensaries to applicants by lottery is a big mistake, for the following reasons: â€¢ The Rules require an applicant to submit a number of items with their application. Included are a business plan, an inventory plan, a security plan and other items. The Department might receive an application from one applicant including a business plan that is thorough and persuasive concerning the likely success of the applicant's proposed operation of a dispensary. Another applicant might submit a sheet that says "Business Plan" at the top, but which contains little that is helpful or persuasive concerning the applicant's likelihood of success. Since the Department's Rules contain nothing to help evaluate or rate or differentiate between the 2 submissions, each will be entitled to be submitted with an equal chance to be chosen from the lottery. (assuming some form of the other required items have been included with each application.) â€¢ The fact that, per the proposed Rule, the business plan and other required submissions will not be read, evaluated or scored renders the required submission of those documents meaningless. â€¢ The Department is charging a fee of \$5,000 to file an application. Only \$1,000 would be refunded to an applicant who submitted a complete application and whose application was therefore submitted to the lottery. People have speculated that 2,000 or more applications could be filed. If 2,000 applications were submitted at \$5,000 each, the gross would be \$10,000,000. If every one of the applications were complete (unlikely), 1,875 refunds of \$1,000 each (\$1,875,000) would need to be made. The net would be a minimum of \$8,125,000. Since some of the applications would likely be incomplete and the applicant would not receive a refund, the net would probably be even more. With this large amount of funds, certainly the Department should have the resources to read, evaluate and score the applications received. â€¢ If AZDHS awards the right to obtain a license to an obviously unqualified applicant because AZDHS has been unwilling to read, evaluate and score the applications received, even though it has received millions of dollars in application fees from applicants, it will subject itself to legal action

by qualified applicants who were denied the right to obtain a license or even the opportunity to have their applications and evidence of qualifications evaluated. The lottery proposal encourages gaming of the system or even fraud. I have heard of groups who intend to submit 20 or more applications. A group of investors could file applications by each of the individuals in the group with an agreement that if any of them were successful, the unsuccessful individuals would be brought into partnership with the successful applicant. There could even be straw applicants submitting applications on behalf of undisclosed principals. All of this would be incentivized by the unwillingness of the Department to read, evaluate and score the applications received. The people who drafted the ballot measure made a great effort to make the Arizona Medical Marijuana system subject to comprehensive and sensible regulations in order to avoid some of the "free for all" problems occurring in some of the other States that have previously allowed Medical Marijuana. Providing a system where applications and the attached submissions are read, evaluated and scored will result in the most qualified applicants being chosen for the limited number of licenses. Refusing to evaluate the applications will promote the opposite, leading to instability in the industry and problems for law enforcement the public and the Agency. If unqualified applicants are chosen by lottery for the right to submit the additional items necessary to receive permission to operate, and are unable to perform because they lack the resources or are incompetent, the dispensary permit could sit idle for a year until the next opportunity for the Department to receive applications. This would deny the public access to a dispensary in that area and would allow patients with cards to grow their own medical marijuana if they were more than 25 miles from the closest other dispensary. Awarding licenses to unqualified applicants will likely cause problems with patient services as well as unpaid bills and other problems related to failure of dispensary businesses due to lack of qualifications of the applicants. If the Department is unwilling to evaluate the suitability and qualifications of the applicants, it should at least require a bond or a posting of a cash deposit, to guarantee performance by a successful applicant. This should be required as a condition of submitting the initial application. The nature of the business as well as the regulations imposed by the Statute and the Agency Rules guarantee that it will be expensive to open and operate a dispensary. If a prospective applicant does not have the financial resources to be able to successfully open and operate a dispensary, he or she should get the backing of someone who does. This is no different from any other business opportunity. While those without resources might complain that it is unfair to deny them the chance to receive a license, it is just as unfair to choose someone without the qualifications, competence and resources necessary to be successful, on the basis of a "game of chance" over someone who has the qualifications, competence and resources required to be successful. It is also unfair to the public who will be using the services of dispensaries to impose upon them, based on a "game of chance", prospective dispensary operators who are not likely to be competent and/or successful in providing good service to the patients. If the State of Arizona wanted to have a low regulation industry and let the market choose the winners and losers, it could do that. Arizona has not made that choice, though. Arizona has chosen a highly regulated system involving very limited access to licenses. The regulations imposed by the State increase the resources and competence required to operate successfully. With this type of system, the State Agency has the responsibility to do what is necessary to increase the odds that the very limited number of business opportunities will be given to those who are likely to be able to perform.

2. The CHAAs. The CHAAs must be eliminated. Will Humble's stated purpose for creating the CHAAs is to spread dispensaries throughout the state to reduce the number of private marijuana growers. That may be a reasonable personal objective of Mr. Humble, but his job is not to impose his private beliefs on the people of Arizona contrary to the express language of Proposition 203. The obvious goal of Proposition 203 is to make medical marijuana available to the Arizona patients who need it. The goal of Proposition 203 was not to minimize the

number of patients who might grow their own marijuana. Let the free market determine where dispensaries will be located. When government gets involved in commerce as in this case, the end result is higher costs to the consumer/patient. Is DHS aware of the laws of economics and how supply and demand relate to price? When you limit the supply, the demand goes up and so does the price. When the supply goes up, the demand goes down and so does the price. The unintended consequence of the CHAA system will be to greatly increase the price of products to patients who live in the highly populated CHAAs where only one dispensary will be located. Dispensaries in these CHAAs will be free to overcharge their patients because they will not have any competition. The following is an article posted on [REDACTED] on February 3, 2011, by Anonymous: I am part of a group that plans to apply for one of the medical marijuana dispensary licenses to be awarded by the Arizona Department of Health Services. I believe the method the AZDHS has chosen to distribute the licenses throughout the State is flawed. Here are some of the reasons. Prop. 203, as it was passed by the voters, expressly based the number of dispensary licenses to be awarded on the number of retail pharmacies in the State. Recently, the total for the State was 1,249, which, if rounded up would result in 125 dispensaries. Prop. 203 does not expressly state how the dispensaries are to be distributed throughout the State of Arizona. There are two obvious methods that could be used. One would be to distribute them among Arizona's 15 Counties according to the number of pharmacies in each county. After all, Prop. 203 based the total for the state on the number of pharmacies statewide. The other method would be to distribute the dispensaries throughout the 15 counties according to the per-capita population of each county compared to the total for the state. Using either the pharmacy method or the population per county method would have similar results. Although urban areas have more pharmacies per capita than rural areas, the differences are not so great as to make the distribution result significantly different based on the method chosen. In general, using numbers of pharmacies per county slightly increases the number of dispensaries in large urban areas and using population per county slightly decreases the share of the large urban areas and transfers a few of the dispensaries to smaller population counties. In the 2d set of Agency Rules distributed by AZDHS on January 31, 2011, they have come up with a different method of distributing the dispensaries. They have used AZDHS's Community Health Analysis Areas (CHAA) and have decided to locate one dispensary in each one of them. There are 126 of these CHAA zones. 19 of them are located throughout the State on Indian Reservations Although I have not seen it in print, I have heard that possibly all of the 19 tribes may allow the State to refrain from locating a dispensary in their lands. I believe that AZDHS is counting on this. The reason I believe this is that in his January 28 posting to his blog, Director Humble stated that individual CHAA districts in Arizona include as few as 5,000 residents and as many as 190,000 residents. If you take into account Indian Reservation CHAA districts, there are 6 districts with fewer than 1,000 residents and 11 with fewer than 5,000 residents. On this basis, I am assuming that AZDHS does not plan to distribute dispensaries to the 19 Indian Reservation CHAA districts. AZDHS has not said whether it intends to distribute 19 additional dispensaries among the non-Indian Reservation CHAA zones in order to bring the total back up to 126. They will likely be required to do something to make up the difference between 107 and at least 125, since Prop 203. specifies that at least 1 dispensary license will be distributed for each 10 pharmacies. Since there are 1,249 pharmacies, AZDHS should be required to distribute at least 125 licenses. To view the CHAAs go to the Medical Marijuana Dispensary CHAA Map. You can zoom in and out or enter an address to determine the CHAA in which the address is located. If you click on a CHAA, the map will display the name of the CHAA, its ID number, 2000 population and 2010 population. Using the CHAA districts as the basis for distribution of the dispensaries throughout the State will result in a radical redistribution of dispensaries from urban areas to rural areas. I have learned, from the AZDHS website, the 2010 population totals for each of

the 107 non Indian Reservation CHAA zones. The smallest is Ajo, in far West Pima County which had 4,290 residents. The largest is Maryvale in Phoenix which had 224,678 residents. I divided the CHAAs into two groups. The first is the 54 CHAAs with the smallest 2010 population totals. The second group is the 53 CHAAs with the largest 2010 population totals. Here is some information comparing those two groups. ¶ The 54 smallest CHAAs have a total of 1,165,676 residents. They average 21,587 residents per CHAA. Their total population represents 18% of Arizona's total non-Indian Reservation population of 6,535,445. ¶ The 53 largest CHAAs have a total of 5,335,808 residents. They average 100,808 residents per CHAA. Their total population represents 82% of Arizona's total non-Indian Reservation population. ¶ Under the AZDHS proposal group 1, representing 18% of Arizona's population will receive 54 dispensaries. Group 2, representing 82% of Arizona's population will receive 53 dispensaries. I have also looked at how dispensaries would be distributed among Arizona's 15 counties based on number of pharmacies per county, per capita population per county and distribution by CHAA. As mentioned above, by pharmacy total Maricopa County would receive 80 dispensaries. By per capita population it would receive 75. Since there are 41 CHAAs in Maricopa County, per the AZDHS proposal, Maricopa County would receive 41 dispensaries. Although Maricopa County has 64 % of the State's pharmacies and 60 percent of the population, it would only receive 38% of the 107 non-Indian Reservation dispensaries. Pima County receives a similar percentage of the number of dispensaries whether they are distributed by number of pharmacies, per capita population or by CHAA. The difference between the 80 dispensaries out of 125 that Maricopa County would receive by pharmacy total and the 41 of 107 it would receive according to CHAAs would be distributed to the smaller and more rural Counties. Here are some facts concerning the population totals that would be served by Maricopa County's 41 dispensaries and those of smaller rural Counties. ¶ Maricopa County's 41 dispensaries would each serve, on average, 98,130 residents. ¶ La Paz County is the 2d smallest population County in Arizona. Its population is 21,616. It was one of the Counties that, per Prop. 203 was guaranteed at least one dispensary even though it would not receive one if it were determined by number of pharmacies or by population. Since La Paz County has 2 CHAAs, it would now receive 2 dispensaries which would each serve 10,808 residents. ¶ Cochise County has a population of 140,623. If dispensaries were distributed by number of pharmacies (23), it would receive 2. If they were distributed by population, they would receive 3. Cochise County has 6 CHAAs and will receive 6 dispensaries per the AZDHS proposal. These dispensaries, would, on the average, serve 23,377 residents, compared to the Maricopa County average of 98,130 residents. ¶ By virtue of distribution by CHAA, Santa Cruz County, Gila County, Navajo County and Coconino Counties would each gain dispensaries compared to the distribution by number of pharmacies or population. In each of these Counties, less than 30,000 residents, on average, would be served by the dispensaries the County would receive according to CHAAs. AZDHS could make up the difference between the 107 non-Indian Reservation CHAAs and the 125 dispensaries required by Prop. 203 by distributing 18 or so additional dispensary licenses. The most logical way to do this would be to assign an additional license to each of the 18 highest population CHAAs, so that each of the 18 largest CHAAs would have 2 dispensaries instead of 1. 16 of these additional dispensaries would go to Maricopa County and 2 would go to Pima County. This would reduce to some extent the radical disparity between the treatment of urban and rural areas. The disparity would still be large. If Maricopa County received 57 dispensaries out of 125 as opposed to 41 out of 107, its share of dispensaries would increase to 46% from 38%. This compares to Maricopa County's 60% share of Arizona's population. This would not alleviate the problems AZDHS will be creating by insisting that every tiny population CHAA receive a dispensary license. These problems are discussed in detail below. According to AZDHS figures, Arizona has 6,535,445 non-Indian Reservation residents. Dividing this total by the 125 dispensaries mandated by Prop. 203 would result

in an average of approximately 52,000 residents per dispensary. Close to this average would result whether the dispensaries were distributed by numbers of pharmacies or by per-capita population per County. Distributing the dispensaries by the AZDHS CHAA proposal radically revises the distribution so that dispensaries in rural areas will serve far fewer residents than those in urban areas. In my opinion the AZDHS proposal is a clear and blatant violation of the Arizona Voter Protection Act and the provisions of Prop. 203. The fact that Prop. 203 provided that the total dispensaries in the State would be determined by a 1 to 10 ratio clearly implies that distribution of dispensaries throughout the State should be done by the same method. As mentioned above, distribution by per-capita population would yield similar results, with just a few dispensaries being transferred from Maricopa and Pima Counties to several smaller rural Counties. Prop. 203 implied that distribution should be based on number of pharmacies. Moreover, it dealt specifically with the situation where a small population County might not be entitled to a dispensary because it has few pharmacies. It provided that each County, no matter how small, would be entitled to no less than one dispensary if there were a qualified applicant. Prop. 203 provided that the State total of dispensaries could be increased above the number specified in the law, if necessary to provide at least one to each County. Distributing dispensaries by CHAA flies in the face of the clear language of Prop. 203. If litigation were filed, the CHAA distribution would probably be struck down by a Court, since it flies in the face of the language of Prop. 203 and its effects are so clearly unjust. It is obvious that the reason AZDHS decided to distribute dispensaries per CHAA is that it will spread the dispensaries out throughout the entire State and increase the percentage of Arizona's land that will be covered by "grow your own exclusion zones" of 25 mile radius which will exist around each dispensary. I can understand how many could consider this to be a worthy goal. Even if the goal is worthy, it does not justify such a radical perversion of the intent of Prop. 203. I can see several specific negative consequences of distribution of dispensaries by CHAA. Since the urban areas will have dispensaries serving very large populations, those dispensaries will become very large operations. This could be difficult in light of the fact that many if not most Cities and Counties are putting square footage limitations on dispensaries. Of the 20 smallest CHAAs, 13 have 2010 populations of less than 10,000. All of the smallest 20 CHAAs have 2010 populations less than 15,000. Some have only the smallest of towns or settlements and may not have commercial suitable space available for a dispensary. Many of these CHAAs are very large geographically with their population densities being extremely low. In many cases, because of the very small populations and very low population densities, these low population CHAAs may not be able to support the operation of a dispensary. Many of these dispensaries could fail and go out of business. As they were in the process of going out of business, numerous problems involving patient services, defaulting on financial obligations and others could arise. Having dispensaries go out of business would decrease the stability of the industry and create additional problems for AZDHS to have to deal with. Presumably if a small population CHAA went out of business, the "grow your own exclusion zone" would go away and the original motive of those proposing distribution by CHAA would be frustrated. The CHAA proposal is not necessary. There are better ways to distribute dispensaries in a way that would not create such radical distortions. Gila County is a good example. It would receive only one dispensary whether they are distributed by number of pharmacies or by population. Gila County's population is divided, more or less evenly, between Payson in the North and Globe in the South. The road between the 2 towns is over 80 miles. They have a legitimate desire to have a "grow your own exclusion zone" surrounding both towns. Here is a way to solve the problem without creating all of the problems involved with the CHAA Rule. AZDHS could write a Rule that would allow a County, such as Gila County, to request, based on its particular circumstances, that it have its one dispensary operate out of 2 locations, one in Payson and the other in Globe. It could qualify as one dispensary rather than 2

by operating out of the 2 locations on alternate days and never being both open at the same time. AZDHS would impose a 25 mile radius grow your own exclusion zone around each location of the one dispensary. Although the dispensary would have increased costs maintaining 2 operating locations, it would be able to share other costs like wages between the 2 locations. A single dispensary operating out of 2 separate limited hours locations would be more likely to survive financially than 2 separately owned dispensaries with larger operating costs. Other rural Counties with large distances separating their population centers could benefit by such a Rule. This would satisfy the goal of reducing the area where self cultivation is allowed while avoiding the instability involved with trying to force people to operate dispensaries in locations that are not viable. There will inevitably remain some locations that will not have dispensary locations even with the suggested Rule. Even the CHAA Rule does not completely eliminate areas where card holders could grow their own. These areas have very low population density and the number of card holders living in them would likely be quite small. It seems unlikely that many cardholders would move to one of these unprotected locations just so they could grow their own medical marijuana.

3. The Medical Director. Eliminate the medical director because it is not provided for in Proposition 203 and the medical director provides no purpose other than to increase the cost for the dispensaries which results in patients paying more to purchase marijuana products. The Rules do not require that the doctor have any training or knowledge about medical marijuana. If the purpose of a medical director was to somehow educate and inform and assist patients using medical marijuana, wouldn't there be some minimum requirements for a medical director that would be evidence that the doctor has some minimal level of knowledge and experience with medical marijuana and its affects on patients? If DHS insists on having a medical director, it should be DHS's own medical director who can then create the pamphlets and literature that DHS wants distributed to patients and charge each dispensary \$500 a month plus the cost to purchase the literature.

4. Principal Officer & Board Member. Throughout the Rules DHS uses the phrase "principal officer and board member." The Rules carefully create requirements invented by DHS that are not in Proposition 203 that every principal officer and board member must meet, including, but not limited to the unconstitutional Arizona residency requirement. The residency requirement may get DHS sued after dispensary licenses are issued. Nobody wants to sue before then because they do not want to get on DHS's "bad actor" list. Why is the phrase principal officer and board member used 50 times in the Rules, but the Rules do not contain a single reference to the owners of the nonprofit entity. The Rules never mention the owners of a nonprofit entity who are called: (i) shareholders when the entity is a for profit corporation, (ii) partners when the entity is a partnership, (iii) member when the entity is a limited liability company, and (iv) sole proprietor when the business is owned by one person who operates without an entity. The current Rules regulate only principal officers and board members. As a 31 year business lawyer who has formed and advised over 3,000 Arizona companies, I am familiar with officers of a corporation, but have never heard of a "principal" officer. Please tell us what a principal officer is and how a principal officer differs from a plain vanilla officer? As a general Rule, only corporations have officers and members of the board of directors. Limited liability companies are run by the members if the LLC is member managed or by one or more managers if the LLC is manager managed. Limited partnerships and general partnerships are managed by one or more general partners. An LLC can create officers and board members, but unlike Arizona corporate law, Arizona LLC law does not provide for either. The current Rules do not prohibit the nonprofit entity from being owned by a person who has an excluded felony or one or more of the other fifteen requirements contained in the Rules that must be met by all principal officers and board members. Doesn't DHS want all of the owners of a dispensary to meet the same eligibility requirements as officers and directors? I recommend that DHS amend the Rules as follows: "Where ever the

phrase "principal officer and/or board member" appears, replace it with "Owner, Officer and/or Board Member." Include a definition for Owner that states: The term "Owner" means: (i) a shareholder of a corporation, (ii) a partner of a general or limited partnership, (iii) a member of a limited liability company, and (iv) a sole proprietor. Include a definition for Officer that states: The term "Officer" means: (i) a president, vice president, secretary or treasurer of a corporation, (ii) a general partner of a general partnership or a limited partnership, (iii) a manager of a manager managed limited liability company, (iv) a member of a member managed limited liability company, and (v) a sole proprietor. Include

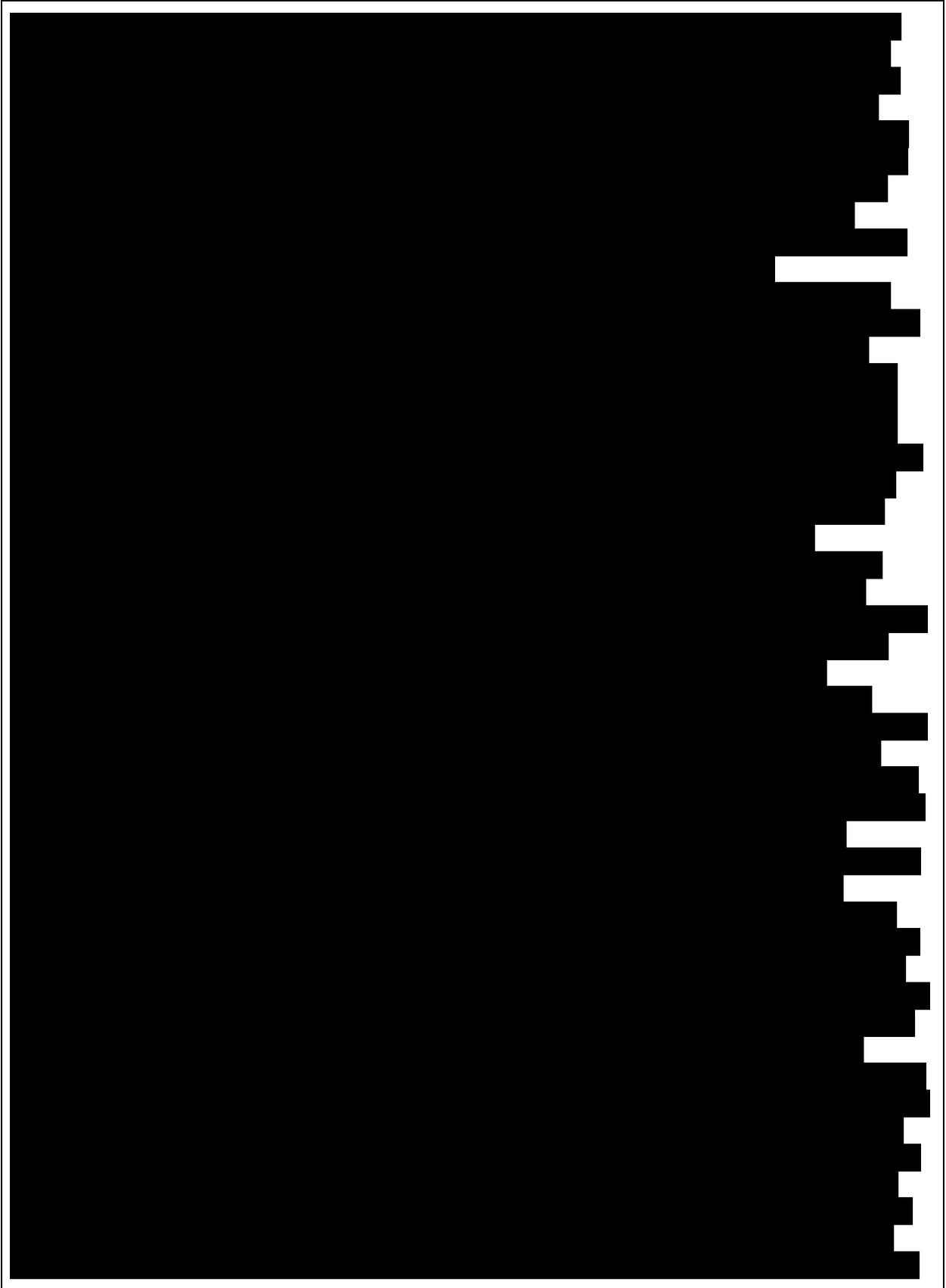
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

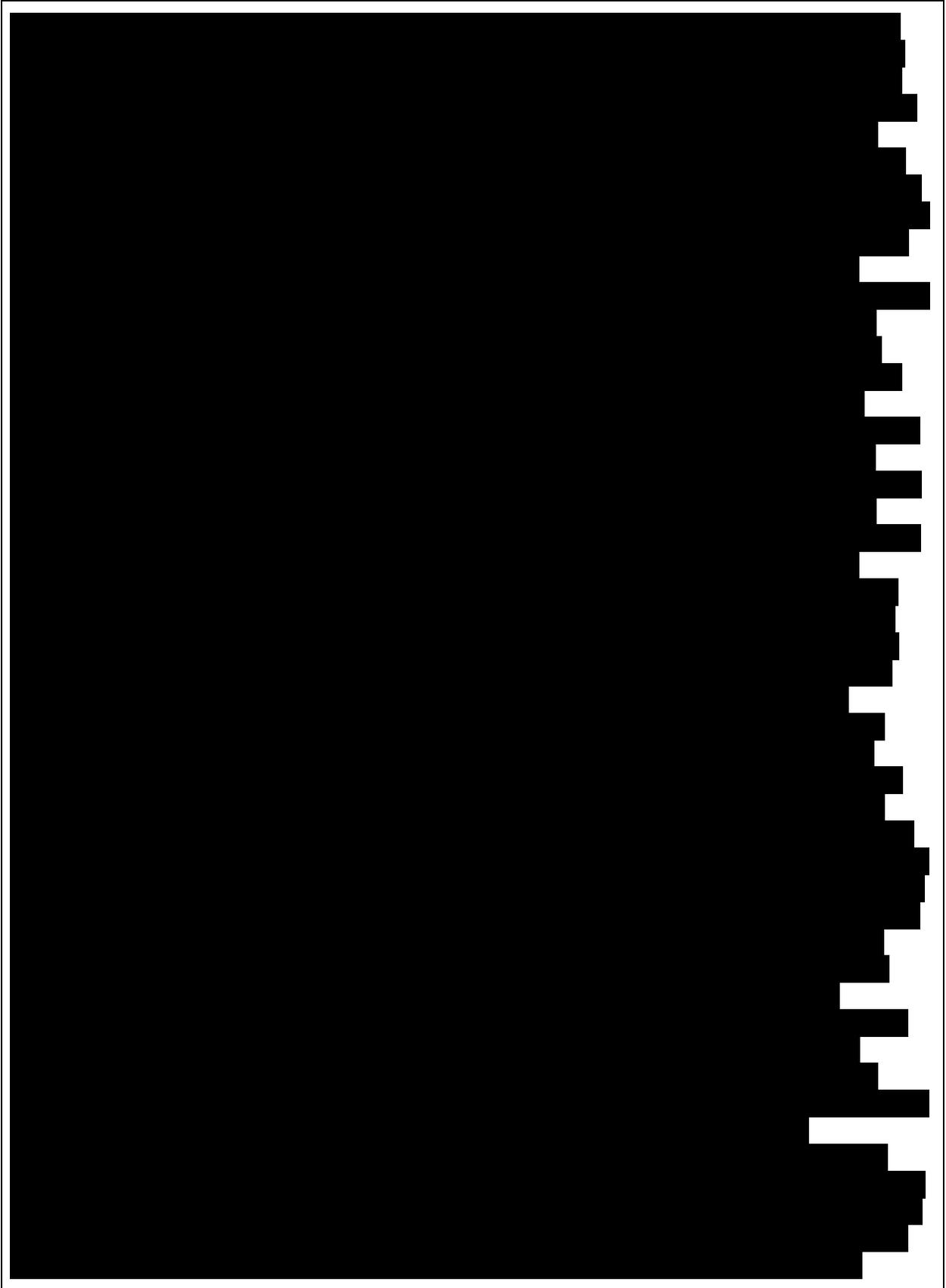
Dispensaries and care takers should be allowed to voluntarily submit samples of batches to private chemical diagnostic labs as well as state officials, in order to determine potency and ingredients. Caretakers should be able to sell any surplus marijuana to dispensaries for a fair price, as long as proper taxes are paid. Farmers do not give their produce away because the store shelves are full.

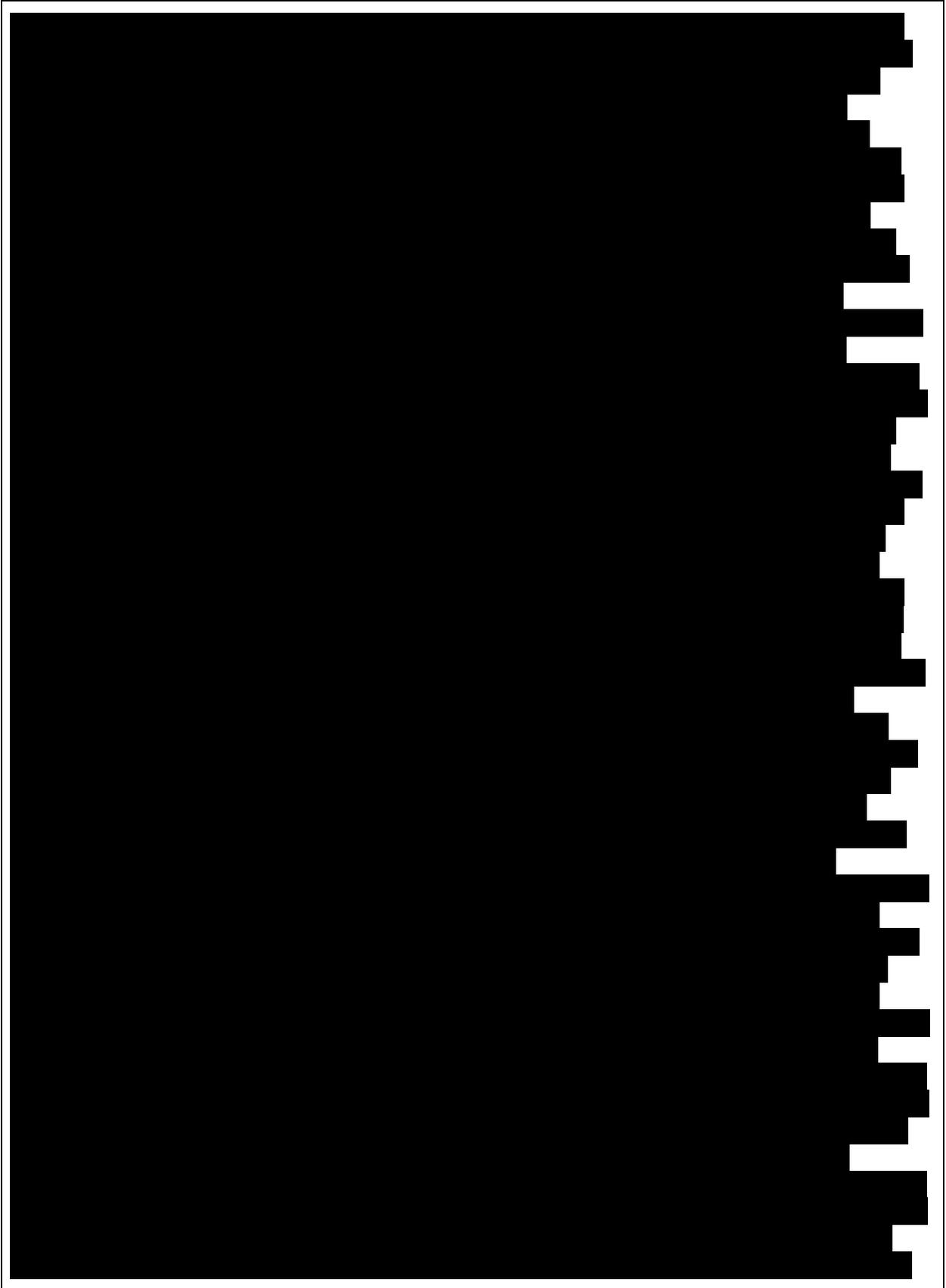
The rule should provide for a lower application fee for those of us on social security.

"Activities of daily living" should include more than just being able to get out of bed, getting dressed and walking a few feet. Fibromyalgia causes me to experience so much pain DURING activities that I am not able to complete them. These activities include sitting in a chair for long periods of time, grocery shopping, standing long enough to cook a healthy meal or do dishes, clean my home, or get vital minimal exercise that would help prevent additional chronic illnesses such as heart disease, etc. I have medication that allows me to get out of bed, shower, dress, & eat, but the quality of my life ends there. The only reason I can work is that I work for a company that allows me to work from home. If that were not the case, I would no longer be employed or employable.









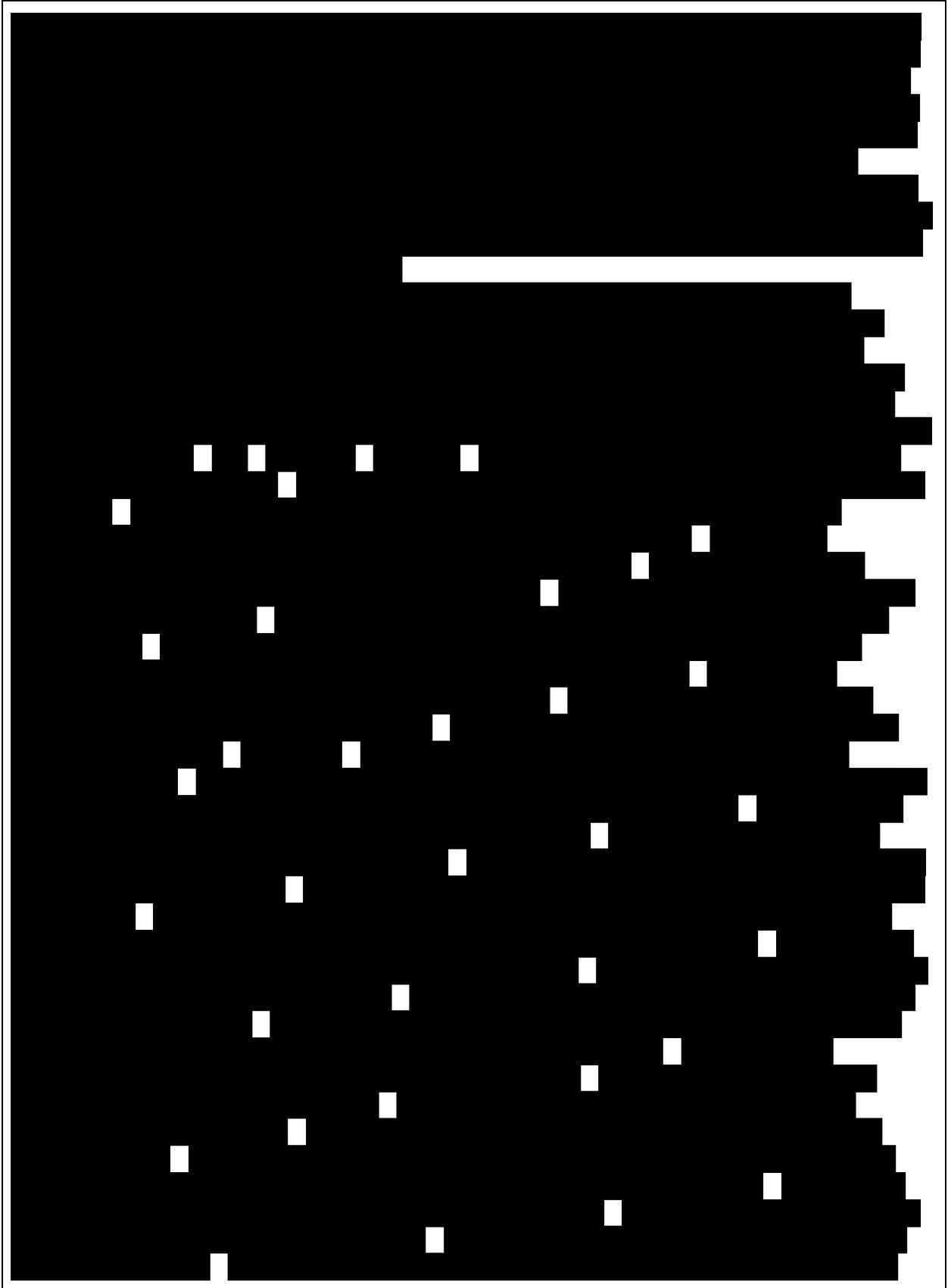


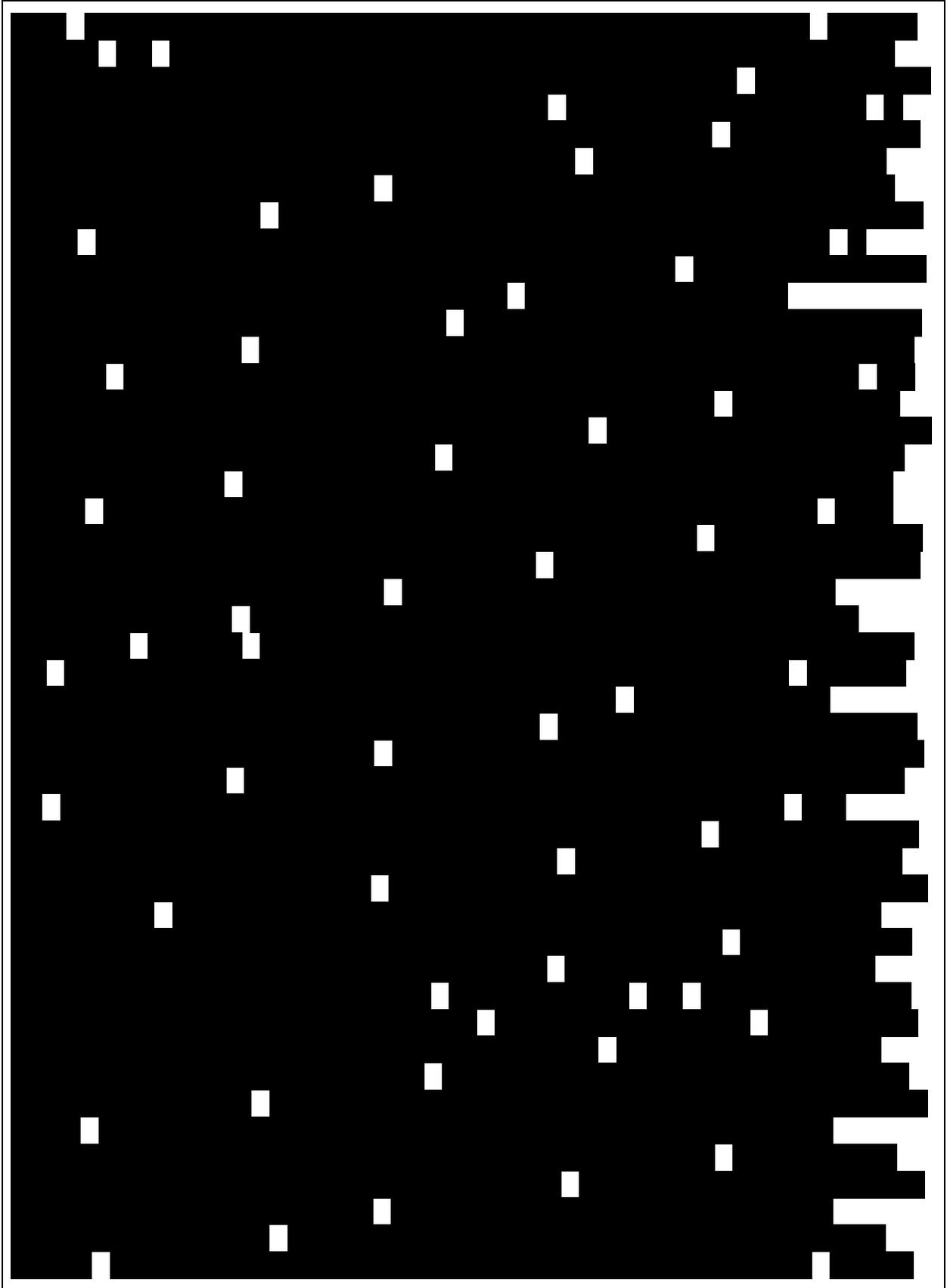
make sure to add a component that discusses the need for a certified employee to dispense the medical marijuana

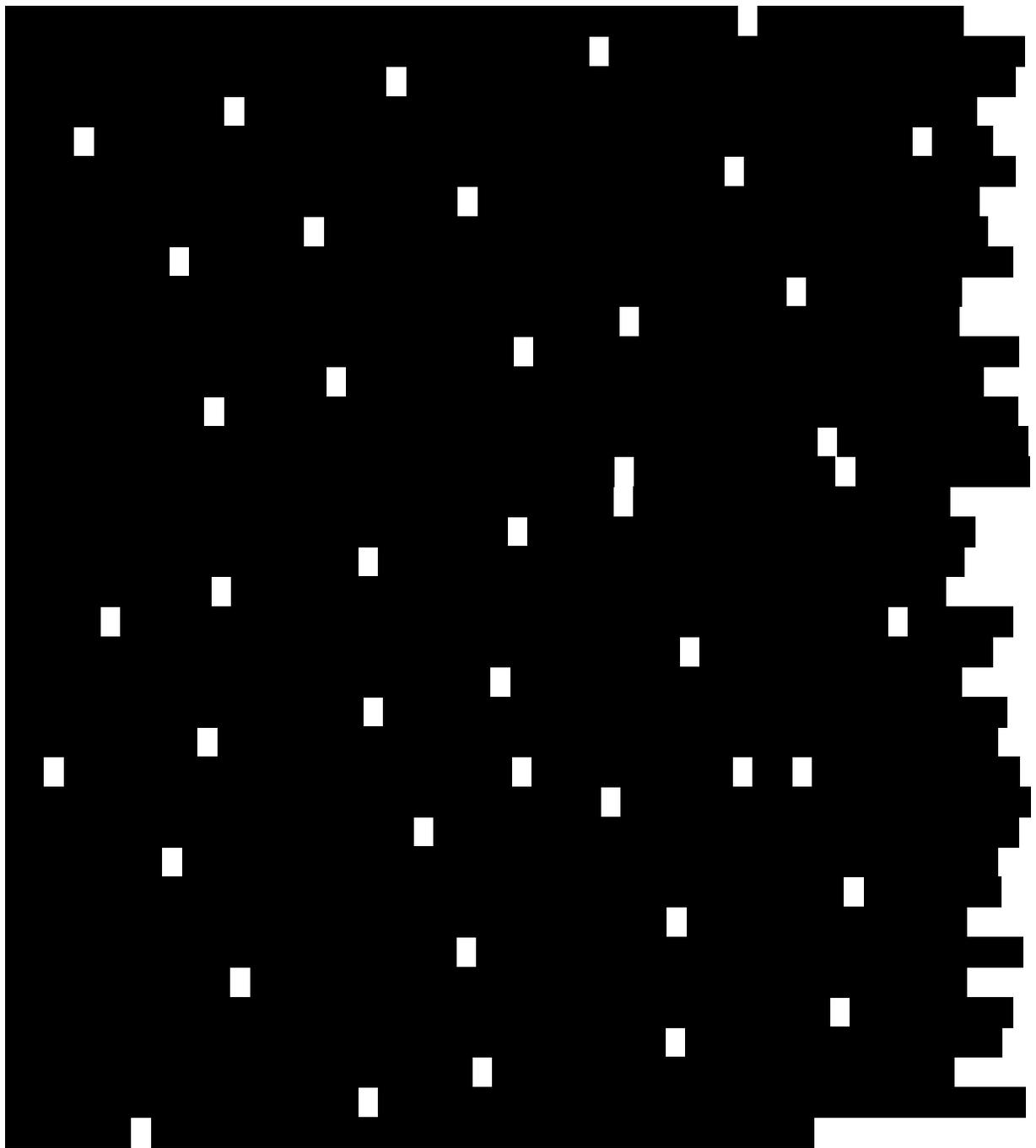
Add language to prohibit smoking Marijuana in a private park in an HOA development. Perhaps add language that says any park with childrens playground equipment, or 'within 1000 feet of childrens playground equipment'.

The price of the medical card is way too much for someone like myself. I survive on ssi alone and by the time bills are paid I am lucky to eat. Its sad to say that the way you have it set up now it will force good people like myself who have never broke the law ( I have not even had a speeding ticket in over 40 years of driving) to break the law. The prices that I have been seeing are more then most of us can afford. There have to be others like myself who's only income is ssi. Please remember not every disabled or ill person has a bank under their pillows. Also please make sure that single woman in their 50s are safe going to get their weed. Some of the places seem to be in seedy areas.

Thank you for the public comment sessions. I was able to speak during both in Tempe. I started my first talk with an analogy referring to a boat builder being much different than the end user. At first it was a comment toward [redacted] and the Presenter for whom he was moving graphs and charts.







Migraines HURT....They cause pain, anxiety and depression . There is no known cure for them. Only deadly harmful drugs are available with some, very habit forming ones, to help with the management of Migraines. This is a chronic condition that deserves to be listed as a reason for the use of marijuana

Discuss the actual method on how medical marijuana is provided to the patient? Is there enough security around this integral part of the rules?

Limit the number of patients a physician can recommend for medical marijuana to no more than 100

per year.

Consider long term illnesses such as Valley Fever which causes many if not all of the required symptoms. Valley Fever is endemic to the southwest, can be lethal and is a life long illness with no cure. M.M. could reduce the amount of expensive drugs prescribed for some of coccidioides certain and life long symptoms.

Add information relating to how medical marijuana is issued. Insist that there is a human to human transaction versus through any type of automated dispensing machines

Suggest adding additional information regarding employees that will be working directly in the dispensary, issuing the medical marijuana. Employees should have full background checks and also make sure there is a protocol for how the marijuana is issued to the patient and how patient is screened to ensure they are certified to receive their supplies.

The language in part R9-17-101.21 b. should include childrens' playgrounds an part R9-17-101.21.c should clarify that private property of Home Owners Association is not included in the definition of "Public Place".

very concerned about the random choosing of permits. This should be changed immediately

Add language on the security aspect for the actual dispensing of the medical marijuana

██████████ plans to provide botanical and drug identification testing, DNA analysis and urine screening. As such, ██████████ is attuned to testing, quality and patient safety-related issues. From this perspective, we believe that the Draft Rules could be improved by addressing the issues outlined below. Specifically, the rules, which comprehensively address issues of importance to the protection of Arizona patients who would be eligible to receive medical marijuana, could be improved by adding a provision that provides for the submission by dispensaries of medical marijuana to qualified laboratories (a) for testing to identify the chemical composition and strains of marijuana and the presence of any chemical additives and (b) for the disposal of unusable marijuana. The proposals that we have outlined would provide significant benefits as described below. 1. Public Safety and Law Enforcement. The Draft Rules contemplate that law enforcement agencies will accept disposal of unusable marijuana from dispensaries. See R9-17-309(A)(1)(c)(v). However, it is likely that some local law enforcement agencies will be unable or unwilling to accept responsibility for disposal of unusable marijuana. Moreover, at a time of tight budgets, limited resources, and increased demands on law enforcement personnel, restricting disposal of unusable marijuana to law enforcement may be viewed



given the interests of dispensaries in successfully marketing medical marijuana; o In a manner that allows patients to have certainty in the standards and methods being used to test and report on the quality, strength and purity of the marijuana being sold as medical marijuana; o In a manner that allows dispensaries to have confidence that the marijuana they sell meets the purity requirements mandated by law or that they can properly and accurately label the strength and purity of the marijuana they sell; o In a manner that allows those who provide certifications for medical marijuana and providers who prescribe medications to patients who consume medical marijuana to make informed medical judgments based on scientifically determined chemical composition. Rules geared to accomplishing these goals would further the intent of Arizonans in approving the Arizona Medical Marijuana Act. Laboratories staffed by experts trained to analyze substances, including marijuana, would play a vital role in patient education. Laboratory testing would be able to scientifically identify the chemical composition and strain of the plant as well as the presence of any mold or pesticides which can cause adverse effects for the patient. Having its marijuana laboratory-tested would increase the accuracy of product labeling and enable a dispensary to confidently inform its patients of the strength, medical benefits and purity of each medical marijuana sample dispensed from dispensaries licensed under Arizona law.

The area of Med Marijuana should be treated no differently than any pharmacy in the State! To issue a perscription should be between the Doctor & Patient. No cameras, no state beauracrats calling. No different than getting a perscription for Oxyconton. Dont waste my tax dollars trying to make this into another losing war on drugs. It should be between the Doc & patient.

I don't know, but they're too complicated to try to take the time to figure out. Simply the languae so people can understand it when they read it..

It has been largely established by numerous instances of anecdotal evidence that marijuana is a very psychotropic medication for the numerous problems for those living with autistic spectrum disorders. See the following links: [REDACTED] I can say that from my own experience, the psychotropic effects of marijuana use have greatly diminished the communication difficulties I have had, as well as severe anxiety and sleep disorder that I have had, unlike any prescription medication that I have ever tried - and I have tried many, including SSRI's, and various other ineffective and highly potent drugs. I would ask you to consider adding this to the list of ailments.

1. Do not tax above the 6.9%
2. Remove the Doctor recommendation on the Non-Profit LLC
3. Do not charge \$5,000.00 per application
4. Charge a fee that is common sense for a business to survie
5. Inspection and oversight should be maintained by DHS on a quarterly inspection. Each month a report should be submitted to DHS on the business plan and sales.
6. Please keep it SIMPLE and MINIMUM on the process!

RE:R9-17-202.F.5(e) is still cruel, arbitrary, unreasonable, and usurps patients' rights to choose other providers or sources of information. IF YOU DO NOT DELETE R9-17-202.F.5(e) FROM THE 01/31/2011 DRAFT RULES, QUALIFIED PATIENTS WITH LIMITED FINANCIAL MEANS WILL BE PREVENTED FROM APPLYING FOR THE REGISTRY IDENTIFICATION CARD, DUE TO EVEN GOING TO A DOCTOR TO "ASSUME RESPONSIBILITY FOR PROVIDING MANAGEMENT AND ROUTINE CARE OF THE QUALIFYING PATIENTS'S DEBILITATING MEDICAL CONDITION..." WOULD MEAN ADDED EXPENSES TO THE PATIENT I.E. PATIENTS WITH MEDICAL COVERAGE THAT DO NOT INCLUDE SEEING DOCTORS OUTSIDE OF THEIR COVERAGE I.E. VA MEDICAL PATIENTS OR UNEMPLOYED WORKERS ON STATE BENEFITS. IF QUALIFYING PATIENTS CAN JUST GO TO THEIR RECOMMENDING MARIJUANA PHYSICIAN TO SEE GET THEIR RECOMMENDATION AND KEEP SEEING THEIR REGULAR COVERED DOCTORS FOR THEIR ILLNESSES, THIS WOULD NOT DISCRIMINATE ON A LARGE POPULATION THAT WOULD BE QUALIFIED FOR MEDICAL MARIJUANA. PLEASE CHANGE THIS. YOU HAVE NO AUTHORITY OR RIGHT AS AN EMPLOYEE OF THE AZDHS (WILL HUMBLE DIRECTOR) TO PLACE YOUR OWN BIASED VIEWPOINTS INTO THE DRAFT RULES. (IN YOUR OWN WORDS ON YOUR OCT. 22, 2010 DIRECTOR'S BLOG " If we have the authority, I'd like to somehow craft some criteria that would make sure that some real assessment happens including a discussion of the range of medical management strategies that could be taken to help manage the patient's condition before a physician can hand out a recommendation. I don't know if we have that authority, but I sure hope so." AGAIN, YOU HAVE NO AUTHORITY AND PLEASE KEEP YOUR DRAFT RULES ALIGNED WITH WHAT THE VOTERS PASSED IN PROP 203. THANK YOU.

Make medical MJ easy to obtain, affordable, and without too many petty rules....for those in pain, please.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

If I have already discussed the use of Marijuana with my physician and he/she recommends it because of my condition, why do I have to discuss this again with a doctor I do not know at a Dispensary. Is this doctor going to be experienced enough to recommend the correct strain of MJ for my illness?

DHS site inspections should happen every year and result in a letter indicating the site's compliance with Arizona law. In order to be sure that dispensary licensees are not in violation of Arizona law and to protect the safety and health of all Arizonans it is essential that each dispensary receive an annual inspection for compliance with law. We propose the following modifications to R9-17-308(B)

It is in everyone's best interest if the medical marijuana industry does not become a predominantly cash business. In fact, the opportunity for abuse grows as the use of cash expands in this industry. A preference for credit or debit card transactions, will create a situation where the State can more readily monitor and trace, if necessary, the source of funds for given transactions. It is a lot more difficult for organized crime to work around and game the system if there are credit and debit card receipts for everything purchased. In addition, the tracking of every seed from planting to the

end customer is more easily accomplished if the transactions accompanying the sale from the cultivator to the dispensary and then from the dispensary to the patient are done to allow easy electronic tracing. We believe this a great opportunity to stop criminals who would otherwise look to profit off this system from taking advantage of the State. With this in mind we propose that a Rule be added to require that 90% of all transactions involving the sale of medical marijuana to patients, be done with credit or debit cards and that all purchases from cultivators be made by way check or wire transfer that will clearly evidence the parties and financial institutions involved. We propose the following additions to R9-17-309(A):

Impose a cash on hand requirement during and throughout the DHS application process. The current lottery system proposed in the Draft Rules has eliminated the ability of the State and local governments to help make sure that only the best and most able applicants actually end up with a dispensary license. The State and local governments in Arizona have a strong public safety interest in making sure that only the most qualified applicants end up with a dispensary license. While having sufficient capital to implement security, health, and other requirements is not dispositive on whether or not an applicant is a quality applicant, it certainly is a least one good piece of evidence that the applying party is likely to be fit to run a dispensary. With that in mind we propose that all applicants for a dispensary license be required to show that they have sufficient funds in the bank to allow them to cover the estimated average costs associated with implementing the rigorous requirements of build-out (including all health and safety/security considerations) in compliance with DHS requirements and to operate over the first year of business. See the attached document for a breakout of these expected costs for startup and operation in year one. Those that cannot currently demonstrate that wherewithal are likely to be the ones that bring on new funding partners after they win the lottery. In these instances the State will have already given its blessing to a group to move forward even though that group is now bringing on new investors who were not previously identified and have not been vetted. The proposed change would require applicants to show their financial viability at the time of the application and again before an application is approved. We propose the following additions to R9-17-303(B):

Will the Medical Doctors hired by the Dispensaries be licensed to discuss Cancer, HIV and all chronic illnesses and the reaction of different strains of Medical marijuana.

The current lottery system for selecting dispensary owners truly troubles me. I believe that Arizona's law, as written, gets us halfway to living in the most efficient, well-run and regulated medical marijuana state in the country. I feel this lottery system will put a huge wrench in what could be a very well-oiled machine because the very best applicants of the applicant pool will not be chosen. As the current draft is written, hospitals will have the exact same chance of operating a dispensary as a failed business owner with no experience in the healthcare field. This, to me, is completely contradictory to what is just and it has the potential to create many problems in the future for our law enforcement, medical marijuana patients, and the industry more broadly. There will only be 125 of these businesses " I believe they should only be the very best (ideally hand-selected from a scoring process), since they will collectively represent Arizona's medical marijuana industry, wholly. We can end up like California, with crooked business owners "circus-calling" patients in from the streets and newspapers, or we can be the example for states with failing policies to look up to. I think we should, and can with DHS' help, be the latter. I believe a capital/ monetary sourcing requirement is essential. Citizens must demonstrate their financial viability at a minimum of \$300,000 of non-borrowed personal resources to be considered to open a McDonald's franchise. I believe dispensaries should be held to

higher standards than a McDonald's restaurant and I hope DHS does, too. The criminal element is extremely tempting to many in this field and I believe that dispensary operators should have to show that they can get through their first year without failure. Beyond fears of criminals entering the medical marijuana field, the scenario I'd hate to see would be this: Patients outside 25 mile halos investing in growing their own cannabis, then when a dispensary pops up they quit growing, then if that dispensary fails, they must invest in another grow project. Patients just can't afford this back-and-forth on top of otherwise expensive pain regimens. I believe that requiring potential dispensary owners to identify their capital sources and ready availability will help all 125 dispensaries succeed, so that no one fools themselves into thinking that they can manage a huge operation (like owning 1 out of only 125 dispensaries would be) when they don't have the necessary funds. A capital requirement, to me, is very small-business friendly because people will know just what they are getting into without the tragedy of idealistically investing in eventual failure.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

Add PTSD and ensure no taxation as it was the original law we voted for!

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Will Humble, Director Arizona Department of Health Services Office of the Director 150 N. 18th Avenue, Suite 500 Phoenix, Arizona 85007-3247 Re: ██████████ Comments for ADHS Informal Draft Rules for Implementation of the Arizona Medical Marijuana Act Dear Director Humble: This correspondence constitutes the ██████████ comments on the Arizona Department of Health Services' (ADHS or Department) Informal Draft Rules (Draft Rules) for implementation of the Arizona Medical Marijuana Act. The Town has reviewed the Draft Rules and offers the following comments focused primarily on improvements to three areas connected to ██████████ local zoning process: 1. notification to ██████████ related to designated caregiver registration applications and dispensary applications proposed for locations within ██████████ corporate boundaries; 2. clarification of the ADHS application requirement for a copy of a dispensary certificate of occupancy from the local zoning jurisdiction (R9-17-304); and 3. prohibition of designated caregiver cultivation and patient cultivation within 25 miles of dispensaries. Because the ADHS Draft Rules appear to contemplate designated caregiver services and/or designated caregiver cultivation as activities moving forward without the same ADHS regulatory oversight as that applied to dispensary operations, the communication/notification between ADHS and ██████████ may prove to be crucial for ██████████ effective zoning oversight of dispensaries, caregiver services, caregiver cultivation and their connected operations. Notification to ██████████ The Draft Rules authorize ADHS to gather diverse categories of information during the application process for

designated caregiver registration and dispensary registration at the state level. Because [REDACTED] may need to apply local zoning regulations to dispensary and caregiver activities, it would promote efficiency for all involved if ADHS could incorporate a notification to [REDACTED] planning and zoning authorities as to the location of potential dispensary and caregiver activities within [REDACTED] zoning jurisdiction during the ADHS process. Such notification would allow the Town to be aware of the status of these medical marijuana activities during the ADHS process, particularly connected to the application, renewal, extension, and revocation of dispensary and caregiver registrations. Clarification of Zoning Verification from [REDACTED] Currently, the Draft Rules contemplate that an application for a dispensary operation must include "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"; [REDACTED] agrees with the requirement that medical marijuana operations comply with local zoning regulations. However, the Draft Rules do not include a similar requirement for designated caregiver services, caregiver cultivation, or infusion facilities. Additionally, local zoning verification for medical marijuana operations may include additional and/or different types of zoning approvals than a certificate of occupancy - the applicant may be required to obtain a conditional use permit, zoning clearance, site plan approval, etc. Specifically, the Draft Rules should reflect [REDACTED] local zoning requirements by requiring caregiver, dispensary and infusion facility applications to include proof of compliance with all local zoning requirements, such as a use permit approval in addition to a certificate of occupancy which may only occur at the end of the zoning process. Local zoning clearance from [REDACTED] for dispensary, caregiver and cultivation activities should be required by ADHS prior to issuance of ADHS approvals for such activities. Restriction on Caregiver Cultivation and Patient Cultivation The Draft Rules should explicitly prohibit any cultivation, including cultivation by patients and all designated caregivers, within 25 miles of a dispensary. Conclusion [REDACTED] appreciates the opportunity to submit its comments during the Draft Rules process. [REDACTED] offers its willingness to assist your department with the above suggestions. Thank you for your consideration of our comments. Sincerely, [REDACTED]

The Arizona Child Care Association would like for the 500 feet prohibition for dispensaries or cultivation sites (p56) to apply to licensed child care facilities.

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I would add the following two recommendations: R9-17-101 Definitions: On page 5, Definition 21 defines "Public place." Paragraph b is too narrow. It should be changed to read, "Includes but is not limited to airports; banks; . . ." since the number of actual public places is not capable of being exhaustively detailed. For example, the definition ought to include residential neighborhood parks

belonging to homeowner associations, not just "parks" as defined by statute, which is a term that could be argued to refer only to parks that are owned by public bodies. Alternatively, paragraphs a, b, and c could be changed as follows: a. Means any location other than a residence; b. DELETED c. RETAIN AS IS, but delete vii. This latter approach would restrict the use of marijuana to private homes and to care facilities that allow it. R9-17-308 Inspections: Paragraph C. states: "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 should be changed to state: "The Department MAY CONSIDER allegations of a dispensary's noncompliance . . . from an anonymous source." If a problem arises in the future with a multitude of allegations of noncompliance from anonymous sources, then this could be revisited, but it should not be presumed that such will be the case.

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sell only through regular pharmacies-just like any other drug.

The fees are too high and should be lowered by atleast 50%. Thanks.

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1. Random or lottery selection of applicants is unprofessional and without precedent. There should be merit, experience and financially based evaluation. Barbers, Realtors, Contractors, and the like are all required to demonstrate or prove merit and education. Lottery selection will have consequences that will add confusion and disrepute to DHS and the industry. 2. Application should be 4 step process " First, \$3,000 fee - make application with business plan and model, demonstrate abilities to carry out the plan and comply with all state regs. The applicant evaluation should be performed by an unbiased third party qualified to judge professional standards and business practices. Second, \$666.67fee and grant conditional license and provide reasonable time for applicant to secure site, use permit, etc " Third - \$666.67 fee - come back to DHS with site, security, zoning, use permit and operational plan and fixed time to get up and running. Fourth - \$666.66 fee " final inspection of plan, site, etc and applicant granted final license. The dollar amounts are just examples of possible break down of the \$5,000 requirement to get the final or all licenses. 3. The CHAA design does nothing except to (hopefully) wall off the state in 25 mile circles to prevent home growers. It's not going to work. Dispensaries in some of the CHAAs cannot work based upon population. The numbers just don't add up. Together with the fact that in the outlying areas " it's still too easy and cheaper to grow your own or get it from a friend rather than go to a dispensary miles away and pay twice the price. The dispensaries will go out of business and the home growers will proliferate. Question " if you lived remotely and grew your own or obtained on the street " would you patronize a dispensary miles way and pay twice the price? If it were me I would hardly be able to contain myself until that dispensary went out of business. Common sense. So " get rid of the CHAAS and develop system based upon population " just like any other business. 4. Don't confuse the responsibility of dispensary licensing with law enforcement against those that are presently using

marijuana recreationally. These are two separate and distinct challenges and one has nothing to do with the other. A combination of law enforcement (recreational use) and providing unique or alternative "medicines" are challenges addressed by their respective Arizona Revised Statutes and not only is it bad idea to combine them " but it's probably unconstitutional as well. 5. tax the industry at 100% is extreme.

is a coalition of over one thousand citizens dedicated to eliminating substance abuse and its effects in . Since its founding in 2006, has played a major role in reducing the use of methamphetamine and other recreational drugs in particularly among teenagers. efforts have also led to a significant reduction in drug related crime in .

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 " and the federal government " 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 "exception" of medical marijuana to swallow the "rule" of marijuana criminalization. This must not be allowed to happen in Arizona. In order to enforce Arizona'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. We suggest the following:

II. 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 "halos.") 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 suggested a form of this concept in proposing the use of CHAA's as the basis for geographic locations in their 1-31-11 rules proposal. However, DHS does not do enough. The rules should mandate that each CHAA will only have one dispensary selected until all CHAA's that are not comprised of Indian reservations have a dispensary. DHS should grant dispensaries that are willing to locate to less desirable areas of the state preference in granting additional licenses in more desirable arease of the state. In short, DHS policies must insure that most if not all of the state is covered with dispensary "halos" 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.

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. §36-2801 defines "Nonprofit medical marijuana dispensary" as an entity that acquires, possesses, cultivates, manufactures, delivers, transports supplies, sells or dispenses marijuana. A.R.S. §36-2804(C) limits the number of dispensary certificates to approximately 124. A.R.S. §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. §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. §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) Strike R9-17-101(10). (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 R9-17-308 to clarify that cultivation sites require separate dispensary certification. (e) Modify R9-17-315 to clarify that cultivation and infusion sites require separate dispensary certification. (f) Modify R9-17-316 to clarify that infusion sites require separate dispensary certification. (g) Modify R9-17-317 to clarify that infusion sites require separate dispensary certification. (h) Modify R9-17-318 to clarify that infusion sites require separate dispensary certification.

DISPENSARIES, CONT. 3. DHS may delegate inspection of dispensaries to local authorities. Rationale: Pursuant to A.R.S. §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 R9-17-308(H): "The Department may delegate its authority under this section to local authority pursuant to A.R.S. §36-136." 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 dispensary'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 "reasonable notice" provision of the initiative. Implementation: Modify R9-17-308(B) as follows: "Except as provided in subsection (D), routine on-site inspection of a dispensary shall occur no earlier than 24 hours after the Department submits written notice of the Department's intent to inspect the dispensary. Routine inspections under this subsection shall occur during the dispensary's normal business hours." 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 R9-17-313(A)(7): "The 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."

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. §36-601.01), severely curtailing the use of smoking in the state. For most people, marijuana'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 R9-17-313 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: "Marijuana 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."

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 dispensary'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 "front" for criminal activity, and that the marijuana produced and dispensed only to those with legitimate medical need. Implementation: Add as R9-17-315(E): "Not 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."

III. 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. The caregivers are linked to the patient by the patient's application, and each patient must pay a registration fee. A.R.S. §36-2804.02. Therefore, by the terms of the act, the caregiver is also applying for recognition of his status as caregiver for each individual patient, not as a caregiver in general. It is logical for the act to require an additional caregiving permit and fee for each patient. Each patient that designates a caregiver requires additional administrative scrutiny by DHS, increasing administrative costs. A.R.S. §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(A)(5)(b) and (A)(6)(b) as follows: “Designated Caregiver, \$200 per patient for which caregiving services are provided.” 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)(I): “Certification of completion of a Caregiver Training Class administered or approved by the Department.” (b) Add R9-17-206: “The 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%.” PATIENTS, CAREGIVERS AND DISPENSARY AGENTS, CONT. 3. Caregivers, Cardholders and Dispensary Agents must be residents of Arizona and must possess an Arizona driver’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 “an Arizona Driver’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 person’s state of residency. In addition, because of the potential for criminal activity inherent in a person’s possession of marijuana, registry with the Department of Public Safety’s driver’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(3)(d) (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)(d) (g) Strike R9-17-204(A)(5)(f)(iv) (h) Strike R9-17-310(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. §36-601.01), severely curtailing smoking in the state. For most people, marijuana’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: "If 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 patient's condition." (b) Add to R9-17-202(G)(13) the following: "If 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 patient's condition." (c) Add to R9-17-204(B)(4)(f) and R9-17-204(B)(4)(g) the following: "If 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 patient's condition." (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 "clubs" 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 "smoking" 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 "smoking clubs" 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: "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."

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. §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 Patient'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. §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.

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. 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 professional'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 patient's condition. MEDICAL PROFESSIONALS, CONT. 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. 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 "doctor shopping." If certification is revoked, the patient must present certifications from two other medical professionals, both of whom state they are aware of the

patient'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 Patient'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.

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. 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 person'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 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 set 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 Arizona'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 provides specific and enhanced criminal penalties for dispensaries, cardholders and caregivers using or transferring marijuana in ways unauthorized by the initiative or regulation.

LEGISLATIVE ACTION, CONT.

3. The legislature should impose criminal penalties for smoking marijuana in public. Rationale: The initiative forbids

smoking marijuana in public, but provides no penalty. Smoking of marijuana in public encourages its illicit use, and exposes marijuana to children. Since mari

I really think the lottery is a bad idea. I understand it is probably the simplest way to solve the problem of handing out dispensary licenses, however, I think that in the long run it is a dis-service to the people of Arizona, especially the patients. Even if a specific application is done properly, deemed worthy to enter the lottery for that CHAA, it can still be ranked somehow against the other qualifying applications for that zone. There will always be a most-capable applicant and a least-capable applicant for each lottery. There are equal probabilities that each zone will get the best or the worst, or something in between. That's where the people of Az suffer. I don't care to speculate on the consequences of a lottery, but it does seem quite evident to me that, from a patient's perspective, the lottery is not the best option! A third party review of these applications, with some standard scoring system, seems more applicable. I know this costs more time and money, but I also know that it couldn't cost more than a couple thousand dollars per application to get it evaluated. The application fee could come in handy here. I truly believe that the merit of each application must be considered. Business and finance experience, capital availability, liquidity, agricultural/horticultural experience, business plan/model. Whose application is the most comprehensive? What is the business going to do with their surplus revenue, what are the not-for profit's values? How sound are the management, operations, and security guidelines? With a eye towards state economics, which potential business would be most successful? Who could employ skilled, well paid persons? What it all boils down to is this - which of these applications will offer the people of Arizona the most unique, quality-controlled, beneficial dispensary? The ones who have put in the work should be rewarded.

I know I will not be able to afford this medication. Currently my insurance pays for my meds, but they will not pay for this. You must allow us to grow our own medication like every other state. The whole reason I voted yes was so I could benefit from this medication, but the way you have designed the laws this medication will only benefit the rich. Please I beg that you consider those of us that can't afford the \$400 it will cost per once. Thank you for the consideration.

Require 3 years AZ tax returns from applicants. Right now only their "word" is required. If there is no requirement to prove that an applicant can complete build-out and start-up of a dispensary, there is not stipulation in the draft rules as to requirements for any partner they would contract with (out of state, or much worse and there will be plenty of them) in order to secure the necessary funding. After they are allotted the dispensary registration certificate, there could be a requirement to review financial information, funding sources, etc. in order to complete the build out. It could be required to disclose any partners (with proof of residency, etc) of more than 50% ownership. Requiring solvent, financially sound applicants would seem like the only way to ensure that the process of opening a dispensary from start to finish would be accomplished as the applicant stated it would be. I know people think that's not "fair" and it would be favoring the "rich", however, this is a business endeavor with much risk on the applicant's side and you want experienced, professional people who will be able to complete the process and have projected the expenses of running the business into the start up cost until the expenses can be met by the dispensary. The Department does not have the resources to babysit un-savy people who have no technical, financial or business background. That would not be

"fair" to the voters, the ill people waiting for this medicine or for anyone who wants this to be as successful implementation as possible.

The draft rules can be improved by discarding the 25 mile rule. Also by approving patients so they can grow their own. Some of us can't work, and cannot afford to buy our supply. How about taking confiscated pot from smugglers and selling it through the dispensaries instead of destroying it. This would help with the state budget!

I have talked with numerous Doctor's and it seems like people are going to have a real tough time getting a Doctor to be a medical advisor for the dispensaries. The Doctors still seem to want to sit on the side lines for now as they are afraid that I may negatively affect them and their license.

I would like to see a more extensive selection process for the granting of permits. This is serious business. If selected, it is going to take major dollars to develop both the dispensary and the growing facility. I really appreciate the fact that the rules require the chosen to be both growers and providers. I know this has to improve the accountability and quality for the patient. I have developed a business in another industry and feel that we have helped to set the gold standard for that industry and would welcome the challenge to do the same here. There was no lottery involved. You got your education and licensure that then allowed you to take your chances at being successful in your chosen profession. Here it appears to be more about chance than proving that you are qualified. My suggestion would be to use past history and present financial proof to prove that you can weather the start up and have the funds to sustain and the funds to be able to give back to society through a generous and prosperous mindset. I guess one more area that I would like to see revised is the Medical Director. I approached a physician, who I believe is one of the sharpest physicians in this state, to see if he would even consider being my Medical Director if chosen. He replied that he would not only consider, but would and felt that it would be an honor. I couldn't believe his knowledge of the subject and is currently advising a few patients who have moved from California. He explained that two MS patients are totally in remission when they are properly dosed. After reading the rules again, it clearly states that a Medical Director can not write the approval for his patients. I could not ask this brilliant man to give up that option for his patients. I can understand how he could not write orders for people who acquire their marijuana through the dispensary over which he was the Medical Director, but his medical license would prevent him from accepting a "kickback" from the dispensary. Also, his contract with the dispensary would not be written to give him a percentage of the receipts. Therefore, no motivation to write questionable orders.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year. Med Marijuana can not be recommended for any person under 18 without the consent of a parent

I believe the 25 mile rule may cause undo hardship on some patients depending on their illness.

I dont see any reason to employing a medical director. I am a dental hygienist we get the came training as a nurse and have to take many continueing educaton courses throughout the year many of these courses are on substance abuse, drug effects, drug addicts, how to educate our patients. we even have to take tobacco cessation classes. so i think i can be appionted to take care of this area of

our dispensary as long as these patients were approved to have a medical card by their physician.

WHAT IS NEEDED BY THE STATE AS TO OWNERS ABILITY TO PERFORM THIS TASK

No one should be allowed to grow medical marijuana on their property. Any rule that allows this should be excluded, and not modified. The reason is because it is not the State's burden if a person has to drive 25 or more miles for medication. If a person required non-medical marijuana medication, the state does not take on the burden to assist that person to the pharmacy or doctor's office. The State's resources likewise should not be expended in monitoring and regulating home cultivation. In addition, such allowance would put the State's enforcement of consumption of home-grown pot by non-qualifying patients. This allowance is an obvious loophole imposed as a result of and will be taken advantage of by the illegal marijuana lobby.

Do not allow rules to be diminished or minimized to the point of being unenforceable. The recommendation by a physician that has been treating and diagnosing a patient should not be changed in any way. This opens the door for "doctor shopping" and physicians that recommend marijuana without an informed long-term doctor/patient relationship.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

The rules can be improved by eliminating the requirement to cultivate you must live outside a 25 mile radius from a dispensary. This is essentially forcing patients to spend large amounts of their income to receive beneficial medicine rather than cultivate their own. If someone is living on limited income and need this medicine they will be forced to pay enormous amounts of money on the medicine and taxes that they will have to reduce their budgets in other aspects of life. This is making someone choose between their medicine and food or bills. I do not agree with this. If someone has the ability to provide their own medicine in the same technique and to the same standards as the dispensaries then they should be able to do so. This is unfair to patients who need medicine.

Under the current Draft, if the Department has received more than one complete initial dispensary application for a CHAA by June 30, 2011, the Department will randomly select the applicant(s) to receive the dispensary certificate(s). I feel that a random selection process is too vague. The Department needs to set minimum benchmarks for a Dispensary to be even considered. Such benchmarks should include but not be limited to: minimum amount of starting capital, years of collective experience in Business ownership/management expertise in Arizona, relationships and number of Physicians contacted that are willing to refer Medical Marijuana patients to the Dispensary, Owner participation required in the day to day operation of the Dispensary, all proceeds after expenses needs to be donated to appropriate charities, etc. The Department plans to refund \$1,000 of the initial \$5,000 dispensary application fee to any dispensary applicant who submitted a complete application but was not selected through the process. I think \$4,000 should be refunded to an applicant that was not selected. Dispensary certificates and registrations should be transferrable if the new Entity meets all of the requirements of the Department.

Selecting the applications based on proximity to the greatest concentrations of populations. This can be done through a rational study of populations of the nearest census blocks within 5 miles. The reason why this criteria should be applied is to not result in the possibility of the only facility in a large district being located on the extremities of the urban area. No person should be allowed to cultivate their own medical marijuana on their own property. This item should be struck. The reason is a vast majority of Arizonans have access to hospitals and doctors' offices through vehicular or public transportation and any subsequently registered medical marijuana dispensary. The purpose of this law is not designed and must not be designed to guarantee such access to such a high risk substance.

We need to see the application before it becomes final. As the draft rules are being reviewed by the public, it is equally important to have the application be available for public review as well. The application is the initial step in reviewing the criteria AZDHS will be using in their due diligence. It is important to get public comments on the content of the application as it is just as critical as the rules used to create it.

So far AZDHS has overcomplicated a seemingly simple law. Medical Marijuana is now legal. Let the entrepreneurs get started doing business and the rules can be adjusted as it goes along. Remove the stigma and start dealing with it as any legal business. Regulations will surely follow. There is no need to delay patients receiving affordable, compassionate care now. DHS is not expert in cannabis. Nor are they in the business of creating market incentives. Some have begun introducing scare tactics including raising the possibility of "Mexican drug cartels" being enticed if a significant financial floor is not instituted. This is ignorant at best. Precisely how and why would any respectable citizen choose to attach themselves to the dangers and risks of "cartel" association? If there is evidence to support these alarmist claims, it is imperative that the evidence be provided immediately and publicly and thoroughly reviewed for accuracy prior to accepting it as fact and designing guidelines to quell it. There is no reason for the requirement for the specific address of the intended dispensary in the application. Given the current real estate market, and the fluidity of all the elements, the exact sites for all the elements, dispensary, cultivation and infusion, should be determined once the license is won.

Draft rule R9-17-306, section A, has the potential to be harmfully restrictive. Both lines should be removed. Dispensary applicants do not have experience in determining what constitutes the attributes of a good location in terms of serving the best needs of patients. Only actual experience is going to indicate what those attributes are. In addition, dispensary applicants must lease or purchase their locations as part of the application process. This is prior to knowing whether they will actually receive approval. This encourages picking locations that are inexpensive. It does not encourage selecting locations that serve the needs of patients. The Health Department has absolute control in deciding whether a new location is appropriate which makes it difficult to understand why this particular rule exists. If the rationale for preventing a change in location is the cost to the department, then raise the fee to relocate. Forcing dispensaries to remain in the same location for three years that they initially selected with their lack of experience and the motivation to keep application costs low is not a good idea.

Please consider the following points and make revisions before the 'final' guidelines are issued. There has got to be a way to have questions and answers on the program before it is finalized. So far AZDHS has overcomplicated a seemingly simple law. Medical Marijuana is now legal. Let the entrepreneurs get started doing business and the rules can be adjusted as it goes along. Remove the

stigma and start dealing with it as any legal business. Regulations will surely follow. There is no need to delay patients receiving affordable, compassionate care now. DHS is not expert in cannabis. Nor are they in the business of creating market incentives. There is no reason for a monetization requirement that has been suggested in the application. It is arbitrary and the law makes no reference to it. As with most other business ventures, it is the responsibility of the certificate owner to obtain the funding needed. While there is no question some financial assets will be needed, requiring inordinate amounts, in the tens or hundreds of thousands of dollars is unreasonable and financially discriminatory. Entities and individuals having extraordinary financial backing does not make them better qualified to provide needed services to the community, it only makes them wealthier. Some have begun introducing scare tactics including raising the possibility of "Mexican drug cartels" being enticed if a significant financial floor is not instituted. This is ignorant at best. Precisely how and why would any respectable citizen choose to attach themselves to the dangers and risks of "cartel" association? If there is evidence to support these alarmist claims, it is imperative that the evidence be provided immediately and publicly and thoroughly reviewed for accuracy prior to accepting it as fact and designing guidelines to quell it. There is no reason for the requirement for the specific address of the intended dispensary in the application. Given the current real estate market, and the fluidity of all the elements, the exact sites for all the elements, dispensary, cultivation and infusion, should be determined once the license is won. I understand there are costs associated with performing due diligence, but the \$5000 application fee is exorbitant. It reeks of a bureaucracy bending entrepreneurs over a barrel for no other reason than that they can. Even more insulting is the 80% (\$4000) loss if you don't get chosen for a certificate. This is another glaring attempt to limit the pool of potential dispensary operators with no logical basis for it. A more reasonable fee and administrative loss directly associated to actual due diligence costs, provided by the AZDHS for transparency, would be appropriate, fair and in your constituent's best interest.

No provision has been made for companies that are engaged in the processing and testing of marijuana. Our company does not grow or dispense marijuana but we do monitor crops, measure toxicity, make weight comparisons, record data, transport, process, analyze, test, research and dispose of inert marijuana waste. The operations of these types of companies are beneficial and necessary for the Medical Marijuana industry. Please take a moment and inform yourself of our patent pending process and technology at [REDACTED] and consider that our equipment is designed in Arizona and functioning in other MM states.

As a healthcare provider I feel strongly that: A recommending physician should not have to assume the care of a patient. Often patients are under the care of other physician who are specialist in a different field. The recommending maybe unqualified to assume that care. Since in my estimation based on an informal survey, a majority of physicians will not make recommendation for cannabis use for many reasons ie fear of DEA, lack of cannabis medicine knowledge, etc. Requiring cannabis testing would greatly add to patient safety. I suggest start and end of harvest cannabis concentrations, and pesticide testing be mandatory. A three year residency requirement of dispensary administrators, owners, etc, is excess, since a number of people in our state are newcomers and or part-time residents. I suggest the requirement be dropped. Since a number of patients are suffering and need immediate access, the rapidity of issuing a dispensary license, should take no more than 30 days to process.

A "doctor" should not be able to have more than 30 medical marijuana patients in a year and any increase in this rule must be approved by AZ DHS. Thanks [REDACTED]

Add PTSD and ensure no taxation as it was the original law we voted for!
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Need specific provisions. Any licensed business dealing with medical marijuana should be bonded and insured. I see no mention of that in any of the literature I have examined. The exposure to torts brought about by a user should allow for the injured party to bring action against the dispensing business. Such businesses should be required (as a condition of getting a license) proof of bonding and liability insurance.
Random selection of MMDs is a disservice to the patients suffering from chronic and debilitating conditions, the voting constituency, and our local communities. I suggest that the selection process be turned over to local governments. They know their communities best and have the capacity to make the best possible choice for their communities. This is made possible by the following: 1) Initial Application Review Panel consisting of County Health Department members, City Government and local Law Enforcement will evaluate MMD applications using methodology established for other entities seeking licensure from the county. 2) The Initial Application Review Panel will make recommendations to the County Board of Supervisors. 3) The County Board of Supervisors will review and make recommendations to AZDHS.
Caregiver training should be added - an 8 hour class to understand the requirements of the laws is very appropriate for caregivers. A maximum number of 100 patients receiving recommendations for medical marijuana from one doctor is a must!!! Without this requirement, pot doctors as seen in California will begin to operate in Arizona. Please add this into your rules, it will in no way limit a patient legitimate ability to receive medical marijuana.

In short, the rules must be improved to ensure that medical marijuana dispensary licenses are awarded to the highest caliber of applicants and to ensure that those with less than pure intentions are prevented from entering the lottery. The legalization of the medicinal use of marijuana is a great triumph for individuals with debilitating medical conditions that traditional medicines have failed to treat, however, it remains a reality that like any drug, the positive benefits can easily be perverted if control of the drug falls into the wrong hands. The Rules need to ensure that it prevents the "bad guys" from taking their business off the streets and moving it into the mainstream, by disguising an otherwise criminal enterprise as a medical marijuana dispensary. The rules and regulations regarding the ownership and operation of medical marijuana dispensaries must clearly purport that Arizona's medical marijuana law is intended to provide individuals with debilitating medical conditions, an alternative option, when traditional treatment has failed them. The law is not a safe harbor for those of a criminal element or those interested in making a quick and easy buck. ^ First, it is imperative that the security plan requirement be strengthened. Just requiring a plan is meaningless unless the plan can be rejected. ^ Applicants should be required to draft a comprehensive security plan, which requires the approval of local law enforcement, prior to submission to DHS. Given budgets are tight and this will take time and funding, applicants should be charged a reasonable fee for this review and approval process. ^ Second, one of the "oldest tricks in the book" is to put forth a nice, shiny, clean product at the outset when scrutiny is the highest, only to regress on all different levels once they have secured the necessary government license. ^ To thwart these people, DHS should conduct regular inspections of all medical marijuana dispensaries and cultivation facilities. Once again, dispensary owners should be charged a reasonable fee for the inspection process. ^ Third, I'm sure the ill-intentioned are rejoicing at the use of a lottery system, as it evens the playing field and increases their chances for receiving a dispensary license, at which they can then turn it into a predominantly cash business, making future transgressions much more difficult to discover. Cash is much harder to track and for that reason, DHS should implement rules discouraging dispensaries from accepting cash in favor of other means of payment that generate a payment trail. ^ Credit and debit cards and cashier's checks are ideal and payment in this manner should be encouraged. ^ Lastly, by virtue of the lottery system which DHS has chosen to utilize in allocating medical marijuana dispensary licenses, there is an incredible amount of risk involved in applying for a license. Those applicants who are doing their best to ensure all of DHS's minimum requirements and met and exceeded are putting a great deal of time and money on the line for just the possibility that a license may be granted. DHS has purposely structured this process so it is not required to review and select applicants based on merits, so it seems extreme that in the even an applicants (with a complete application) is not awarded a dispensary license that DHS would only refund \$1,000.00 of the initial \$5,000.00 application fee.

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Add PTSD and ensure no taxation as it was the original law we voted for!

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The draft doesn't clearly state how many proposed addresses a person can submit on one application. It would be nice if I can submit more than one address seeing how the addresses are only proposed addresses and if I don't get picked at random I could be out \$4,000. Also, I want to send in an application in Tucson and in Phoenix both under my name/corp. Am I able to do that in two different cities/two different CHAAs. This is not clearly stated either.

(1) There should be a limit of one application per entity. Certainly, the department may not favor this rule because that might decrease the initial license fees expected to be generated. However; if this is not put into place; big money will have a tremendous advantage over the rest. This would be very unfair. Theoretically, a big player can come in and submit 125 applications for every CHAA. That entity would have a 12,500% greater chance of receiving a dispensary license than the entity submitting only one application. Any way you slice it - NOT FAIR. (2) Only ONE dispensary license should be granted per entity. Otherwise, again, big money will come in and dominate industry. (3) Requiring a medical director should be dropped. (4) Allow caregivers to receive the similar compensation to that of a dispensary when caregivers generate excess medicine as long as it tests out clean. The rule should be the same for Dispensary "A" acquiring medicine from Dispensary "B" as it is from acquiring medicine from a compliant caregiver. Otherwise - the way the law is written - it will drive most of the excess medicine from caregivers into the black market - exactly what Arizona wants

to prevent! On the other hand, if the caregiver's product is cleanly analyzed why shouldn't it be incorporated into the legal medicinal market (dispensaries) and allocated accordingly with batch numbers. No one knows how much excess product that all the caregivers will produce; however, it could be a lot more than the Department anticipates. WHY NOT KEEP MOST OF THE ARIZONA GROWN MEDICINE IN THE LEGAL FRAMEWORK SO IT CAN BE TRACKED AS IT IS ALLOCATED INSTEAD OF DRIVING IT INTO A BLACK MARKET AND GENERATING MANY CRIMINALS OUT OF PEOPLE WHO WOULD NOT BE CRIMINALS OTHERWISE. This will also alleviate excessive price spikes because it increases supply. I do not think that the department's intention is to increase black market supply, but will do just that if it is not changed. As a dispensary owner, I want to have access to the best medicine available to ensure steady supply of medicine for patients. Many caregivers will produce better medicine than that produced by many of the dispensaries. If my application for a dispensary license is approved, I would like to work with the health department to set up a fund where ten percent of all medicine produced be put into be allocated across the state to suffering patients who cannot afford the medicine.

You are making this too hard. Don't make it so difficult to obtain, sell and grow. When it's harder to get pot than narcotics something has gone wrong and prices will go up due to regulation that is not needed. We don't need Medical Directors for the dispensaries. Let the Doctors who prescribe also educate. Let doctors determine who needs it and who doesn't. Why do I need a card to get pot? I don't need a card to get narcotics. A prescription is all I should need. Why combine dispensaries with growing? split them and let the growing happen in rural areas where it will be more affordable to run the business. Security is good but don't go overboard. a metal cage around the pot is not going to do anything but make it more expensive. Greenhouses in rural areas with cameras and some man power should do the job. Set your criteria for a grower and a dispensary and then take applications. If you have more than one acceptable applicant then have a drawing. If you want big business to run this sell it out of the pharmacies we now have. Fee should cover the cost of the program.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

Please make costs low for the patient by (1) keeping dispensary costs down (2) keep application fees down (3) don't require a doctor for a dispensary (4) keep delivery costs down. (5) a truly needy patient doesn't need to pay a lot of costs for a marijuana doctor, one visit is enough. The patient should always come first. Thank you

-Eliminate the need for an exact location on the application. Like the idea of a 2 step process but please approve the applicant first for a specific area or zone, then allow them to find the most suitable location to fit both the city's needs and the di

OK...THE BRASS TAX..... This is a direct response to the town hall meetings on the subject of Dispensaries. I am very glad to have this electronic opportunity to add some input to the draft rules...THANK YOU... 1) \*\*\*\*\*Broadening the definition for a Dispensary Agent.

Chronic pain caused by migraines should be listed as a condition that permits the use of marijuana

The consumer(s) /qualified patient(s) wellbeing is of the utmost importance. I feel there are unnecessary redundancies with requiring a dispensary to have a medical director on staff. The information provided to the qualified patient by the dispensary is redundant and comes at a premium. The draft rules can accomplish the same goal of offering the qualified patient the same information regarding the potential risks by improving the rules as follows: The physician to hand out a pamphlet of the potential risks to the qualified patient to include physician name, number and address. Qualified patient to hand copy of pamphlet to dispensary to insure such information has been disclosed. Dispensary required having a pamphlet for every qualified patient. This will reduce the overhead expense of operating a dispensary and any risk associated with the convolution of physician and dispensary business arrangements. In addition, Article 1 section R9-17-106 (Adding a Debilitating Medical Condition) and R9-17-107 (Time-frames) only in relation to section R9-17-106 can be simplified. It should not have to be such a long and arduous process to add a legitimate medical condition if such a condition is present. This can be achieved by shorting the time it takes to make a decision as the outcome of the decision should be the same either way...

AZDHS, There is no need to have a Doctor on staff or call for a dispensary. One Doctor has made a recommendation and that should suffice. A patient has the right to choose their care and provider. An application fee at 5K is fine but to only review for accuracy and put into a lottery seems an exorbitant amount with only 1K being returned. I understand this is a large task for your team but since the application are not being graded or scored in any way what are you doing for 4K? I believe a qualified complete application that is not chosen should have at least \$2500 of the application fee returned. You are imposing an undue burden on patients with excessive fees for obtaining a registration ID card; these fees should be reduced to \$50-\$60. CHAA choosing is not the way to go; dispensaries should be allotted according to population. Rural areas will not be able to support a dispensary which will drive up cost and direct patients to illegal markets. If you are a patient holding a valid ID card you should be allowed to grow your own no matter your proximity to a dispensary. Security guidelines are too strict for cultivation and dispensary sites. Owners will want their property and medications secured; allow them to choose at what level with minimum guidelines. Provide guidelines for facility access. How will telephones and toilets be serviced if the only persons allowed in your facilities are board members, principals and employees. Thank you

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

RE: R9-17-317 D,G Security - deletion of unnecessary regulations As an insurance specialist I wanted you to be aware that while the safety of licensees, their customers and staff as well as the general public is always of tremendous importance, there is no need for ADHS to mandate ultra-specific security measures for transportation, dispensary or cultivation locations. Instead, the owners of these operations will implement such measures simply as good general business practices, with the need for and practicality of these measures reinforced by the requirements of their insurance carriers. For example: our MMJ specialty program forms are designed to accurately assess all likely risk elements, as follows (and these are just for dispensaries): That staff confirm that customers have valid patient status, if the store has security personnel (armed or unarmed), that product inventory

is locked overnight, the vault's type and rating, how stock is displayed during business hours, whether there is a double entrance (man trap), if the building is alarmed, if there is a closed circuit camera, with video retained for a reasonable period, if the building has windows, and if so, how they are secured, and, written records of all products. There are many more, but these should make the point. Also, there are similarly specific questions for grow sites (about security, of course, and growing conditions, as we cover crops too); transportation (requiring business auto coverage), and infused product (product liability); in short, every aspect of the MMJ business needs to be insured, at least as much as any other business if not more so. So I ask that you give strong consideration to eliminating the government mandate in those areas where good business practice, reinforced by private market requirements, will result in meeting ADHS' goal of protecting MMJ business owners, employees and customers and the general public without overly intrusive government mandates.

Should "Public Space" also include common areas in Homeowner Association subdivisions, i.e. parks and recreation areas? [REDACTED] 21. "Public place": a. Means any location, facility, or venue that is not intended for the regular exclusive use of an individual or a specific group of individuals; b. Includes airports; banks; bars; child care facilities; child care group homes during hours of operation; common areas of apartment buildings, condominiums, or other multifamily housing facilities; educational facilities; entertainment facilities or venues; health care institutions, except as provided in subsection (21)(c); hotel and motel common areas; laundromats; libraries; office buildings; parks; parking lots; public transportation facilities; reception areas; restaurants; retail food production or marketing establishments; retail service establishments; retail stores; shopping malls; sidewalks; sports facilities; theaters; warehouses; and waiting rooms; and c. Does not include: i. Nursing care institutions, as defined in A.R.S. § 36-401; ii. Hospices, as defined in A.R.S. § 36-401; iii. Assisted living centers, as defined in A.R.S. § 36-401; iv. Assisted living homes, as defined in A.R.S. § 36-401; v. Adult day health care facilities, as defined in A.R.S. § 36-401; vi. Adult foster care homes, as defined in A.R.S. § 36-401; or vii. Private residences.

If Proposition 203 has outlined the number of dispensaries as being a percentage of pharmacies, then common sense would be that the location of the dispensaries would mirror the geographic locations of pharmacies around the state on a percentage basis. Following this logic, then one would think that a city such as Phoenix with a large populace to have a higher distribution of dispensaries than Payson. By selecting locations by CHAA, this defeats having even distribution of locations for the people of the state. Doesn't it make sense that the market has already determined the need for medicine by location with the locations of existing pharmacies? Please, let's take what the people have voted upon, that being having having dispensaries made available to patients based upon the number of pharmacies, and apply that logic to geographic locations. I don't remember Proposition 203 stating that the number of dispensaries will be based upon the CHAA's as being the driving force for geographic locations. Finally, with this limiting amount of dispensaries in the metro area, some smaller townships will be losing out on valuable sales tax revenues which are desperately needed during the difficult times.

I DO NOT BELIEVE it is proper or legal for the commission to hold a lottery. This is in the purview of the Arizona Gambling Commission. I have a very uneasy feeling about the lottery proposal, as there is a lot of money involved, and there should be another independent in charge of such a lottery. The present commission members do not have the experience, or knowledge required for such an activity.

Limit number of patients that a doctor can recommend marijuana to 100 a year.

#NAME?

Please refer to the previous comment above. There are many things that can and should be changed. Please consider the following ideas as starting points and make revisions before the 'final' guidelines are issued. There has got to be a way to have questions and answers on the program before it is finalized. So far AZDHS has overcomplicated a seemingly simple law. Medical Marijuana is now legal. Let the entrepreneurs get started doing business and the rules can be adjusted as it goes along. Remove the stigma and start dealing with it as any legal business. Regulations will surely follow. There is no need to delay patients receiving affordable, compassionate care now. DHS has not become experts in treatment and are not a regulatory body. We need to see the application before it becomes final. As the draft rules are being reviewed by the public, it is equally important to have the application be available for public review as well. The application is the initial step in reviewing the criteria AZDHS will be using in their due diligence. It is important to get public comments on the content of the application as it is just as critical as the rules used to create it. There is no reason for a monetization requirement that has been suggested in the application. It is arbitrary and the law makes no reference to it. As with most other business ventures, it is the responsibility of the certificate owner to obtain the funding needed. While there is no question some financial assets will be needed, requiring inordinate amounts, in the tens or hundreds of thousands of dollars is unreasonable and financially discriminatory. Entities and individuals having extraordinary financial backing does not make them better qualified to provide needed services to the community, it only makes them wealthier. Some have begun introducing scare tactics including raising the possibility of 'Mexican drug cartels' being enticed if a significant financial floor is not instituted. This is ignorant at best. Precisely how and why would any respectable citizen choose to attach themselves to the dangers and risks of "cartel" association? If there is evidence to support these alarmist claims, it is imperative that the evidence be provided immediately and publicly and thoroughly reviewed for accuracy prior to accepting it as fact and designing guidelines to quell it. I understand there are costs associated with performing due diligence, but the \$5000 application fee is exorbitant. It reeks of a bureaucracy bending entrepreneurs over a barrel for no other reason than that they can. Even more insulting is the 80% (\$4000) loss if you don't get chosen for a certificate. This is another glaring attempt to limit the pool of potential dispensary operators with no logical basis for it. A more reasonable fee and administrative loss directly associated to actual due diligence costs, provided by the AZDHS for transparency, would be appropriate, fair and in your constituent's best interest. Overall, it would be good to start over with common sense, market-driven rules based upon realistic economics and historical lessons. The rules in current form are unnecessary, over bearing, controlling, economically ignorant, and most likely illegal and unconstitutional.

Why should Marijuana be treated differently than other drugs? It should be dispensed by already existing pharmacies that qualify to be marijuana dispensaries. In California some of the dispensaries for just marijuana look rather shady. Allow qualified pharmacies to dispense marijuana. Why not take the major working chemicals and the marijuana plant and make pills that would be dispensed through qualified pharmacies. (They put marijuana in brownies and people still get the needed effects) Use of Marijuana needs to be in private and separate spaces from other people.....so no second hand smoke problems cause problems for those around the patient using it if they are smoking it. If pill form is adopted this would not be a problem. People under the influence of marijuana should not be allowed to drive, operate machinery, make important decisions if the



this is allowed to continue it will be the first step to the feared Californization of our program. The AZDHS should either require all members of a legal entity to be an Arizona Residents and prove it, or in the alternative, only allow individual Arizona residents to apply for licensure. 2. We again address the same concerns that we had in our previous response. We believe that certain employees of the health Department are in direct contact with, and are being influenced, and/or manipulated by Individuals, organizations, Associations and other entities whom will gleam direct financial benefit from their intrusive behavior. While Director Humble has repeatedly stated that he wanted the application and selection process to be fair, open to all and transparent, it appears this is not the case. We believe that these organizations, specifically [REDACTED] are being given preferential treatment and open-ended access to AZDHS employees. While, Mr. Humble has stated that his agency will not have any contact with anyone who may derive financial benefit from the process, he and his staff has repeatedly been in attendance at events with [REDACTED] and other individuals who will derive direct benefit from the favorable outcome of the rules. For Example; [REDACTED] represents numerous clients who are seeking Dispensary Licenses. Yet, [REDACTED] was recently pictured sitting next to [REDACTED] of AZDHS at the Pinal Partners conference on Medical Marijuana. [REDACTED] who alleges to be a co-director of [REDACTED] stated at a recent [REDACTED] meeting in Tucson that he has been in contact with the Health Department and is working to get the rules established. He further stated that his organization was working together with the League of Arizona City and Towns to develop the Health Department Rules. This fact was supported by the recent League of Arizona Cities and Towns training program where again Mr. Humble was present together with the representatives of the alleged [REDACTED]. This is a small example of some of the events that lend itself to an appearance of impropriety, and cause us great concern. \*NOTE: While [REDACTED] has made lengthy presentations at all of your public forums, and has submitted public comments to AZDHS, It is important to note that [REDACTED] does not legally exist. Contrary to all the fraudulent public representations made by [REDACTED] there is simply no such Association. The fact is that as of the date of this writing, the Association has never legally formed. There is no corporate entity filed under that name in Arizona. (Note: The name [REDACTED] has been reserved but no corporate filings have ever completed.) Consequently, any proposals or recommendations made under the color of such Association should not be taken into consideration by AZDHS. 3. [REDACTED] promotes excessive financial qualification procedures including minimum cash liquidity standards, and other abusive financial requirements intended to create an elitist program. The underline goal of [REDACTED] is to eliminate and manipulate lesser funded, but otherwise qualified applicants for the benefit of their influential members. We hope the AZDHS will not be fooled into accepting their Kentucky fried Chicken\* arguments. \*( [REDACTED] has argued that Dispensary Candidates should have a million dollar net worth, citing the basis that to open a KFC or Subway shop you need at least a Million Dollar net worth). 4. [REDACTED] and [REDACTED] have promoted the idea of one or more large cultivation centers in lieu of individual centers for each dispensary. This would be in clear violation of the Title 36-2804 B,1,(b) ii. It is apparently the private agenda of one or more of the [REDACTED] members to open large cultivation facilities across Arizona. [REDACTED] is conspiring to capture and control the medical marijuana cultivation marketplace in Arizona. We hope that that AZDHS will take into consideration the self-serving agenda of [REDACTED] when considering recommendations received from them. 5. There are no provisions in the rules for dispensaries to file modifications or procedural changes concerning their operations. There should be some rule to allow for such modifications. 6. ARS 36-2803.4 of the Arizona Medical Marijuana Act requires that the Arizona Department of Health Services will be made "without imposing an undue burden on nonprofit medical marijuana dispensaries". 7. We believe that Doctors should be entrusted to perform

the services required under Title 36 without undue burden or duress. Doctors should be considered innocent till proven guilty. Doctors should be free to recommend Medical Marijuana to the patients they believe qualify and will receive therapeutic benefit. The AZDHS, working in conjunction with the various medical boards has the ability to sanction or penalize Doctors who have been found to violate the law. Pre emptive rules and excessive regulations only serve to limit access of the medical marijuana to the individuals it was intended help.

8. 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.

9. 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.

10. 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.

11. 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)II 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).

12. 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.

13. 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.

14. 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. 15. 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. 16. R9-17-202.B is cruel, arbitrary, and unreasonable. Qualifying patients may need more than one caregiver to ensure an uninterrupted supply of medicine. 17. 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. 18. 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. 19. 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. 20. 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. 21. 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. 22. 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 geaponics, in cultivation of medicine. 23. 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. 24. 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. 25. 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. 26. 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. 27. The [REDACTED] will continue to act as A Watchdog Group and, to assure fairness, we will carefully scrutinize all applications approved by the AZDHS. 28. At the direction of its Board of Directors the [REDACTED] will seek legal recourse for any actions taken by AZDHS which it deems to be in violation of Title 36, actions which appear to be made in bad faith, or actions which lend itself

to the appearance of preferential treatment. 29. The [REDACTED] again recommends that AZDHS open its doors and give equal access to all legitimate Medical Marijuana Industry leaders. We again extend the offer to bring together all such industry leaders to meet with AZDHS and present ideas and proposals intended to further the success of the Arizona Medical Marijuana Act. Sincerely [REDACTED]  
[REDACTED]

R9-17-106 Adding a Debilitating Medical Condition. Six months is an unreasonable amount of time to wait for medication to be approved. Workmans comp insurance companies doesn't even take that long to approve medical necessity for treatment. R9-17-202. F. 1. f. The 25 mile rule must be removed for two reasons (a) it creates a monopoly for dispensaries and (b) will cause the products to become unaffordable to the law abiding citizens. Excess cultivators will not become a burdon on the state... growing a successful crop is not an easy task. Nature will processes the elemination on its own, trust it to do so. R9-17-204; 307; 311 Renewing a Qualifying Card; Renewing a Dispensary Registration Certificate; Renew Dispensry Agents Registry ID Card rules would greatly be improved if it weren't as cumebersome a process as the initial application. It actually makes the state look incompetent to the citizens when it requires redundant information every year. Surely the state could employ competent record clerks with revenue generated by the Medical Marijuana Program to keep accurate records and eleminate the necessity for redundancie. I would also like to petition the board to create a lifetime card for thee patien based on medical diagnosis that need not be renewed unless changes are made to recommended use by the patients physician. R9-17-302. Despensary Registration Cerificate Allocation Process. B. 2. b. RANDOM SELECTION PROCESS. Please reconsider using the random selection process. I would like to petition the board to put forth as much time and energy into selecting the aplicants as is proposed in the approval process for qualifying medical conditions. Applicants should be selected based on MOTIVE; VISION; AND BUSINESS PLAN. It is surprising that the state has worked so hard to create strict restriction and maintain intense control over this program that they would even consider using the Random Selection Process. Frankly it makes the state look clueless, like the elected officials have declared defeat and really don't know how to manage this program with integrity... that they just want to "wash their hands of it" and be done. If the state just wants to legalize an illicit drug incognito under the aka of Medical Use Permits they should just legalize it across the board, however, if they truely want it to be a program with integrity and merit the selection process MUST be based on those things. Dispensary owners and managers WILL BE a direct reflection on the state. Does the State really want to be represented by citizens randomly selected? One solution to this delima might be to use random selection but only after the applicants have been extensively screened.... remembering always two things...(1) Capitol DOES NOT equal integrity and (2) the 'winner' WILL BE a direct reflection on the state. Now would be a good time to reflect on the States Vision for this program... Medical Use Program or Illicit Drug Use Special Permit... and act accordingly. . R9-17-309 Administration B. I would petition the board to remove "enclosed" and release it to "Secured". Forcing cultivators to grow inside would be a "non-Green Friendly" reflection on the state of AZ because it is non green friendly and will create a huge carbon footprint. R9-17-312 Medical Director. I move the board remove this position all together. The message the state is sending to it's citizens with this requirement is that this program is really an ilisset Drug Special Use Permit incognito as Medical Use. The patients phyician or natural path should be quite capable to manage their Medical Marijuana patients with integrity and discretion. R17-316 Product Labeling and Analysis A. 3. This label is not truthful and inaccurate, please reconsider using language that doesn't assume all cannabis products are "smokes" and followup with some accurate studies that prove marijuana is NOT addictive . R9-17-317.com Security A. Again please consider removing the 'enclosed' restriction for same reasons listed above.

Will there be classes to help people to learn how to cultivate or will there be a program for caregivers that will be set up to help people wanting to become caregivers to get licensed.. Being that this proposition is new to the state I feel that there will be a need for education of this considering people from other states aren't allowed to cultivate if they haven't been here for at least 2 years. And once a dispensary is opened who will actually know how to cultivate??

Don't borrow trouble. We do not have to anticipate problems from other states. Just hold a lottery, then let people decide where to locate. I for one would happily go to Kingman.

I think a proof of residence should be added to the requirements to obtain or renew a card, i.e., a utility bill that matches the applicants D/L address. I also think each renewal should require a new signed affidavit from the prescribing physician that the original RX was from. Studies have shown marijuana's ability to manage chronic pain, involuntary muscle movements, spasticity, nausea and vomiting, wasting. So just because someone is diagnosed with cancer or any of the other diseases on the list, does not mean they are experiencing any one of the five conditions that marijuana has been shown to treat effectively. Also marijuana is not the treatment of choice for glaucoma, as I understand it, because eye pressure rebounds quickly after marijuana use. There are also antiemetics that are just as effective as marijuana for nausea, although they are more expensive. In short, I believe the rules as written allow for too much prescribing of marijuana without solid medical evidence. I believe that there should be added some guidelines for physicians and that the rules regarding a documented patient-physician relationship should be added back in. The guidelines should include proof of one of the five conditions, and evidence that smoking marijuana will not aggravate any other medical conditions. I do not believe marijuana should be dispensed to regular users of tobacco, or people with multiple drug convictions. I also believe the state should provide discounted vaporizing equipment to promote that safer alternative to smoking.

There are no over dose risks. You are exaggerating the risks. You are using out dated information.

There are no over dose risks. You are exaggerating the risks.

In cases of permanent disabilities or handicaps,there should be a one time reccomendation,not a renewal yearly. Not everyone can afford the reccomendation renewal fee yearly.

Please consider the following points and make revisions before the 'final' guidelines are issued. There has got to be a way to have questions and answers on the program before it is finalized. So far AZDHS has overcomplicated a seemingly simple law. Medical Marijuana is now legal. Let the entrepreneurs get started doing business and the rules can be adjusted as it goes along. Remove the stigma and start dealing with it as any legal business. Regulations will surely follow. There is no need to delay patients receiving affordable, compassionate care now. DHS is not expert in cannabis. You are not in the business of creating market incentives. There is no reason for a monetization requirement that has been suggested in the application. It is arbitrary and the law makes no reference to it. As with most other business ventures, it is the responsibility of the certificate owner to obtain the funding needed. While there is no question some financial assets will be needed, requiring inordinate amounts, in the tens or hundreds of thousands of dollars is unreasonable and financially discriminatory. Entities and individuals having extraordinary financial backing does not make them

better qualified to provide needed services to the community, it only makes them wealthier. Some have begun introducing scare tactics including raising the possibility of "Mexican drug cartels" being enticed if a significant financial floor is not instituted. This is ignorant at best. Precisely how and why would any respectable citizen choose to attach themselves to the dangers and risks of "cartel" association? If there is evidence to support these alarmist claims, it is imperative that the evidence be provided immediately and publicly and thoroughly reviewed for accuracy prior to accepting it as fact and designing guidelines to quell it. There is no reason for the requirement for the specific address of the intended dispensary in the application. Given the current real estate market, and the fluidity of all the elements, the exact sites for all the elements, dispensary, cultivation and infusion, should be determined once the license is won. I understand there are costs associated with performing due diligence, but the \$5000 application fee is exorbitant. It reeks of a bureaucracy bending entrepreneurs over a barrel for no other reason than that they can. Even more insulting is the 80% (\$4000) loss if you don't get chosen for a certificate. This is another glaring attempt to limit the pool of potential dispensary operators with no logical basis for it. A more reasonable fee and administrative loss directly associated to actual due diligence costs, provided by the AZDHS for transparency, would be appropriate, fair and in your constituent's best interest.

I believe there would be a great improvement to the system as a whole if instead of requiring the location of the dispensary to be pre-designated you base it on the qualifications of the organization and people involved. I am in a position to open a dispensary in ANY location in AZ. Unlike some people who might wish to open a dispensary in their own community and might have questionable resources or limited financial support, I am able to live in ANY community that will allow for a dispensary. Subsequently, I could then pick a location and invest the time and money required to make sure it meets with all ADHS guidelines and local and state laws. It is unreasonable to expect that there are enough people in every community to invest in "doing this right" which is based on the fact that only 2 county's carried the vote thru in the whole state. All other county's might be required to have a dispensary in their local, but might not have an organization or group of people able to meet all the requirements. If my Non-Profit were to receive a license I could work with community leaders and law enforcement to make sure it is located in an area that meets with their approval. Anywhere in Arizona,,,,,anywhere.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

Remove the requirement for two officers. Make it officer instead of officers.

I am a Navy veteran, contacted Hep -C, which in time turned to liver cancer. Marinol was prescribed @ \$85 x 3 pills a day and did very little to overcome the nausea and vomiting (every 10 min.). Several of my doctors wish they could prescribe real THC, but could not. My point is mmj needs to be affordable to the patient. Isn't this what it's all about. Medicine, set-up for Non-profit. I'm afraid if it is too costly, black market will replace the dispensaries. It should cost no more than tobacco, which is known and proven to cause multiple health problems, besides nicotine IS a narcotic.

The proposed 160 dollar cost of a card is too much for a lot of people. Especially folks who are already paying for other costs that are related to their diseases. It does not cost anywhere near that much for a drivers license. I don't want to hear that old saga about we have to investigate. Like I said, if you can check out an applicant for a driver's license, something that entails a person driving a dangerous object that can kill other people, 160 for a card is TOO much. On top of that I heard that it will have to paid every year!! We need to go to court on this one!

Need to limit the number of patients a doctor can recommend for marijuana treatment. This would eliminate the temptation for a doctor to be "the pot doc", the one provider people know they can go to in order to get their medical high.

In short, the rules must be improved to ensure that medical marijuana dispensary licenses are awarded to the highest caliber of applicants and to ensure that those with less than pure intentions are prevented from entering the lottery. The legalization of the medicinal use of marijuana is a great triumph for individuals with debilitating medical conditions that traditional medicines have failed to treat, however, it remains a reality that like any drug, the positive benefits can easily be perverted if control of the drug falls into the wrong hands. The Rules need to ensure that it prevents the "bad guys" from taking their business off the streets and moving it into the mainstream, by disguising an otherwise criminal enterprise as a medical marijuana dispensary. The rules and regulations regarding the ownership and operation of medical marijuana dispensaries must clearly purport that Arizona's medical marijuana law is intended to provide individuals with debilitating medical conditions, an alternative option, when traditional treatment has failed them. The law is not a safe harbor for those of a criminal element or those interested in making a quick and easy buck. First, it is imperative that the security plan requirement be strengthened. Just requiring a plan is meaningless unless the plan can be rejected. Applicants should be required to draft a comprehensive security plan, which requires the approval of local law enforcement, prior to submission to DHS. Given budgets are tight and this will take time and funding, applicants should be charged a reasonable fee for this review and approval process. Second, one of the "oldest tricks in the book" is to put forth a nice, shiny, clean product at the outset when scrutiny is the highest, only to regress on all different levels once they have secured the necessary government license. To thwart these people, DHS should conduct regular inspections of all medical marijuana dispensaries and cultivation facilities. Once again, dispensary owners should be charged a reasonable fee for the inspection process. Third, I'm sure the ill-intentioned are rejoicing at the use of a lottery system, as it evens the playing field and increases their chances for receiving a dispensary license, at which they can then turn it into a predominantly cash business, making future transgressions much more difficult to discover. Cash is much harder to track and for that reason, DHS should implement rules discouraging dispensaries from accepting cash in favor of other means of payment that generate a payment trail. Credit and debit cards and cashier's checks are ideal and payment in this manner should be encouraged. Lastly, by virtue of the lottery system which DHS has chosen to utilize in allocating medical marijuana dispensary licenses, there is an incredible amount of risk involved in applying for a license. Those applicants who are doing their best to ensure all of DHS's minimum requirements and met and exceeded are putting a great deal of time and money on the line for just the possibility that a license may be granted. DHS has purposely structured this process so it is not required to review and select applicants based on merits, so it seems extreme that in the even an applicants (with a complete application) is not awarded a dispensary license that DHS would only refund \$1,000.00 of the initial

\$5,000.00 application fee.

Add PTSD and ensure no taxation as it was the original law we voted for!

Recommend to DELETE the random selection of MMDs and base the selection on experience, expertise and merit, along with quality of services and products being delivered. The merit system should be based on the ability of each applicant to develop their program based on demonstrated needs, individual community assets and issues, public perceptions, existing and potential resources, the interests of public health system partnerships, and the unique cultural and geographic diversity of each county. Appropriate experience and expertise of key personnel in each of these areas will guarantee a successfully integrated dispensary. I would also like to recommend including city council representatives and county board of supervisors to be involved with the selection process. County and City representatives are very familiar with the needs of our local community and will, in the long run, have more involvement with the selected MMDs.

Add PTSD and ensure no taxation as it was the original law we voted for!

Add PTSD and ensure no taxation as it was the original law we voted for!

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

As mentioned by a very large number of the speakers at the public hearings in Tempe; I believe that the CHAA's really do not better the process of setting locations for dispensaries. Each cities zoning laws are doing well enough to force dispensaries into the areas they are comfortable with and by only limiting their locations even more by only allowing only one in these arbitrary zones you effectively eliminate huge areas that a dispensary could possibly be. For example as it stands right now there are areas that will NOT have a dispensary, such as Indian Reservations, yet there are multiple CHAA zones that are only on reservation land. Your goal seems to be to effectively both spread these dispensaries out, but also to cut down on patients growing their own marijuana. This method while spreading out the dispensaries will lead to not only dispensaries that are unable to sustain a large enough client base to survive in some areas, but also a lack of enough dispensaries to meet demand needed in areas with MUCH larger populations. Another issue with the CHAA's that is where cultivation sites fall into the equation. Are you limited to only one cultivation site per CHAA as well or only one dispensary site/cultivation site/or infusion site per CHAA. Why are cultivation sites even put into these CHAA requirements. The smart and practical thing to do would be for cities to dictate where these cultivation sites will be so that they are lumped into areas that can be more closely watched and secured then being forced to once again being forced to conform to arbitrary boundaries that severely limit them and put them in places that are less desirable locations that often times are less secure areas and spreads them out making them more difficult for law enforcement and ADHS to monitor. There are many other issues that have been addressed in other comments. One area in particular that was very lightly and quite confusingly touched on in the second draft of the rules I never heard discussed was the matter of disposal of unusable marijuana. In the draft rules it actually only throws out one option for this, even though it is a required step for both dispensaries, cultivation sites, and infusion facilities. The only option that is mentioned is to drop it off with local law enforcement. Really? If there is no more clarification on this you are leaving this completely up to everyone what they want to do, and I doubt that local law enforcement will appreciate bags of dead plants thrown on their

steps. Please address this matter.

I recommend that the rules limit the number of patients a physician can recommend for marijuana management; perhaps 200 per year?

Thank you all for working so dilligently at working out the regulations. I feel as though the lottery system is a poor method to choose who gets permitted. It does not ensure that the most qualified aplicants are chosen. It also allows goups with more start up capital to apply for more permits giving them an unfair advantage. If there are five teachers applying for the same position, or five nurses, they are not chosen randomly. The most qualified applicant is chosen. I feel permits should given to the most qualified applicants, not randomly. Again I say thank you.

Limit the number of patients a physician can recommend for the medical marijuana to no more than 100 per year.

In short, the rules must be improved to ensure that medical marijuana dispensary licenses are awarded to the highest caliber of applicants and to ensure that those with less than pure intentions are prevented from entering the lottery. The legalization of the medicinal use of marijuana is a great triumph for individuals with debilitating medical conditions that traditional medicines have failed to treat, however, it remains a reality that like any drug, the positive benefits can easily be perverted if control of the drug falls into the wrong hands. The Rules need to ensure that it prevents the "bad guys" from taking their business off the streets and moving it into the mainstream, by disguising an otherwise criminal enterprise as a medical marijuana dispensary. The rules and regulations regarding the ownership and operation of medical marijuana dispensaries must clearly purport that Arizona's medical marijuana law is intended to provide individuals with debilitating medical conditions, an alternative option, when traditional treatment has failed them. The law is not a safe harbor for those of a criminal element or those interested in making a quick and easy buck. First, it is imperative that the security plan requirement be strengthened. Just requiring a plan is meaningless unless the plan can be rejected. Applicants should be required to draft a comprehensive security plan, which requires the approval of local law enforcement, prior to submission to DHS. Given budgets are tight and this will take time and funding, applicants should be charged a reasonable fee for this review and approval process. Second, one of the "oldest tricks in the book" is to put forth a nice, shiny, clean product at the outset when scrutiny is the highest, only to regress on all different levels once they have secured the necessary government license. To thwart these people, DHS should conduct regular inspections of all medical marijuana dispensaries and cultivation facilities. Once again, dispensary owners should be charged a reasonable fee for the inspection process. Third, I'm sure the ill-intentioned are rejoicing at the use of a lottery system, as it evens the playing field and increases their chances for receiving a dispensary license, at which they can than turn it into a predominantly cash business, making future transgressions much more difficult to discover. Cash is much harder to track and for that reason, DHS should implement rules discouraging dispensaries from accepting cash in favor of other means of payment that generate a payment trail. Credit and debit cards and cashier's checks are ideal and payment in this manner should be encouraged. Lastly, by virtue of the lottery system which DHS has chosen to utilize in allocating medical marijuana dispensary licenses, there is an incredible amount of risk involved in applying for a license. Those applicants who are doing their best to ensure all of DHS's minimum requirements and met and exceeded are putting a great deal of time and money on the line for just the possibility that a license may be granted. DHS has purposely structured this process so it is not required to review and select

applicants based on merits, so it seems extreme that in the even an applicants (with a complete application) is not awarded a dispensary license that DHS would only refund \$1,000.00 of the initial \$5,000.00 application fee.

Health professionals should be able to prescribe the use of medical marijuana--phys asnt, nurse practitioners, maybe even chiropractors/

Please limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

Adding other conditions not yet looked at

First of all, the Department has introduced a couple of items that were not in the original Prop 203.

1. Remove the requirement for the Dispensary to have a Medical Director on staff. The truth of the matter is that many or most doctors don't have a clue about medical marijuana as it is a Class 1 controlled illegal substance. They have no training or information on medical marijuana and have no idea how to proceed with Prop 203. In various states that have legalized medical marijuana the people that are growing it know a lot about the strains they are growing and the medicinal value of the strains. I talked to a grower in Colorado who said that for whatever reason, there is no medical study, a strain called "Golden Goat" works really well for MS patients. It is very low in THC but since there are over 200 compounds in medical marijuana and no study has been done, it's hard to figure out why it works. But it does work and that knowledge is out there with the caregivers, patients that grow, and in other states. Doctors, in Arizona, know less about medical marijuana, than most of the population at this point in time. I don't think is a valid requirement and should be struck from the rules. It just adds cost all around and no value for the dollars spent.
2. Remove the CHAA- Community Health Analysis Area. Introduced in draft 2 of the rules this appears to be a concerted effort to create a "halo effect of 25 miles" around all dispensaries to eliminate patient growing. It is not part of the Health Department's mandate to add more zoning to the rule making process. From Prop 203: i) 36-2806.01. Dispensary locations\_CITIES, TOWNS AND COUNTIES MAY ENACT REASONABLE ZONING REGULATIONS THAT LIMIT THE USE OF LAND FOR REGISTERED NONPROFIT MEDICAL MARIJUANA DISPENSARIES TO SPECIFIED AREAS IN THE MANNER PROVIDED IN TITLE 9, CHAPTER 4, ARTICLE 6.1, AND TITLE 11, CHAPTER 6, ARTICLE 2. Throughout the state of Arizona zoning has been put into effect. Some of it may not be reasonable. Nowhere in the Citizen's Initiative/Prop 203 is there any mandate for the Department of Health to add another level of zoning on top of what has already been put into effect. This additional filter would make it impossible for people who don't already own property in just the right location to open a dispensary. There are numerous other arguments against the CHAA system including population density. If you look at the Census data for the city of Tucson, the population is estimated to be around 550,000. Santa Barbara, California has a population of 407,057 and according to the internet has 14 dispensaries. Long Beach has a population of 461,522 and has 40 dispensaries. Glendale, Colorado has a population of 4, 547 and has 2 dispensaries. Denver, Colorado has a population of 610,345 and there are 275 or so in the greater metro area, which includes Boulder, Fort Collins, etc. The CHAA system doesn't take into account population or demand and supply. 65.5% of the voters in Pima County supported Prop 203 which suggests that a larger percentage of the general population supports this measure in the metropolitan area. Major problems, i.e. continued black market supply

of marijuana arise in under-serviced areas of high demand. It is important that regulations create a legal system rather than foster illegal markets to continue to supply “ that is the whole point of this act. 3) Remove the random selection of dispensary applications. A point based rating system as has been put in place in Rhode Island makes much more sense. What business backgrounds and experience do the individual applicants have? What kind of business model are they proposing? What kind of non-profit contribution to the community does the entity create? Are they economically viable? Can they prove they are not being funded by out of state large money interests? What sort of system have they put into place to ensure those segments of the market they are serving, i.e. veterans, terminally ill, etc are being served in a compassionate way? What is their pricing structure? Do they have a sliding scale for the very ill and very poor? If the Department decides to retain the concept of random selection, which has been dubbed “The New Arizona Lottery,” the Department must specify exactly how they plan to randomly select and must perform the random selection in a public forum. 4) Some specificity is needed with regard to starting up cultivation sites. How is a grow operation to legally obtain genetic material, i.e. clones or seeds? How is a cultivation site to legally acquire certain strains of medical marijuana, i.e. seeds and clones? How is a caregiver to legally acquire such items? 5.) Address the issue of multiple applications by denying any dispensary applicant to submit more than one application to the Department of Health. If any applicant submits more than one application to the Department of Health they are immediately denied. 6) Confusion in R9-17-302 B. Says the Department will accept applications for 30 calendar days then in subsection a) mentions 60 calendar days. This is confusing. If the initial application period is for only 30 calendar days then the language should be altered to say that.

1. Let out of state patients use their cards in AZ dispensaries. 2. Allow deliveries to registered patients. 3. Separate grow license 4. Allow more stores to open - just regulate and license them like any Walgreens or CVS 5. Allow AZ property owners to be part of a dispensary, not just AZ residents.

Reduce the volume of medical marijuana allowed to be grown and harvested. The proposed amounts of plants to grow are much more than a patient could reasonably use so the potential for misuse is too great. Increase the distance from a dispensary from the current limit to 50 miles for those who will have permission to grow their own supplies. I drive my spouse over three hours for medical care twice a month, what is fifty miles once a month or so?

Allow patients to grow their own no matter where they live. The 100% tax is ridiculous! It may be cheaper to buy it illegally. This bill should try to take the criminal element out of the sale market, however if it is going to cost twice as much to buy from a dispensary, then why would someone pay the extra money? Allowing those who can't afford the extra money for the tax should be able to grow it on their own. One should be able to purchase a growing license for a nominal fee. Perhaps it would be best to give a growing permit for a 2 year period then you would have to renew it and pay another license fee. Of course all that would be grown would be for that person's personal use only, not allowing that person to sell or give the product away.

I disagree with the 25 mile radius. I have been considered disabled by the Social Security Admin. for over ten years. I live on a very small fixed income. A price of \$400.00 is an outrage. I could be helped

by this product, and will be unable to afford it. I have been on Vicodan 10mg four times a day. This would negate that being necessary. But only if made affordable, or, I would be allowed to grow. I have lived in Phoenix, AZ. for over 40 years. I live by using busses and public transportation so moving outside the 25 mile area is out of the question. Please help those of us who ar indigent and really need the help.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

Regarding R9-17-312. Medical Director There is currently nothing in the rules about the responsibilities of a Medical Director that would require a medical director to be present on-site or available for consultation, nor is there anything a medical director is required to do that is specifically related to a physician. The current rules describe the responsibility of the Medical Director as thus: 1. Develop and provide training to the dispensary's dispensary agents 2. Develop guidelines for providing information to qualifying patients related to risks benefits, and sides effects associated with medical marijuana 3. Recognizing signs and symptoms for substance abuse 4. Guidelines for refusing to provide medical marijuana to an individual who appears to be impaired or abusing medical marijuana 5. Assist in the development and implementation of review and improvement processes for patient education and support provided by the dispensary These responsibilities are critically important, but are not within the training or scope of physicians, who have not been trained regarding medical marijuana. There is no quality control regarding the information being presented to the patient. Within current systems of medicine, this information is produced by the pharmacy companies and approved by the FDA. There are also no current standards in the rules for training of dispensary personnel. Fortunately or unfortunately, AZ DHS will need to provide oversight on this to help provide appropriate protections for the public. The best way to do this would be for AZ DHS to certify persons/companies that will provide these to dispensaries with significant quality controls in place. The quality and scope of information presented would then be standardized as well as standardizing policies and procedures ensuring patient safety and appropriate use between dispensaries. This is not to say that the goal of ensuring the medical nature of a dispensary is not critically important. It is just that these rules do not get you there.

RE CHAAs - encourage healthy competition so consumers can get good prices by increasing the numer of CHAAs or eliminating that rule/reg totally. R9-17-102-A6a - Why is the registry identification so expensive? Is this a yearly fee? Even the suggested \$80 will be hard for some people. R9-17-318-A 1b - I suggest ONLY the dispensary be allowed to make edibles R9-17-318-A2 - Again, only the dispensary should be allowed to make edibles for public health and safety and to eliminate the possibility of fraud

There needs to be a process for changing and/or adjusting a dispensary's policies and procedures and getting those changes approved by the department. As these are new businesses, we do not know exactly what will work in practice. Considering the requirement to comply with the approved policies, a dispensary should be able to inform the department of a proposed change and then have that change approved so it can make adjustments in response to real world issues that arise in the course of its business.

DO NOT TAX 300%, that is unbelievable.

Many areas of the draft can be improved, but my post here is to address only one area which is how a patient gets his medication, the patient's costs for medication and his/her right to privacy. Under the current draft I believe you will be violating the Patient's Bill of Rights specifically to his/her privacy. Under the current draft you require all patients to purchase their medical marijuana from one of the 124 dispensaries if they reside within 25 miles of a dispensary. By requiring this you violate the patient's right to privacy. Why? Because there is only one reason a person would enter a dispensary and that is to purchase medical marijuana. These dispensaries will sell nothing more than marijuana. Anyone seeing the patient enter a dispensary knows exactly why he/she is there. Now if medical marijuana was sold at CVS for example, their rights would not be violated because CVS sells many different products including Aspirin, cough syrup, potato chips and even milk. When my neighbor enters our local CVS I do not question why they are there. In fact, my neighbor could be entering his local drug store to purchase almost anything and therefore does not violate his right to privacy. There is a simple way to fix this problem. The solution is to allow the patient to cultivate his/her own medical marijuana if they so choose to. By allowing this you do NOT violate his/her right to privacy. If they choose to enter a dispensary then that is their choice, but to require them to do so, will without doubt violate his/her privacy and therefore I believe the state of Arizona will soon be inundated with lawsuits. In fact, if the draft rules stay as they are, I promise I will personally seek council in an effort to fight this unnecessary burden and violation of my privacy as a patient. Yesterday I heard a person at your town meeting recommend at least one plant. But that will not work of course. Marijuana has both a female and a male plant. Only the female plant can be used for medical purposes. At least 50% of all plants will be male which will take a couple of months before it is established. I recommend a minimum of 3 plants for patients living within 25 miles of a dispensary or keep the original number as you have included in the draft as is.

While there is language referring to residency for any potential dispensary operator, however there is no such information regarding residency for prospective dispensary agents. If nothing is implemented regarding prospective dispensary agent residency requirements then the requirements for dispensary operator does little to no good. What you will have is out of state owners using a current resident as their 'Puppet' to apply for and receive a dispensary license. while this resident will be the owner on paper, the out of state agent will be running the dispensary and the majority of the capital earned from the dispensary will be going out state. No agent residency requirement is the down fall to keeping this money in our much needed cash strapped state. Please also dont make potential dispensary owners invest more money than necessary to apply for a license. ie: pay for a lease or location, have a physical address. the \$5000 application fee should be the only gamble and a monetary risk a potential dispensary operator should have to risk

If you were really informed you wouldn't need me to tell you what's wrong with these laws. Making possession criminal is the biggest waste of resources. If you really look at it, alcohol and narcotics are way, way worse and we don't have a problem regulating them without absurd restrictions. MM restores a sense of well being without the destructive side effects. So, why make it such a crime? Fear of a stigma? Get the facts! There are lots of documentaries out now, free on Netflix. Check out The Union: The Business of Getting High. The doctor that is advising you is either ignorant, misinformed, or has alterier motives.

a random selection of applicants who properly filled out an application is not the BEST way to make a

decision. the state is regulating this whole affair , and when it comes to choosing who they will allow to administer their plan they want to take a "back seat"? take a look at who is applying, what credentials they have, who are they in the community, experience.

From this draft it looks like i need to start seeing a doctor and get put on non organic pain pills like vicoden or oxycoton before i can see about getting a recomendation from a doctor. I have found the answer to my pain along time ago and its easly managed by cannabis. Do i have to stop using what works for me just to start going and getting my medical records before any doctor will be allowed to recommend i get a card to use cannabis. I have been in pain and the only thing that works is medical marijuana. I dont have doctors notes for this since we are just getting to that now. What about those of us that figured out how to treat our pain already. Ive been using this for 20 years and know it works. I dont want to have to take the man made pills they push on people now.

take control of the "care takers" and make them follow the 25 mile rule to stop growing in City and Towns

The people who use marijuana medically should have their driver's license suspended while they use marijuana.

**APPLICATION FOR DISPENSARY REGISTRATION CERTIFICATE SHOULD REQUIRE ADDRESS(ES) OF DISPENSARY AND CULTIVATION LOCATIONS** At one of the public forums I heard a participant advocate the elimination of the requirement that applicants list their dispensary and cultivation locations in their initial application. His reasoning was that the process of applying for zoning permits and other costs involved in certifying that locations meet local zoning requirements are high and can make things difficult for applicants without substantial financial resources. He mentioned that there might be applicants that were so well financed that they could make an application in each CHAA. Eliminating this rule would be a mistake for several reasons. • First, it would make an attenuated process even longer. The Department already initiated a 2 step process whereby it eliminated the necessity of submitting a Certificate of Occupancy with the initial application. This was an appropriate response to the burden of someone who might spend large amounts of money on building improvements etc. in order to get a COO only to see it all wasted if the applicant did not receive a license. The cost of identifying an address and certifying that it meets local zoning regulations is less and should not be considered to be unduly burdensome. Eliminating the need to specify an address would make it impossible for the Department to determine in which CHAA the applicant wanted to operate. • Although the process of finding a location, and a landlord who is willing to rent for Prop

203 and confirming it meets zoning requirements is less than obtaining a COO, it is still time consuming and relatively costly. If this requirement were eliminated, it would have an obvious unintended consequence in terms of the issue the speaker was concerned about; e.g. the ability of well capitalized applicants to apply in multiple locations. Since identifying a location is costly and especially since it is time consuming, eliminating this requirement on the initial application would make it easier for well capitalized applicants to file multiple applications. The ability of an applicant to deal with potential landlords, zoning officials and law enforcement (see suggested Sheriff sign-off on location above) should be one of the factors involved in separating those who have the motivation and ability to succeed in the industry from those who don't. If an applicant is not able to clear this relatively minor hurdle, the chances they would ultimately succeed are likely lower.

i was able to speak at both meetings and stay through out both meetings. the duplicity of the get rich, we want a dispensary and the rules are fines but must evolve was certainly exposed by the very first speaker of the second meeting. he spoke at the first as "the little guy" doesn't even live here and he is the only one in his family not already in the industry said his plants don't produce much and it's a lot of effort. i addressed that with the various size plants can get and what they will yield. personally,,, if these owners can't see far enough ahead to produce the 8'-12' type plants that produce 2-40 pounds a year each i would rather not be forced to do anything that involves trust and my health with them. with those sort of conditions in mind i can't see where the patient should ever have a need to pay for anything but the card the state issues for all retirees and folks on gov assistance,,, ie medicare medicaid. the testing and all can be done in home. they are now producing in pharmacy analyzers,,, later as the rules revision continue allow pharmacies to provide those services. if the patient has no control over the actions of caregivers and big dispensaries the patient may want the testing done on for themselves after delivery to see what, as the end user, they are getting. the other set up for fraud is when the growers have one test done then dispose of a whole section or batch,,, which may not carry anything but what it should,,, be done away with at someone's expense and inconvenience. again a way to jerk around the state and patients. if these practices were committed against a racial group or religious group or an alt. life style group should be hate crimes. they should be hate crime protection guaranteed from the state when any kind of manipulation of the markets toward the disabled or heavily suffering from an impairment to the degree that marijuana has been recommended. i felt what i hope is a small in comparison feeling of rights and freedoms granted me when the ADA passed. i'm feeling that freedom again now but am deeply concerned about the undue expense and disrespect the patients may have to contend with if other states practices are allowed to cause influence have an open gift fund to be spent as the director sees fit. it's the thought i don't mind that rule but i don't have the 40 million i would stuff it with just to give you and your great staff enough room to take a breath of clean air and have a real look at what we can have for arizonans here. thank you all very much.

**MEDICAL DIRECTOR RULE** As it exists in the Department's 1/31/11 draft the duties of a medical director primarily include preparation of patient education and patient logs and being available for consultation (presumably by telephone) with dispensary staff and/or patients. It seems beyond obvious that someone will make available to the industry forms for use by the medical director for all of the publications that would be required. It is unlikely that much of the drafting of these materials will actually be done by the individual medical directors. I suggest that the requirement that each dispensary retain a separate medical director be eliminated. In its place I suggest that the Department make a rule providing that the Department will retain a staff of medical directors that could provide the necessary services to the industry. The Department could prepare all of the patient education materials and logs required by the current rules. The industry and patients would

benefit by the fact that the materials would be standardized and, presumably, guided by Department research on best practices. It would be easy for the Department to have a staff medical director on call during all business hours to provide the necessary consultations anticipated by the rules. The cost of providing this service could be covered by a monthly fee charged to each dispensary. The fee could be the same for all dispensaries in the beginning. Since the rules require dispensaries to submit annual financial statements, the fees could eventually be adjusted to provide that high volume dispensaries that would presumably use more services could be charged more than low volume dispensaries that would use less. In the alternative some sort of log could be kept by the medical director staff identifying the dispensaries w that use the services each time they are used so that fees could be adjusted in the future. (These logs should omit any reference to the details of the consultations in order to protect patient confidentiality). If this rule were implemented, it could reduce costs to the industry and therefore to patients and could significantly improve the quality of the services that the Department wants to have available for patients. It could make the difference between financial survival or non-survival for a dispensary in a low population CHAA.

The applicants for dispensary licenses need to be scrutinized much more carefully than the state seems willing to do. If there were more than one physician, nurse, pharmacist, teacher or day care provider applying for a state job, it would not be in the public's interest to make the final choice by randomly drawing a name from hat. It would seem reasonable that after meeting some minimal criteria, the best applicant would be chosen by a careful review of their job qualifications, experience, credentials and some form of personal recommendation. Given the small number of licenses available, even a personal interview to break the tie would not seem overly time-consuming. By choosing an applicant through the spin of a wheel, you are no longer looking for the most qualified individuals. Please consider awarding these licenses based on qualifications rather than chance and the price of an application.

**RULE PROHIBITING CHANGE OF DISPENSARY OR CULTIVATION LOCATION SOONER THAN 3 YEARS SHOULD BE MODIFIED.** R9-17-306(a) specifies that a licensee may not change its dispensary or cultivation location sooner than 3 years after the initial issuance of the dispensary registration certificate. This rule should be modified to specify that the rule could be waived if the request was necessitated by circumstances beyond the licensee's control. A few possible examples are: • The landlord of the location could lose the property due to foreclosure and the licensee's lease cancelled as a result. • A location could be destroyed by fire or other natural disaster and might not be able to be re-built due to changes in zoning or other regulations. • A location could be subject to governmental condemnation proceedings related to the need for a road, park, or other public use. The rule should be amended to provide that an applicant could be relieved from its operation if the applicant could prove that it needed to move for reasons beyond its control.

**CERTIFICATION THAT PRINCIPALS OF APPLICANT HAVE BEEN ARIZONA RESIDENTS FOR 3 YEARS** R9-17-303(B)(3)(b) requires that an applicant include an attestation signed by each principal officer or board member that each has been an Arizona resident for at least 3 consecutive years immediately preceding the application. R9-17-301 provides that applications can be submitted by individuals, corporations, partnerships, limited liability companies, associations or cooperatives, joint ventures and other unspecified business organizations. Many of the potential applicants listed in R9-17-301 do not typically have principal officers or board members. This would include all of the applicant types except corporations, although some, like LLCs could have officers and directors though they usually don't. LLCs generally have members and managers, for example. The rule should be changed to

specify that any person who would be, to any degree, an owner of, or have any equity interest in any applicant should be required to make the 3 year residency certification. This would close a gaping loophole in the rules that would, if not fixed, allow non Arizona residents to game the system to avoid the 3 year residency requirement.

Including Reciprocity; Will there be a provision that allows for card carrying registered user from another state, that may be visiting to either obtain a temporary card or use the valid card from a different state to obtain the medical marijuana. ? without going thur hiring a doctor, getting copies of all paperwork etc. thank you

COUNTY SHERIFF SHOULD SIGN OFF ON APPLICANT'S SECURITY PLANS Per R9-17-303(B)(4)(c) an applicant for a Medical Marijuana Dispensary License must submit a Policies and Procedures for a Security Plan to DHS, in order to submit a complete application for a dispensary license. While I think this is a great step in the right direction, I believe this requirement should be strengthened to require that the County Sheriff's Office also approve of an applicant's Security Plan Policies and Procedures, prior to an application to DHS being considered complete. This will give the State of Arizona, as well as the local jurisdictions a much higher degree of comfort knowing that dispensary applicants have been required to put in the necessary amount of time and thought into exactly how it plans to operate a safe and secure dispensary, in compliance with the law and the Rules, before an application has even been submitted. Any applicant who is unwilling or unable to meet this requirement is simply not the type of medical marijuana dispensary owner and operator which DHS and the State of Arizona should be interested in granting a license to. The following addition to the proposed Rule is our suggested implementation of this additional requirement: R9-17-303(B)(4)(c) "Security Plan approved by the Sheriff's Office of the County in which the proposed dispensary is to be located." This may also involve charging the applicant a \$157.00 fee for the review of its Security Plan Policies and Procedures.

CONFIRMATION IN APPLICATION THAT APPLICANT'S PROPOSED DISPENSARY AND CULTIVATION LOCATIONS COMPLY WITH MUNICIPAL OR COUNTY ZONING RULES. The local government should confirm land use entitlements. DHS Draft Rule R-17-303(B)5 currently states that before a dispensary registration certificate application will be processed the applicant himself must certify that he is in compliance with local zoning restrictions. The language should be more specific and require that the appropriate jurisdiction complete a form certifying that the applicant's location meets all of the local jurisdiction's zoning restrictions necessary to operate as a medical marijuana dispensary including if applicable a use permit and any other special requirements under that jurisdiction's land use regulations. Having the local government confirm land use entitlements will filter out some potential lottery participants who either do not understand that they do not have the proper entitlement or who would be dishonest in self reporting the same. Changes are suggested below. Rule R9-17-303(B): To apply for a dispensary registration certificate, a person shall submit to the Department the following: 5. A sworn statement signed and dated by the individual or individuals in R9-17-301 [principal officers of the dispensary] certifying A completed certification using the prescribed form signed by a representative of the appropriate jurisdiction's planning department or other equivalent authority that the dispensary is in compliance with local zoning restrictions and has received all necessary approvals and permits (i.e. Use Permits, Variances, etc.) required by the jurisdiction and is fully entitled by that jurisdiction to obtain a building permit with the intent to lawfully operate as a medical marijuana dispensary subject to the provisions of this Chapter

Rule 17-302 (A)(b) Selection between multiple applications by Lottery I believe that the proposed AZDHS rule whereby the Department will allocate Medical Marijuana Dispensaries to applicants by lottery is a big mistake, for the following reasons:

- The rules require an applicant to submit a number of items with their application. Included are a business plan, an inventory plan, a security plan and other items. The Department might receive an application from one applicant including a business plan that is thorough and persuasive concerning the likely success of the applicant's proposed operation of a dispensary. Another applicant might submit a sheet that says "Business Plan" at the top, but which contains little that is helpful or persuasive concerning the applicant's likelihood of success. Since the Department's rules contain nothing to help evaluate or rate or differentiate between the 2 submissions, each will be entitled to be submitted with an equal chance to be chosen from the lottery. (assuming some form of the other required items have been included with each application.)
- The fact that, per the proposed rule, the business plan and other required submissions will not be read, evaluated or scored renders the required submission of those documents meaningless and will inevitably lead to the choice by AZDHS in a lottery of applicants who are utterly unprepared to successfully operate.
- The Department is charging a fee of \$5,000 to file an application. Only \$1,000 would be refunded to an applicant who submitted a complete application and whose application was therefore submitted to the lottery. People have speculated that 2,000 or more applications could be filed. If 2,000 applications were submitted at \$5,000 each, the gross would be \$10,000,000. If every one of the applications were complete (unlikely), 1,875 refunds of \$1,000 each (\$1,875,000) would need to be made. The net would be a minimum of \$8,125,000. Since some of the applications would likely be incomplete and the applicant would not receive a refund, the net would probably be even more. With this large amount of funds, certainly the Department should have the resources to read, evaluate and score the applications received.
- If AZDHS awards the right to obtain a license to an obviously unqualified applicant because AZDHS has been unwilling to read, evaluate and score the applications received, even though it has received millions of dollars in application fees from applicants, it will subject itself to legal action by qualified applicants who were denied the right to obtain a license or even the opportunity to have their applications and evidence of qualifications evaluated.
- The lottery proposal encourages gaming of the system or even fraud. I have heard of groups who intend to submit 20 or more applications. A group of investors could file applications by each of the individuals in the group with an agreement that if any of them were successful, the unsuccessful individuals would be brought into partnership with the successful applicant. There could even be straw applicants submitting applications on behalf of undisclosed principals. This would increase the likelihood of participation in the system by unsavory actors who would not positively contribute to operation of the system. All of this would be incentivized by the unwillingness of the Department to read, evaluate and score the applications received.
- The people who drafted the ballot measure made a great effort to make the Arizona Medical Marijuana system subject to comprehensive and sensible regulations in order to avoid some of the "free for all" problems occurring in some of the other States that have previously allowed Medical Marijuana. Providing a system where applications and the attached submissions are read, evaluated and scored will result in the most qualified applicants being chosen for the limited number of licenses. Refusing to evaluate the applications will promote the opposite, leading to instability in the industry and problems for law enforcement the public and the Agency.
- If unqualified applicants are chosen by lottery for the right to submit the additional items necessary to receive permission to operate, and are unable to perform because they lack the resources or are incompetent, the dispensary permit could sit idle for a year until the next opportunity for the Department to receive applications. This would deny the public access to a dispensary in that area and would allow patients with cards to grow their own medical marijuana if they were more than 25 miles from the closest

other dispensary. â€¢ Awarding licenses to unqualified applicants will likely cause problems with patient services as well as unpaid bills, payroll and other taxes and other problems related to failure of dispensary businesses due to lack of qualifications of the applicants. â€¢ If the Department is unwilling to evaluate the suitability and qualifications of the applicants, it should at least require a bond or a posting of a cash deposit, to guarantee performance by a successful applicant. This should be required as a condition of submitting the initial application. I suggest a requirement that proof of a bank deposit in the amount of not less than \$150,000 be submitted with the application under R9-17-303. The applicant should be required to re-certify the cash deposit during the process of applying for approval to operate a dispensary per R9-17-304. â€¢ Some have said it is not necessary to worry about applicants without sufficient financial resources being chosen, since upon being chosen the applicant will surely be offered ample financial resources by others who have not been chosen and who want to participate. How would those new partners be then vetted, in terms of all of the requirements included in R9-17-303? â€¢ The nature of the business as well as the regulations imposed by the Statute and the Agency rules guarantee that it will be expensive to open and operate a dispensary. If a prospective applicant does not have the financial resources to be able to successfully open and operate a dispensary, he or she should get the backing of someone who does who can join in the initial application under R9-17-303. This is no different from any other business opportunity. While those without resources might complain that it is unfair to deny them the chance to receive a license, it is just as unfair to choose someone without the qualifications, competence and resources necessary to be successful, on the basis of a "game of chance" over someone who has the qualifications, competence and resources required to be successful. It is also unfair to the public who will be using the services of dispensaries to impose upon them, based on a "game of chance", prospective dispensary operators who are not likely to be competent and/or successful in providing good service to the patients. â€¢ If the State of Arizona wanted to have a low regulation industry and let the market choose the winners and losers, it could have done that. Arizona has not made that choice, though. Arizona has chosen a highly regulated system involving very limited access to licenses. The regulations imposed by the State increase the resources and competence required to operate successfully. With this type of system, the State Agency has the responsibility to do what is necessary to increase the odds that the very limited number of business opportunities will be given to those who are likely to be able to perform.

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In R9-17-318 Edible Food Products Draft rules should more fully address the security, accountability

and oversight for the medical marijuana that is being infused into food products. We have rules to address the security of the marijuana in the dispensaries, but we are lacking security, accountability and oversight at the bakeries, etc. It would be much better to keep the marijuana at the dispensary to be infused there with proper permitting if the dispensary is going to sell infused products. Dispensaries could also give people recipes that they could use or have their caregivers prepare for them. There could be a huge potential to divert the medical marijuana from the bakeries without oversight.

Why did you change the residence requirements to allow the Marijuana growers from California and Colorado to set up shop in Arizona. Do we really want our state to look like a haven for Pot Smokers and an annex of CA & CO.

1) CHAA's. The only reason these outdated zones make sense is to ELIMINATE the ability for caregivers to grow their own product by placing dispensaries within the 25 mile limit. These "zones" do NOT benefit dispensaries as they don't take into account the population of per zone and how that will effect the dispensary within that zone. Some of these CHAA's have populations of less than 10,000 people while others have 200,000. How is a dispensary going to actually stay in business with a population of 10,000 people total.... with maybe 100 or so patients with cards?!? Follow the rule of the pharmacies. 1 per every 10 is how prop 203 allocated a 124 dispensaries. If there are 57 pharmacies in Scottsdale, then there should be a minimum of 5 permits allocated for Scottsdale. 2) Make AGENTS be required to have a minimum of 1 to 2 years AZ residency. This program will be corrupted with out-of-state AGENTS "running" these businesses while using AZ Residents to act as a front during the application process. I noticed many people speaking from other states at the open forums on Tuesday and Thursday. Why would they be interested?.....because although they can't be legal owners, they WILL be running these dispensaries as agents. REQUIRE AGENT RESIDENCY!!! AZDHS has already bumped up applicants from 2 to 3 years, why not require agents to be residents for at least a year. KEEP MONEY IN AZ! 3) Why do potential owners need a actual location for their facility before approval? Why not apply for a specific area or town then, if accepted go and find a suitable location for their facility. Now you have potential owners scrambling around, trying to tie up locations with the hopes of actually getting approved. Approve the applicant first. Let them find a suitable location, then inspect and grant them final approval. 4) Get rid of the need for a medical director. Walgreens doesn't have a medical director I can call when I get a prescription for oxycontin which is way more dangerous. That's when I call my doctor who actually prescribed it. Same should go for medical marijuana which is less harmful.

Why are you requiring a doctor on staff at all dispensaries? I will not discuss my health issues with a stranger. If he wants to contact my doctor that's fine, but I will not allow a doctor I do not have a relationship with tell me what is best for me after my Doctor and I have had the same discussion and decided that Medical Marijuana is a good treatment.

1. Do away with the random lottery and implement a "GRADING" or "POINT" system. 2. Mandate BIOMETRICS and DATABASE that can be easily synched into the AZDHS's database providing REAL TIME data/transactions/monitoring.

I object to the requirement that I have to give up my association with my doctor and start going to a

doctor associated with a dispensary. What happens if the quality of health care is not to my satisfaction. I have been going to the same doctor for seven years. After the dispensary doctor reads seven years of medical history what happens to me if he doesn't agree with my doctor.

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By elimination of the pot doc and having the AZ DHS control this industry.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

R9-17-318. Edible Food Products There need to be a lot more controls and oversight of the subcontractor food establishments. There is good control of the marijuana product at the dispensary, but no discernible oversight at the food establishments. Will they be inspected for records of product received, product used, etc., or some standards about reducing theft and loss? The best way to deal with this is to only allow the dispensary to make the marijuana infused food product.

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Get rid of the random choosing process for dispensaries. Have a grading process to choose based off the overall business plan & security. Also let the town or city have a voice in the process to choose who they want. Allow other materials to be used in fencing the outdoor cultivation of medical marijuana. Allow chain link with the privacy material, & barbed wire on the top. The current materials are outrageous & treats the Medicine as something it's not. Allow greenhouses to be used for outdoor cultivation. Do not discriminate against doctors that recommend Medical marijuana.

Requiring dispensaries to have an MD serve as medical director is ludicrous. This is unreasonable as a doctor already interacted with respective patients. In addition, it places undue financial burden on prospective dispensary operators. If DHS must have a medical professional affiliated with dispensaries, an RN would provide a happy medium. This person should only be required to advise and should not have to work on-site as an employee.

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MM for whom? I have worked with people that have disabilities for over twenty years and the

passage of prop 203, the Medical Marijuana act was such a welcome relief to me and many of my clients. No more would honest law abiding citizens have to choose between relieving their ailments and breaking the law, no more would they have to worry about being arrested and doing jail time. We had such great hopes when prop 203 passed, however, most of my clients who this law was intended for are not going to benefit. The \$160.00 registration fee for a MM card prohibits most people with disabilities, who exist on an average of \$750.00 per month Social Security benefits, from legal relief. The price of MM at \$400.00 per ounce prohibits most people on Social Security benefits from being able to purchase from dispensaries. Unable to afford dispensary prices, MM Patients will be risking arrest if they grow MM for their own consumption and live closer that 25 miles from a dispensary. A caregiver would also only be able to cultivate MM 25 miles from a dispensary. I am proposing that services for low income MM Patients be instituted, by providing product on a sliding fee basis, as well as lifting distance restrictions for MM patients and allowing them to cultivate 12 plants for their own consumption in their home, under restricted conditions. Distance restrictions would also be lifted for the cultivation of MM by Caretakers. It is my hope that programs to assist low income MM patients to access MM become a reality. Obtaining the benefits of MM should be available to all intended individuals and not to only a chosen few.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year. I am terribly concerned about the DUI rules. I think they MUST be clarified. Will our police officers, bus drivers, and emergency workers be allowed to go to work with marijuana highs?

let Doctors determine(practice medicine) who and how many pain patients they can prescribe to.

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per year
How would a patient that lives in both Colorado and Arizona be able to transfer their medical marijuana card to use in both states?
You should allow prescription records as sufficient enough as to the length of time that the people should not need to see a PCP one-on-one for a year (they all are to afraid to recommend it). This entire rule should totally revised.
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
I read the first set of draft rules and I am a little confussed. Did sentences with lines going thru them mean they were scratched? Particularly about a years on going relationship with a doctor?
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
A "doctor" should not be able to have more than 30 medical marijuana patients in a year and any increase in this rule must be approved by AZ DHS.
Remove any cost to the patient for the ID card. If there is a charge, it should be about \$25 the cost of any other license. The patient Doctor Relationship definition is not in the new law and should be removed. Remove medical director or pharmacist requirements, as they are not in the new law. Remove CHAA and let the city's zoning determine where the dispensaries are. Allocate one to each CHAA and then allow the most qualified based upon evaluation of facilities and business plan to succeed.
I believe they also need to include PTSD as a chronic medical condition.
The 70/30 clause needs to be added back in, why would this be removed in the first place?
Add Migraine headaches to the approved medical conditions list.
Take out the time restriction for the residency requirements. This is the 2nd most poverty stricken state in the country. Most people who have lived in Arizona for longer than 3 years are struggling. If they are chosen to open a dispensary they will have a difficult time getting the funds together to start one up. You will have a lot of dispensary owners slipping through the cracks without financing. You need to put in place a better structure that will allow residents to own these dispensaries but allow investors the freedom to become part of the business structure. Take out section B in R9-17-301 that restricts everyone in that section to being a principal officer.
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.

Add wording to exclude common areas of planned communities for using medical marijuana. In these common areas, the marijuana could more readily be given to those who do not require the marijuana. Getting to the common areas often requires arriving by some mode of transportation. If people have consumed the marijuana, they may be impaired while driving and endanger other residents.

carefully label the marijuana -- what can it be medically used for...ie; use for chronic pain, sleep disorders etc

consider adding physician assistants and nurse practitioners recommending marijuana

be very specific about the illnesses treated limit the number of prescriptions a doctor can prescribe per month limit the number of patients that can be treated by each doctor per month

First off, I have heard that those who are awarded Med. Marijuana cards will have to see the Dr's 4 times a year. What if you are permanently disabled? This measure only adds to the cost of being legally able to use Med. Marijuana, as who knows what the cost will be to see them, the charge of seeing the Dr. is averaged at \$150.00, then there's the licence itself at \$150.00, now figure in the additional Dr.s visit{4} and now you have a very expensive licencing procedure, not to mention the renewal fee every year. The initial start up fee's are very high, and in many cases cost prohibitive for those on permanent Disability and on fixed incomes. And then there's the price of the Med. Marijuana, anywhere from \$20 per gram and up. That would mean to have just 1 ounce of the proposed 2 1/2 oz every 2 weeks allowed would cost \$560, and I believe, 1 1/2 ounce every 2 weeks is more realistic. This program is destined for the rich, as no insurance is going to help. As I have mentioned in the past. The state could easily open their own dispensaries with all the illegal confiscated pot. Although not all would qualify, at least 10% could be used for this purpose, run by the state, and when, or if taxed, which I believe it should be, so that the State could benefit from the sales, it's a win, win situation for the State as the Pot would not cost them anything, and the Pot could become much more affordable. There's no reason why there can't be the \$100.00 per ounce brand. Please, don't make it monetarily unaffordable for those who will have a hard time getting this program integrated to help. I believe you have to look through the patients eyes first, before you set the rules in stone. [REDACTED]

I think the (quasi)-criminalization and the extreme difference in treatment, for persons seeking marijuana treatment is paramount to gestapo tactics. Why should patients seeking medical care be treated differently than person receiving other medical treatments involving narcotics, which on the whole are more accessible; and infinitely more dangerous (i.e., Demerol, delatidid, morphine, percodan(cets), vicodin, benzodiazpines, etc ...) or any of the other powerfully addictive and life threatening medications, for that matter? Why should patients lose their anonymity and relinquish their privacy rights under HIPPA to get medications to relieve suffering (i.e., photos plus info accessible to various agency including law enforcement)? That seems utterly ridiculous and a set up for a law suit alleging discrimination and violations of federal health laws. I think these people should be treated with dignity and respect! And given the same access to care and medications as any

other persons seeking medical care. And, if that faith walk begins to break apart or show signs of abuse THEN change the procedures and policies. But to preemptedly treat Arizona citizens like criminals -right out of the gate, I think, is outrageously absurd and hinges on a plethora of illegalities, possible law suits and the embarrassment of our State's Health Department and policy makers. Thank you for your time.

NO YAX MEDICATION IS NOT TAXED. IF YOUR GOING TO TAX THIS YOU HAVE TO TAX ALL MEDICATION. MOST PEOPLE WHO ARE IN CRONIC PAIN LIVE BELOW FEDERAL POVERETY STANDARDS. WE DON'T HAVE ENOUGH MONEY TO PAY BILLS NOW.WE DIDN'T ASK TO GET DISABLED.

I am concerned about several issues relating to dispensaries. 1. I do not like the CHAA's as they now stand to allocate dispensaries. I understand that they were existing divisions in the department that serve to cover the state geographically, but the divisions do not relate well to population, and quite a few (like Sun City, Sun City West, Salt River) are a waste. Others have irrational geographic boundaries for this purpose, like the Cottonwood CHAA which covers the Verde Valley cities of Cottonwood and Camp Verde but then extends into Sedona city limits and over the mountains to Prescott Valley! Divisions in and around Flagstaff and Prescott are also chopped up. Perhaps they could be fine tuned to better represent population distribution. The states population divided by 124 dispensaries equals about 53,000. Perhaps a better attempt could be made to modify the CHAA map to come closer to this figure. 2. I understand the departments reluctance about entering a subjective competition in selecting dispensary licensees, but a pure lottery will do a disservice to the industry and the residents of AZ by ignoring the best qualified applicants. Perhaps a compromise that would not overwhelm the department's resources would be to establish additional minimum standards for application to raise the bar. Minimum standards could include proof of minimum cash to open and get a dispensary running until such time as it might be expected to carry itself, minimum standards for security and computerization (clearly spelled out so applicants know how to meet them), prior business experience, and some sort of plan to give back to the community (although that gets rather subjective).

The medical director must go. No where in any pharmacy requires there to be a doctor on staff. As you heard in the public comment. I would be ok if there was literature there to show the patients with medical strain helps most with their current ailment. That should be good enough. r9-17-303 A statement in a department format that dispensaries have to post 25% revenue into local chariteies believe in the Dispensary application there should be at least 15-25% revenue going into local charities. These Dispensaries here are trying to make a lot of money off of the patients. My only issue with this is that they have to be a NON-PROFIT organization. R9-17-101 21 viii Where smoking is allowed as long as it is 500 feet away from any school, church, or learning institution. If we can't have smoking we must be able to use edibles or vapor. Patients are not always at home, some have jobs that keep them away from their private residence for more then 8 hours at a time. They will need to medicate, under this current draft the patients will suffer. And that was not the purpose of the Arizona Medical Marijuana act

With regards to the addition of debilitating medical conditions - 36-2801.01. The regards to R9-17-

106 A 7, this provides a "Catch-22" because peer reviewed research is so limited because of Federal law. Please take the cries of our veterans into account and allow for a method so that PTSD could actually be effectively petitioned and added to the list of eligible conditions.

With regards to the designated caregiver (R9-17-202 F 6) My mother, who is in her 70's, suffers from diabetic neuropathies, glaucoma, asthma, and Alzheimer's. Much to my surprise and relief, she would like to try medical marijuana. Her current medication regime is a balance between leaving her in constant pain or being, as she says "doped up." Since I have returned to Arizona to help with her care I have take great effort to build a health care team for her of very highly qualified and trained health care practitioners. I would hope to be able to offer her no less with regards to her consumption of medical marijuana. 1. Please require any designated caregiver to have attended a training regarding benefits, but also risks and potential side effects of medical marijuana. Please also make sure this training includes specific training on methods of ingestion and how to use equipment associated with those forms, such as vaporizers. 2. Please make sure that my mother's current health care-givers are allowed the opportunity to provide this service for her. Any time we have to introduce a new person into her care team, it is difficult and strenuous for her. She trusts her current care providers, from her doctors to her nurses to the hospice aides who help with her cleansing and grooming. Alzheimer's and the needs of geriatric patients are specifically addressed in the law. Please make sure you take their genuine medical needs into account in the rules.

With regards to the CHAAs: I appreciate and support the geographic distribution of the CHAAs to limit the amount of medical marijuana being grown outside of strict quality and medicinal controls. The current way these were determined, however, is inappropriate and laden with the potential for unintended consequences. These problems could legitimately put the Department at risk for litigation. 1. Data determining the CHAA is reportedly from 1998. The use of data that is not the most current available in the public health records is inappropriate and misleading. This can easily be corrected by utilizing the most recent public health records. 2. CHAAs are based solely on cancer statistics. This is clearly inappropriate as the law refers to 9 categories of debilitating medical condition, and again leaves the department at risk for legal challenge by not incorporating the conditions of the law into the rule-making. This is again easily remedied by mapping the CHAAs according to current public health records for each of the medical conditions. (It is a relatively simple matter to program a GIS to maximally balance eligible patient population while considering the lowest number of potential patients not within a 25 mile radius.) 3. Those who propose that CHAAs reflect general population are not accounting for the fact that this is a law referring to medical distribution for patient populations. The appropriate metric is patient population, not general population. 4. The utilization of current data examining all eligible medical conditions may well better equate patient populations within each individual CHAA. 5. If the Department chooses not to use GIS with current public health records, an alternative mapping that would likely also be appropriate would be to create CHAAs representing the footprint of 10 pharmacies, again referring back to the enabling law. As each pharmacy constitutes a viable business, this approach would certainly help to equate population disparities within the current CHAA system. 6. A CHAA that does not have a large enough patient population will create a dispensary that will not truly be able to meet the medical needs of qualifying patients, again putting the Department at risk for litigation. Current state-of-the-art cultivation of medical marijuana produces specific medicines (ratios of active ingredients) for optimizing medical benefit for specific conditions. A dispensary in a CHAA that does not have a sustaining patient

population will be forced to not provide a full range of medicinal strains or will face challenges with freshness and, therefore, potency (medicinal efficacy). 7. By average usage standards of other States, a CHAA with a general population of 100,000 persons may well have a patient population of 5,000 for a single dispensary. Not only does this have a serious implication for the impact on the community, the sheer volume within what would likely be a size limited facility may well seriously impair the capacity to offer high quality medical care and consultation, leading to a California style "pot shop" as compared to a genuine health care facility. The logistics involved in supplying this size of a dispensary is also highly problematic.

I believe that the 25 mile rule, for growing medical marijuana, should be eliminated. The prices that will be charged at a Dispensary will be higher than most low income patients will be able to afford. These patients will be penalized for something that is beyond their control.

My main complaint with this draft is the 25 mile rule for cultivation. I strongly feel that a registered patient should have their own right to cultivate their own medicine with reasonable limitations if they do not wish to use a dispensary to acquire their medical marijuana medicine for their own medication usage. From a personal experience that happened to me for the very first time a few weeks ago where I was self-medicating and I had the unfortunate experience of having a seizure for the very first time in my entire life. After spending 4 days in the hospital, a social worker came to me and asked directly why I was using PCP and I replied that I have no desire to do any PCP or have looked for that substance in my life because I already know how dangerous it is to ingest PCP. Social worker explained to me that the PCP was still in my system after 4 days in the hospital and it showed up on one of my blood tests that the hospital tested during my stay at the hospital. I was in a state of shock when I learned that fact which made me to think very seriously how it could have possibly gotten into my system and only conclusion I came to is that one of my medical marijuana medication from the state of California was laced with PCP which is exactly why I want the legal right and this prop 203 draft to be revised to allow medical patients to have their own right to grow their own medicine if they chose to within reasonable limits which can be determined at later date. If I had that right then I would know exactly what is in my medicine when I ingest it once it is ready to be ingested. Also the patient should have the right to choose which specific strains that relieves their medical conditions better than other certain strains which might be better match for different types of medical conditions that might not fit to the condition that a patient has and the dispensary might not have in their own stock at the time of medical need. Which I have personally seen many times in state of California where dispensaries would only carry specific stock to produce the most profit as possible and not focusing on the true medical needs of the patient whereas a different strains from other areas of this planet would help to alleviate their medical conditions hence the registered patient should have the legal right to grow their own medicine!

I believe the "25 mile rule" should be rescinded, and allow any qualified patients to grow cannabis for medicinal purposes for themselves. They wouldn't have to drive 50 miles round trip for their medicine, or be at the mercy of possibly price gouging merchants. I also believe the privacy of patients and caregivers should be PARAMOUNT in this law. Rules to protect the patients and caregivers from state and federal government agencies, in case the federal and state go back on what they have pledged. If state health officials or the DEA decide they think they know better and decide to go after these patients after they have registered, they should NOT be allowed to use patients and caregivers records against them. I can just see Will Humble and the DEA getting together, going through the records and getting addresses and turning them over to the feds so they know right

where to go to pick up the patient/caregiver. Mr. Humble has fought tooth and nail against this proposition since before it was passed, and is annoyed by the "distraction" of having to carry out his duty. He should be replaced by someone who is less "distracted" and honored to obey the will of the people and put this law into place.

Marijuana is classified as a drug. It should be grown by the states Universities so it can be studied and maybe improved. When I am prescribed a regulated drug I go to a licensed pharmacy not to a head shop run by a bunch of get rich quick amateurs.

We are thinking that the responsibilities that have been delegated to the physicians take care of the responsibilities of the medical director. We understand the need to for oversight but there seems to be a lot of duplication of efforts and it's very inefficient.

Why do the rules say a room must be four sided? We cannot grow in a five sided room? This is legislating simply to legislate. Also a four sided room is less effecient for wattage and lumen ussage than is a room shaped like an arc or at least an 8 sided room

Eliminate or soften some of the numerous and excessive requirements for dispensaries. This is driving the cost up which will be passed along to the patients and possibly making dispensary marijuana too expensive. This will drive people to blackmarket sources or have to do without medical marijuana.

Prop. 203, as it was passed by the voters, expressly based the number of dispensary licenses to be awarded on the number of retail pharmacies in the State. Recently, the total for the State was 1,249, which, if rounded up would result in 125 dispensaries. Prop. 203 does not expressly state how the dispensaries are to be distributed throughout the State of Arizona. There are two obvious methods that could be used. One would be to distribute them among Arizona's 15 Counties according to the number of pharmacies in each county. After all, Prop. 203 based the total for the state on the number of pharmacies statewide. The other method would be to distribute the dispensaries throughout the 15 counties according to the per-capita population of each county compared to the total for the state. Using either the pharmacy method or the population per county method would have similar results. Although urban areas have more pharmacies per capita than rural areas, the differences are not so great as to make the distribution result significantly different based on the method chosen. In general, using numbers of pharmacies per county slightly increases the number of dispensaries in large urban areas and using population per county slightly decreases the share of the large urban areas and transfers a few of the dispensaries to smaller population counties. In the 2d set of Agency rules distributed by AZDHS on January 31, 2011, they have come up with a different method of distributing the dispensaries. They have used AZDHS's Community Health Analysis Areas (CHAA) and have decided to locate one dispensary in each one of them. There are 126 of these CHAA zones. 19 of them are located throughout the State on Indian Reservations Although I have not

seen it in print, I have heard that possibly all of the 19 tribes may allow the State to refrain from locating a dispensary in their lands. I believe that AZDHS is counting on this. The reason I believe this is that in his January 28 posting to his blog, Director Humble stated that individual CHAA districts in Arizona include as few as 5,000 residents and as many as 190,000 residents. If you take into account Indian Reservation CHAA districts, there are 6 districts with fewer than 1,000 residents and 11 with fewer than 5,000 residents. On this basis, I am assuming that AZDHS does not plan to distribute dispensaries to the 19 Indian Reservation CHAA districts. AZDHS has not said whether it intends to distribute 19 additional dispensaries among the non-Indian Reservation CHAA zones in order to bring the total back up to 126. They will likely be required to do something to make up the difference between 107 and at least 125, since Prop 203. specifies that at least 1 dispensary license will be distributed for each 10 pharmacies. Since there are 1,249 pharmacies, AZDHS should be required to distribute at least 125 licenses. To view the CHAAs go to the Medical Marijuana Dispensary CHAA Map. You can zoom in and out or enter an address to determine the CHAA in which the address is located. If you click on a CHAA, the map will display the name of the CHAA, its ID number, 2000 population and 2010 population. Using the CHAA districts as the basis for distribution of the dispensaries throughout the State will result in a radical redistribution of dispensaries from urban areas to rural areas. I have learned, from the AZDHS website, the 2010 population totals for each of the 107 non Indian Reservation CHAA zones. The smallest is Ajo, in far West Pima County which had 4,290 residents. The largest is Maryvale in Phoenix which had 224,678 residents. I divided the CHAAs into two groups. The first is the 54 CHAAs with the smallest 2010 population totals. The second group is the 53 CHAAs with the largest 2010 population totals. Here is some information comparing those two groups. The 54 smallest CHAAs have a total of 1,165,676 residents. They average 21,587 residents per CHAA. Their total population represents 18% of Arizona's total non-Indian Reservation population of 6,535,445. The 53 largest CHAAs have a total of 5,335,808 residents. They average 100,808 residents per CHAA. Their total population represents 82% of Arizona's total non-Indian Reservation population. Under the AZDHS proposal group 1, representing 18% of Arizona's population will receive 54 dispensaries. Group 2, representing 82% of Arizona's population will receive 53 dispensaries. I have also looked at how dispensaries would be distributed among Arizona's 15 counties based on number of pharmacies per county, per capita population per county and distribution by CHAA. As mentioned above, by pharmacy total Maricopa County would receive 80 dispensaries. By per capita population it would receive 75. Since there are 41 CHAAs in Maricopa County, per the AZDHS proposal, Maricopa County would receive 41 dispensaries. Although Maricopa County has 64 % of the State's pharmacies and 60 percent of the population, it would only receive 38% of the 107 non-Indian Reservation dispensaries. Pima County receives a similar percentage of the number of dispensaries whether they are distributed by number of pharmacies, per capita population or by CHAA. The difference between the 80 dispensaries out of 125 that Maricopa County would receive by pharmacy total and the 41 of 107 it would receive according to CHAAs would be distributed to the smaller and more rural Counties. Here are some facts concerning the population totals that would be served by Maricopa County's 41 dispensaries and those of smaller rural Counties. Maricopa County's 41 dispensaries would each serve, on average, 98,130 residents. La Paz County is the 2d smallest population County in Arizona. Its population is 21,616. It was one of the Counties that, per Prop 203 was guaranteed at least one dispensary even though it would not receive one if it were determined by number of pharmacies or by population. Since La Paz County has 2 CHAAs, it would now receive 2 dispensaries which would each serve 10,808 residents. Cochise County has a population of 140,623. If dispensaries were distributed by number of pharmacies (23), it would receive 2. If they were distributed by population, they would receive 3. Cochise County has 6 CHAAs and will receive 6 dispensaries per the AZDHS proposal. These dispensaries, would, on the

average, serve 23,377 residents, compared to the Maricopa County average of 98,130 residents. By virtue of distribution by CHAA, Santa Cruz County, Gila County, Navajo County and Coconino Counties would each gain dispensaries compared to the distribution by number of pharmacies or population. In each of these Counties, less than 30,000 residents, on average, would be served by the dispensaries the County would receive according to CHAAs. AZDHS could make up the difference between the 107 non-Indian Reservation CHAAs and the 125 dispensaries required by Prop. 203 by distributing 18 or so additional dispensary licenses. The most logical way to do this would be to assign an additional license to each of the 18 highest population CHAAs, so that each of the 18 largest CHAAs would have 2 dispensaries instead of 1. 16 of these additional dispensaries would go to Maricopa County and 2 would go to Pima County. This would reduce to some extent the radical disparity between the treatment of urban and rural areas. The disparity would still be large. If Maricopa County received 57 dispensaries out of 125 as opposed to 41 out of 107, its share of dispensaries would increase to 46% from 38%. This compares to Maricopa County's 60% share of Arizona's population. This would not alleviate the problems AZDHS will be creating by insisting that every tiny population CHAA receive a dispensary license. These problems are discussed in detail below. According to AZDHS figures, Arizona has 6,535,445 non-Indian Reservation residents. Dividing this total by the 125 dispensaries mandated by Prop. 203 would result in an average of approximately 52,000 residents per dispensary. Close to this average would result whether the dispensaries were distributed by numbers of pharmacies or by per-capita population per County. Distributing the dispensaries by the AZDHS CHAA proposal radically revises the distribution so that dispensaries in rural areas will serve far fewer residents than those in urban areas. In my opinion the AZDHS proposal is a clear and blatant violation of the Arizona Voter Protection Act and the provisions of Prop. 203. The fact that Prop. 203 provided that the total dispensaries in the State would be determined by a 1 to 10 ratio clearly implies that distribution of dispensaries throughout the State should be done by the same method. As mentioned above, distribution by per-capita population would yield similar results, with just a few dispensaries being transferred from Maricopa and Pima Counties to several smaller rural Counties. Prop. 203 implied that distribution should be based on number of pharmacies. Moreover, it dealt specifically with the situation where a small population County might not be entitled to a dispensary because it has few pharmacies. It provided that each County, no matter how small, would be entitled to no less than one dispensary if there were a qualified applicant. Prop. 203 provided that the State total of dispensaries could be increased above the number specified in the law, if necessary to provide at least one to each County. Distributing dispensaries by CHAA flies in the face of the clear language of Prop. 203. If litigation were filed, the CHAA distribution would probably be struck down by a Court, since it flies in the face of the language of Prop. 203 and its effects are so clearly unjust. It is obvious that the reason AZDHS decided to distribute dispensaries per CHAA is that it will spread the dispensaries out throughout the entire State and increase the percentage of Arizona's land that will be covered by "grow your own exclusion zones" of 25 mile radius which will exist around each dispensary. I can understand how many could consider this to be a worthy goal. Even if the goal is worthy, it does not justify such a radical perversion of the intent of Prop. 203. I can see several specific negative consequences of distribution of dispensaries by CHAA. Since the urban areas will have dispensaries serving very large populations, those dispensaries will become very large operations. This could be difficult in light of the fact that many if not most Cities and Counties are putting square footage limitations on dispensaries. Of the 20 smallest CHAAs, 13 have 2010 populations of less than 10,000. All of the smallest 20 CHAAs have 2010 populations less than 15,000. Some have only the smallest of towns or settlements and may not have commercial suitable space available for a dispensary. Many of these CHAAs are very large geographically with their population densities being extremely low. In many cases, because of the very small populations and very low

population densities, these low population CHAAs may not be able to support the operation of a dispensary. Many of these dispensaries could fail and go out of business. As they were in the process of going out of business, numerous problems involving patient services, defaulting on financial obligations and others could arise. Having dispensaries go out of business would decrease the stability of the industry and create additional problems for AZDHS to have to deal with. Presumably if a small population CHAA went out of business, the "grow your own exclusion zone" would go away and the original motive of those proposing distribution by CHAA would be frustrated. The CHAA proposal is not necessary. There are better ways to distribute dispensaries in a way that would not create such radical distortions. Gila County is a good example. It would receive only one dispensary whether they are distributed by number of pharmacies or by population. Gila County's population is divided, more or less evenly, between Payson in the North and Globe in the South. The road between the 2 towns is over 80 miles. They have a legitimate desire to have a "grow your own exclusion zone" surrounding both towns. Here is a way to solve the problem without creating all of the problems involved with the CHAA rule. AZDHS could write a rule that would allow a County, such as Gila County, to request, based on its particular circumstances, that it have its one dispensary operate out of 2 locations, one in Payson and the other in Globe. It could qualify as one dispensary rather than 2 by operating out of the 2 locations on alternate days and never being both open at the same time. AZDHS would impose a "25 mile radius grow your own exclusion zone" around each location of the one dispensary. Although the dispensary would have increased costs maintaining 2 operating locations, it would be able to share other costs like wages between the 2 locations. A single dispensary operating out of 2 separate limited hours locations would be more likely to survive financially than 2 separately owned dispensaries with larger operating costs. Other rural Counties with large distances separating their population centers could benefit by such a rule. This would satisfy the goal of reducing the area where self cultivation is allowed while avoiding the instability involved with trying to force people to operate dispensaries in locations that are not viable. There will inevitably remain some locations that will not have dispensary locations even with the suggested rule. Even the CHAA rule does not completely eliminate areas where card holders could grow their own. These areas have very low population density and the number of card holders living in them would likely be quite small. It seems unlikely that many cardholders would move to one of these unprotected locations just so they could grow their own medical marijuana.

argument and suggestion: A single cultivation site would be hard pressed to fill the continuous supply needs of a dispensary. With a single cultivation site struggling to meet the inventory demands of the dispensary there will be little or no room to worry about the quality of the product, only the quantity. The crop will probably be limited to one or two strains that are the fastest and easiest to grow. This would leave the patient with a generic medication when a different strain may be more effective at treating the condition that they suffer from. Limiting the operation of the cultivation sites only to the same people that also operate the dispensaries does not only limit the quality of the medicine, but it very well may also increase the cost of it. With little to no competition a single dispensary/cultivation site operator will be able to set almost any price that they want. The only alternative that the patient will have to this is the illegal black market. Independent cultivation sites on the other hand would have to compete with each other for the business of the limited number of dispensaries. The cultivation sites would need to differentiate themselves by offering a higher quality product, more variety of strains, and better prices. All of this would benefit the patient. Allowing additional independent cultivation sites will not result in an increased exposure to medical marijuana for the general public, only a better, less expensive medication. Strict rules have already been defined in regards to the security and inventory controls for cultivation sites in the latest draft rules. A

cultivation sites' interactions will be restricted to dispensaries and other cultivation sites, limiting the general public's access to medical marijuana to the number of dispensaries. Additional cultivation sites will also mean additional revenue for the state. More cultivation sites will mean more people employed in the industry which will bring in more payroll taxes to the state. Each cultivation site will need to buy equipment and supplies which will generate more sales taxes for the state. Since this industry does not exist yet I cannot present the above as fact, only as my opinion, but it is historical fact that increased competition has always benefited the customer (who in this case is a person with a serious illness or condition whose medication is not covered by insurance). With the need to limit the number of dispensaries competition must be driven by the cultivation sites. Therefore I do not believe the state should place a limit on the number cultivation sites. Any number limiting cultivation sites picked by an individual would simply be a guess and may still have the effect of limiting competition (lower quality and raising price). The market will determine the correct number. The cultivation sites that offer an inferior product or one that is too high in price will have to make a correction or go out of business when no one buys from them. The draft rules state that if an applicant is not allocated a dispensary registration certificate that they will be issued a partial refund. I would suggest that if you decide to allow additional independent cultivation sites, instead of offering a partial refund to those who have submitted a complete application but are not allocated a dispensary registration that they are offered approval to operate a cultivation site. During the Tucson meeting held Wednesday many expressed a strong dislike for what they called a lottery where only a few would receive the golden ticket. While only a few would still receive the dispensary registration certificate, everyone that has displayed such passion for this industry would be able to participate in it and succeed or fail based upon their efforts and not the random decision of the state. Page 35 of the 1/31/2011 Draft Rules R9-17-302: F. If the Department does not allocate a dispensary registration certificate to an applicant that had submitted a dispensary registration certificate application that the Department determined was complete and in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall return \$1,000 of the application fee to the applicant. Thank you for your time and consideration, [REDACTED]

More respect and latitude for caregivers. Caregivers are the counterbalance, the threat, the sobering influence that will keep prices down and quality up. I plan to pursue a dispensary licence, however, I understand the value of competition for me and other dispensaries. Quality, service, and product availability, are a must for patients. A better caregiver bill of rights would keep prices under \$250 ounce, maybe under \$200. I understand the 203 dictates the 25 band, which is really a 50 mile halo - ouch. It is a very suspicious thing to be in the prop.

You have absolutely no right to use the CHAAs to spread the dispensaries around. People should be able to open one wherever the zoning allows. By the way, the zoning regulations adopted by most towns and cities are unreasonable to begin with, and you want to place more hurdles every time! You are usurping authority denied to you by the law. Caregivers are legal and can grow and should be able to. Why do you want every one to have to buy from what will become dispensaries with grows with thousands of plants? Are you afraid something bad will happen if a caregiver can grow for a few patients? It's not like they won't have full fingerprints and background checks.

The Fact that you require a patient to purchase medical marijuana from a dispensary if they live within a 25 mile radius is wrong. A patient should be able to grow himself no matter what their proximity to

a dispensary. If i grow better medicine, why am i forced to buy it from someone else???!!!!!!!

R9-17-316. 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: 3. The following statement "ARIZONA DEPARTMENT OF HEALTH SERVICES' WARNING: Smoking marijuana can cause addiction, cancer, heart attack, or lung infection and can impair one's ability to drive a motor vehicle or operate heavy machinery"; Lies, lies, and more lies. There are many studies proving the opposite.

f. A list of all chemical additives, including non-organic pesticides, herbicides, and fertilizers used in the cultivation; (fertilizers are not 'chemical additives.')

R9-17-312. Medical Director This has no authorization in prop 203. You must remove it. There's no reason why you should not ask dispensaries to have and hand out information pertaining to mmj. That part's mostly OK, but to have to have a doctor on staff or available and on contract I think will add significantly to the costs and therefore the price of medication. You'll end up with even higher than black market prices. ===== Stuff you think the MD should train the DAs for: c. Recognizing signs and symptoms for substance abuse; and (because we all know that 'potheads' need 'help' d. Guidelines for refusing to provide medical marijuana to an individual who appears to be impaired or abusing medical marijuana; and (because we all know how those 'potheads' can't walk straight after a couple bong hits.) ===== D. A medical director shall provide oversight for the development and dissemination of: 1. Educational materials for qualifying patients and designated caregivers that include: a. Alternative medical options for the qualifying patient's debilitating medical condition; (why, does the pharmacist council you on other options than what your doctor recommended? This is the alternative!) b. Information about possible side effects of and contraindications for medical marijuana (That's for the patient's doctor with the physician patient relationship to discuss) including possible impairment with use and operation of a motor vehicle (there have been many studies showing marijuana does not cause impairment in driving {it's not like when you guys get drunk}) or heavy machinery, when caring for children (this is an outrageous, how dare you try to say that a patient somehow endangers their child because of his medical marijuana use. I bet you don't require such for people being prescribed assorted nasties like opiates like hydrocodone or all the restoril and flexoril {that do actually impair you}that's being pushed by the doctors and pharmaciers out there), or of job performance ( never saw this, all the people I know who smoke pot work and are good at what they do.); c. Guidelines for notifying the physician who provided the written certification for medical marijuana if side effects or contraindications occur; d. A description of the potential for differing strengths of medical marijuana strains and products; e. Information about potential drug-drug interactions, including interactions with alcohol, prescription drugs, non-prescription drugs, and supplements; f. Techniques for the use of medical marijuana and marijuana paraphernalia; g. Information about different methods, forms, and routes of medical marijuana administration; h. Signs and symptoms of substance abuse, including tolerance, dependency, and withdrawal; and(There is no withdrawal when you discontinue the use of marijuana. You may crave it and want it, but there are no physical withdrawals at all, and there's no problem with dependency because it's OK to use it regularly) i. A listing of substance abuse programs and referral information; (This is ridiculous. Users of marijuana do not 'need help.'

Please make costs low for the patient by (1) keeping dispensary costs down (2) keep application fees down (3) don't require a doctor for a dispensary (4) keep delivery costs down. Thanks. The patient should always come first.

17-302 D.1.b. I would certainly hope that the health depts random selection for CHAA cell winners mirrors something like the state lottery as anything less points to a rigged system of payoff, kickback and favoritism which if you talk to long time Arizonians is the way the state is ran anyway. Why change the system? It is well demonstrated by now that the AZ Dept of Health has been heavily influenced by sectors of the population that have much to benefit and little to loose. Also why are cells with no competitors given a 60 day priority head start to production capability over cells that have competing applicants. The 60 evaluation period before granting licensing is unwarranted and unnecessary under a truly random selection process that could be held the next day. 17-306 A. The 3 year time frame is unreasonable and burdensome for the applicant. There are way to many scenarios that would cause the need to move the business, fire, breakins, neighborhood troubles, landlords, and any number of other factors. Zoning has made guidelines for dispensary and cultivation placement, what happens when you have a separate dispensary from your cultivation site and you have made the operator designate a grow location (located in another cell) on the application but then the winner of the CHAA cell is too close to your grow location. You must allow for alternate selections. It also seems to be unreasonable that the license & business cannot be transferred to a qualifying individual. I can imagine very legitimate reasons why a person may want to rid himself of his investment especially viewing this mess of regulation that is being proposed. I can easily see this being the first challenge of many many legal challenges that the state will face because of your actions. 17-304 D. Medical directors are a totally unnecessary part of this equation. The patient is already under a doctors care. Who can be a medical director and what credentials does that person need? Seems this is simply another unnecessary burden to load on the shoulders of business owner in the hopes of causing as many companies as possible to fail and to favor certain participants who have built in self serving interest.

I planned to speak this am but the line was too long and i had to get back to work... Good morning. My name is \*\*\*\*\*. I stand before you today as a person who has suffered with Crohn's Disease for the past 22 years, and as a disenchanted former prospective dispensary owner. DHS's over-reaching and arbitrary attempt to regulate and stifle the medical cannabis industry in Arizona is appalling, and is doing nothing but harming the people this law was passed to help- the patients. DHS and its director Will Humble have not proved to be fair nor impartial arbiters during this implementation. The department's role is to educate the public and to implement this program fairly, safely, and for the utmost benefit of the patients in need. DHS has been severely lacking in its duties. Through both statements in the media and postings on his blog, Mr. Humble continues to perpetuate the negative image of medicinal cannabis and shows the true biased feelings of the dept. and its director. Posting topics such as "Marijuana Use and Earlier Onset of Psychosis" without posting topics that show medicinal cannabis in a positive light is not fair, nor do I believe in the best interest of the public or the department's stated mission. You should be ashamed of yourself Mr. Humble. As a patient I find the department's attempt to regulate the doctor/patient relationship absurd, probably illegal and definitely dangerous. Dealing with a lifelong chronic medical condition often requires a team of doctors- a primary care physician to handle normal day to day medical issues, a specialist to manage the chronic condition, maybe a pain specialist- you get the picture! I wouldn't trust my primary care physician, pain specialist nor any doctor other than my gastroenterologist to manage my Crohn's Disease yet through your regulations you are attempting

to force me to see a specific, unqualified doctor to oversee my care? You are setting a dangerous precedent. There is no way a doctor recommending medical cannabis is going to assume responsibility for providing management and routine care of a qualifying debilitating medical condition nor should they be forced to. This regulation needs to be removed immediately. If you want to regulate anything make sure that the quality and purity of the medicinal cannabis in the system is of the highest degree. Ensure patients have consistent, safe access to their medication and stop regulating this industry to the lowest common denominator. There will always be people who attempt to abuse the system. Stop concentrating on them and focus your efforts on compassionately addressing the patients' needs. Everything else will fall into place. You guys have stirred up a hornet's nest of anger and determination within me and many others through your lack of attention to the patients and your overwhelming desire to stifle the industry, keep the little guy out of the picture and satisfy the big money interests who wrote the law. In the coming weeks, months and years, I'm going to do everything within my power to ensure this program is patient-centric--- that patients are the #1 focus and priority, and that our access to pure, clean, well grown, medically diverse and abundant cannabis is assured in AZ. Thank you.

Eliminate the "lottery" if several members of one group can submit applications. For example, if one group can only afford one application, but the another group can afford 20 applications since they have huge financial resources because of their investments in other programs in other states, THAT WOULD BE UNFAIR! Instead of a 50% chance of obtaining a dispensary, the chances of the first group getting permission to open a dispensary plummets to 5% if the other group can afford to submit 20 applications at \$5000 each.

R9-17-312. Medical Director This has no authorization in prop 203. You must remove it. There's no reason why you should not ask dispensaries to have and hand out information pertaining to mmj. That part's mostly OK, but to have to have a doctor on staff or available and on contract I think will add significantly to the costs and therefore the price of medication. You'll end up with even higher than black market prices. Also, I notice most of the MD regs are about substance abuse etc, as though we are talking about something illegal.

R9-17-306. Applying for a Change in Location for a Dispensary or a Dispensary's Cultivation Site A. A dispensary shall not change the dispensary's location during the first three years after the dispensary is issued a dispensary registration certificate. That's ridiculous. What if your location turns out to be a sucky one and you need to move? What's the point of this?

take this out: iii. Profile on the Arizona Board of Pharmacy Controlled Substances Prescription Monitoring Program database;

R9-17-202.F.5. c. A statement that the physician has made or confirmed a diagnosis that the qualifying patient has a debilitating medical condition as defined in A.R.S. § 36-2801 for the qualifying patient; Hoping you'll scare off some doctors from providing recommendations?

A "doctor" should not be able to have more than 30 medical marijuana patients in a year and any increase in this rule must be approved by AZ DHS.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

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More clear about the above matter.

The doctors accountability pg 4 Sec. 16 a and b; pg 5 Sec 16 b cont. and 21; pg 15 Sec. 5. i and ii; pg 20 Sec, e. i and ii Pg 25 Sec e i and ii and g; Pg 29 Sec iii,i and ii plus g need to be reinstated. Do you really want a bunch of potheads attracted to Arizona by lax oversight of medical need for marijuana? Pages 50 Sec. h i and ii plus 52 Sec c 1 and 2 seem to leave openings for abuse.

A "doctor" should not be able to have more than 30 medical marijuana patients in a year and any increase in this rule must be approved by AZ DHS.

Do not allow any physician to have more than 100 patients with medical marihuana per year. In other states, physicians prescribe as much as they want with NO oversight by the state Board of Medicine.

see next window

R 9 17 302 Dispensary Registration Certification Allocation Process: LOTTERY: DROP THIS. It encourages "organized crime" to enter our State. It discourages honest business people from investing the thousands of dollars necessary to comply with the many rules set by DHS only to enter a "Luck of the Draw" final process. Good, successful business people, the type DHS NEEDS to make this successful, do not stay successful with these types of actions. They simply will NOT participate. CHOOSE THE LICENSEES BASED ON MERIT....not CHANCE CHAA'S: Certainly these seemed logical, but they will stifle competition and drive UP the price of the product for those least able to afford the drug. The "PHARMACY CONCEPT" is a good one. They have done the population demographics for the DHS. Use their data. The Cities also have established limits on what they believe their populations will need. Allow the market to work for you. R 9 17 312 Medical Director should be a Physician (M.D. or D.O.): [REDACTED] believes this is a MUST item to keep. This Marijuana is just, "Not your Father's Marijuana". It is carefully genetically engineered to have THC/CBC levels of 16% to 22%. Combustible delivery systems are now less than 1/2 of the administered methods. Synergism effects (i.e. 1 + 1 = 5) are a definite probability for patients on highly potent opioid prescription medications (hydrocodones, oxycodones,etc). If after three years it is demonstrated that a Physician oversight is redundant, it can be dropped. Thank you for allowing [REDACTED] this opportunity to respond.

A "doctor" should not be able to have more than 30 medical marijuana patients in a year and any increase in this rule must be approved by AZ DHS.

Write it completely over. Start by asking those in need how their needs may be met instead of allowing individuals with dollar signs in their eyes to setup a program.

Thank you for all the time and effort DHS has put into the Medical Marijuana drafts. It is apparent in looking at the improvements in the second draft that the process Arizona DHS uses will be a model for other States implementing MMJ. My suggestion concerns R9-17-302, the allocation process. The CHAA's are a good way to ensure there is not a "zoned light district" of dispensaries and that dispensaries are spread out based on population and geography. While this is fair I believe a better allocation process would be one of the following:

1. In the likely event more than one applicant receives a dispensary registration certificate for a certain CHAA a points system similar to what is often used by Arizona State Procurement (SPIRIT) should be used. Points could be awarded based on factors that would increase the probability the applicant would be able to successfully operate and maintain a dispensary and/or cultivation and/or infusion facility.

A. verifiable experience starting a business  
B. no personal or professional bankruptcies  
C. a business plan that shows ongoing viability, verified by a CPA  
D. perhaps even an interview process.  
E. Sufficient funds or lines of credit to actually start a business. ( \$100,000 is a small amount to start a business considering there will be expenses but no revenue IF THE LAW IS FOLLOWED for at least 4 months after final approval )

The goal is to have 124 active MMJ businesses helping Arizona's citizens in need of MMJ. Many people with good intentions and big dreams will apply not realizing all the factors that lead to 1 in 3 small businesses folding within the first 3 years.

2. Award the first 200 successful certificate applicants (SCA). The very first SCA gets their choice of all 124 CHAA's. The second successful applicant gets to choose from the 123 remaining and so on until all 124 are filled. If a SCA doesn't want any of the available CHAA the applicant would be first on the waiting list if/when more dispensaries are approved this SCA would have right of first refusal. I believe awarding this way will encourage people to make sure ALL information is correct upon initial submission and also rewards ambitious applicants.

My self and my husband are on ahccs and he is on medicare. we live on his disability - we pay rent and water gas electric car insurance phone and try to keep gas in the car we also receive food stamps. after paying all those bills we dont have any left over and most of the time we dont have enough to pay all the bills we have to ask our church or relatives for help a few times a year. now we have to do co-pays and pay for prescriptions my husband all ready takes 9 prescriptions from \$1.10 to \$ 7.00 and \$5.00 co-pays . how are we ever going to pay for this or the ID there has got to be a better way for those in need.. . First of all my husband was shot in the head his bullet went in one side and out the other the man that shot him turned the gun on him self and is no longer living. my husband was a very hard worker before he was shot and now he can not work at all and i stay home to take care of him. trust me life has not been fair to us. its not our fault that we have to live like this and we understand that there are going to be people that take advantage but we are not one of them. we are willing to have him be a test study on this to make it easier for us and you please let us know what and if there is any thing that we can do to make this easy.

I do not believe in the lottery. I think that a test that would include issues such as legal amounts you are allowed to grow, how to operate a business and items that are in the draft. When ever you want a license of some kind there has always been a test that you must pass first. I also think that personal

interviews with everyone that puts in for a dispensary license would be another way to determine who you would want to run a dispensary in Arizona. I take pride in running a dispensary and it would hurt the dispensary family if there were one or more making them look bad. I think both of these combined would be a good basis in determining who would be awarded the certificates. Another idea would have the cities that drew up the drafts for their county's do a recommendation of who they feel did the best presentation.

A "doctor" should not be able to have more than 30 medical marijuana patients in a year and any increase in this rule must be approved by AZ DHS.

I have an opinion concerning the 25 mile radius and being allowed to grow your own medicine. I am a patient in California and soon to be one here in Arizona. I have a green thumb as many seniors do, I like to grow my own vegetables and flowers. I feel I am more than qualified to grow my own medication, but will fall into one of these 25 mile radiuses! I feel I should be allowed to grow my own medicine, regardless of where I reside. I have an opinion concerning the lottery of future dispensary owners. A lottery system I feel will not bring in the most qualified individuals required to head this new endeavor. I feel the application process for a dispensary should be graded on a points system, which requires future owners to provide all the necessary information and documents required to start a business and be graded accordingly. All the requirements are laid out in the Prop203 and they should be provided as directed to comply. A lottery just has the opportunity to bring in the wrong people and tarnish the already problematic subject.

if more than one qualified applicant is received for the same chaos let the town or city have the final voice who they want to have the permit. If a town or city does not have preference than go to a random drawing. If an area such as Tonto Basin falls between Chaos than let a sub dispensary open there. The dispensary could be part of a pharmacy or just be opened two days a week or so. Thank you and I feel you have done a good job and only slightly been influenced by the amma. [REDACTED]

I would like a couple of things changed. 1 I would have a two part sticker with the number of the dispensary on it. Part one of the sticker would be filed at the cultivation site and the other would be kept in a book at what ever dispenser was to purchase the produce. Each lot would have a number, This way you would have a trail of each lot that was sold. 2 I would have a cultivation licence for people that only what to grow, If you have a dispensary licence you can have your own cultivation site. 3 I would make a 4 month period that dispensary can get supply from other dispensary in other states that have medical marijuana and that dispensaries do this at their own risk. After 4 months you must buy all of your produces in Arizona only.

limit the number of patients a doctor can see and recommend to 100

There is no reason for a monetization requirement that has been suggested in the application. It is arbitrary and the law makes no reference to it. As with most other business ventures, it is the responsibility of the certificate owner to obtain the funding needed. While there is no question some financial assets will be needed, requiring inordinate amounts, in the tens or hundreds of thousands of dollars is unreasonable and financially discriminatory. Entities and individuals having extraordinary financial backing does not make them better qualified to provide needed services to the community, it only makes them wealthier. Some have begun introducing scare tactics including raising the possibility of 'Mexican drug cartels' being enticed if a significant financial floor is not instituted. This is

ignorant at best. Precisely how and why would any respectable citizen choose to attach themselves to the dangers and risks of "cartel" association? If there is evidence to support these alarmist claims, it is imperative that the evidence be provided immediately and publicly and thoroughly reviewed for accuracy prior to accepting it as fact and designing guidelines to quell it.

Please consider the following points and make revisions before the 'final' guidelines are issued. There has got to be a way to have questions and answers on the program before it is finalized. So far AZDHS has overcomplicated a seemingly simple law. Medical Marijuana is now legal. Let the entrepreneurs get started doing business and the rules can be adjusted as it goes along. Remove the stigma and start dealing with it as any legal business. Regulations will surely follow. There is no need to delay patients receiving affordable, compassionate care now. DHS has not become experts in treatment and are not a regulatory body. We need to see the application before it becomes final. As the draft rules are being reviewed by the public, it is equally important to have the application be available for public review as well. The application is the initial step in reviewing the criteria AZDHS will be using in their due diligence. It is important to get public comments on the content of the application as it is just as critical as the rules used to create it. There is no reason for a monetization requirement that has been suggested in the application. It is arbitrary and the law makes no reference to it. As with most other business ventures, it is the responsibility of the certificate owner to obtain the funding needed. While there is no question some financial assets will be needed, requiring inordinate amounts, in the tens or hundreds of thousands of dollars is unreasonable and financially discriminatory. Entities and individuals having extraordinary financial backing does not make them better qualified to provide needed services to the community, it only makes them wealthier. Some have begun introducing scare tactics including raising the possibility of 'Mexican drug cartels' being enticed if a significant financial floor is not instituted. This is ignorant at best. Precisely how and why would any respectable citizen choose to attach themselves to the dangers and risks of "cartel" association? If there is evidence to support these alarmist claims, it is imperative that the evidence be provided immediately and publicly and thoroughly reviewed for accuracy prior to accepting it as fact and designing guidelines to quell it. As there will most likely be significantly more applicants than certificates provided, there is no perfect way to distribute the certificates. Given the opportunity for many to do everything they can to circumvent any system put into place, the only fair way is to use a simple, transparent, public lottery. Any other option will cause cries of foul play, collusion and will most likely end up in litigation, potentially delaying progress for years due to useless litigation. The lottery rules should be posted clearly and simply with any questions being posted for public viewing and clarity. I understand there are costs associated with performing due diligence, but the \$5000 application fee is exorbitant. It reeks of a bureaucracy bending entrepreneurs over a barrel for no other reason than that they can. Even more insulting is the 80% (\$4000) loss if you don't get chosen for a certificate. This is another glaring attempt to limit the pool of potential dispensary operators with no logical basis for it. A more reasonable fee and administrative loss directly associated to actual due diligence costs, provided by the AZDHS for transparency, would be appropriate, fair and in your constituent's best interest.. There is no reason for the requirement for the specific address of the intended dispensary in the application. Given the current real estate market, and the fluidity of all the elements, the exact sites for all the elements, dispensary, cultivation and infusion, should be determined once the license is won.

You should leave the zoning the way it originally was and give people the freedom to open wherever they want as long as they follow the zoning rules and regulations of the city

See Above Comments

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

1. The definition of "Acquire" in R9-17-101(1) is too broad. Obtaining through "any means" would include illegal means such as theft or purchase on the streets. Obtaining from "any source" would include drug dealers and other illegal sources. 2. The definition of "Public place" in R9-17-101(21)(b) should also include COMMON AREAS OF PLANNED COMMUNITIES. 3. R9-17-101(24) should be clarified to reflect that "statewide furlough day" applies to state employees. 4. With regard to the caregiver cultivation issue, it makes sense to require that both the caregiver and the qualifying patient live more than 25 miles from a dispensary before the caregiver is permitted to grow medical marijuana for a qualifying patient. There is currently no such requirement, which could give rise to a situation where a qualifying patient who lives 30 miles from a dispensary has a designated caregiver who is cultivating marijuana for him and the caregiver lives a mile from a dispensary. This goes against the intent of the statute. We would recommend adding to R9-17-202(F)(6) the following required information: IF THE QUALIFYING PATIENT RESIDES AT LEAST 25 MILES FROM THE NEAREST OPERATING DISPENSARY AND IF THE DESIGNATED CAREGIVER WILL BE CULTIVATING MEDICAL MARIJUANA FOR THE QUALIFYING PATIENT: i. A STATEMENT FROM THE DESIGNATED CAREGIVER THAT IT WILL ONLY CULTIVATE MARIJUANA FOR THE QUALIFYING PATIENT AT THE QUALIFYING PATIENT'S RESIDENCE; OR ii. A STATEMENT FROM THE DESIGNATED CAREGIVER THAT THE DESIGNATED CAREGIVER RESIDES WITHIN 25 MILES OF A MEDICAL MARIJUANA DISPENSARY AND WILL PURCHASE MEDICAL MARIJUANA FROM THAT DISPENSARY ON BEHALF OF THE QUALIFYING PATIENT; OR iii. A STATEMENT FROM THE DESIGNATED CAREGIVER GIVING THE LOCATION OF THE CULTIVATION SITE AND THAT THE CULTIVATION SITE IS LOCATED AT LEAST 25 MILES FROM THE NEAREST MEDICAL MARIJUANA DISPENSARY AND THAT ALL CULTIVATION OF MEDICAL MARIJUANA BY THE DESIGNATED CAREGIVER WILL BE DONE IN FULL COMPLIANCE WITH ALL LOCAL ZONING REGULATIONS FOR THE JURISDICTION WHEREIN THE CULTIVATION SITE IS LOCATED. 5. Rule R9-17-304(4) requires the applicant to provide distance to the closest public or private school, but does not say how this distance is measured. We suggest wording such as: MEASUREMENTS SHALL BE MADE IN A STRAIGHT LINE IN ANY DIRECTION FROM THE CLOSEST PERIMETER BUSINESS WALLS. 6. ARS § 36-2806(C) requires a registered nonprofit medical marijuana dispensary to have a single secure entrance. Could you please clarify in the Rules whether a separate exit is permitted? This could be added to R9-17-304 as part of the requirement to provide a site plan in (6)(e). It would appear that the statute would only allow for one point of access and that would be a secure access. Allowing a separate means of egress would increase the possibility of unauthorized access. 7. Rule R9-17-307 does not require a sworn statement that the dispensary is in compliance with local zoning regulations at the time of application for renewal. A.R.S. § 36-2804(b)(1)(d) requires a dispensary to submit a sworn statement certifying compliance with local zoning restrictions when it applies for registration. The Department should not renew a registration certificate unless it has verified continuing compliance with local zoning regulations. Therefore, either a sworn statement of continuing compliance with local zoning regulations or a letter from the local jurisdiction confirming compliance with zoning regulations should be required as part of the renewal application. 8. If "food establishments" are permitted to process the marijuana, there should be requirements that they: • Maintain separation from other products prepared at the site; • Use processes to ensure the effectiveness of the medical marijuana is preserved, including spillage and cleanup procedures in the event of spillage or overflows; • Not emit dust, fumes, vapors or

odors into the environment; â€¢ Screen employees for drug offenses before contracting with medical marijuana dispensaries to process the medical marijuana; â€¢ Notify local police departments of the processing; â€¢ Provide adequate security to protect against the marijuana being diverted to persons not registered as qualifying patients, caregivers or dispensary agents. â€¢ Not dispense any medical marijuana or infused product. 9. R9-17-318(C) makes no sense. Adding medical marijuana (or any drug) to an edible food product will adulterate that food product. What may have been intended by this provision would be: A DISPENSARY SHALL ENSURE THAT INFUSING MEDICAL MARIJUANA TO AN EDIBLE FOOD PRODUCT DOES NOT ADULTERATE THE MARIJUANA. 10. R9-17-316 should include a labeling requirement for all infused products as containing medical marijuana and a statement as to the potency and dosage of the edible food product. Wording could be something like: A DISPENSARY SHALL NOT SELL OR PROVIDE AN EDIBLE FOOD PRODUCT THAT IS NOT PROMINENTLY LABELED AS CONTAINING MEDICAL MARIJUANA AND A STATEMENT AS TO RECOMMENDED DOSAGE AND POTENCY OF THE INFUSED DRUG. 11. A.R.S. Â§ 36-2806G requires medical marijuana dispensaries to prohibit persons from consuming medical marijuana â€œon the propertyâ€ of the dispensary. For purposes of the Rules, â€œon the propertyâ€ should include parking lots, sidewalks and other facilities that would generally be considered as part of the â€œpremisesâ€. This would further the intent of the language and prevent a situation where a dispensary has leased space in a shopping center or office complex and the â€œpropertyâ€ of the dispensary could be interpreted as not including the sidewalk or parking lot. Submitted by: [REDACTED] If you have questions, I can be reached at [REDACTED]

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

Allow other health professionals access to recommending medical marijuana, ie, physician assistants, nurse practitioners.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

See above

There should be some kind of limit in the number of medical marijuana patients a given doctor might have. I have no idea what the magic number should be.

Work with the dispensaries to reduce the cost of producing marijuana, right now it looks very expensive to produce with so many stipulations that the patient will not be able to afford the final product (for their illness).

I believe the rules can be improved in the following ways: 1. Include general language on how the seeds and cuttings for the very first crops are to be obtained. 2. Create a rule allowing patients who have recently lost the right to cultivate their medical marijuana and find themselves in possession of an illegal amount of legally grown medical marijuana to transfer the excess amount of medical marijuana to a dispensary and reacquire their own medical marijuana in legal amounts at a cost per acquisition no greater than \$5. 3. Remove the requirement for a medical director for the following reasons; a. A medical director is redundant when the physician recommending the patient receive medical marijuana gives the patient the information s/he should be giving every patient concerning any medication the patient receives and answers the patients questions. b. When a person goes to several doctors looking for one that will recommend medical(?) marijuana, that person does not care about medical advice and would not listen to a medical director either, making the medical director pointless. c. The requirement for a medical director would increase the cost of this medication to the patients who need it. 4. Instead of using the CHAA boundaries, use geographic areas of equal size and, to the degree possible, equal shape for the following reasons: a. Every patient in the state should have an equal chance of having a medical marijuana dispensary within a reasonable distance. b. It seems apparent from published questionnaire/survey results that most patients would rather acquire their medical marijuana from a medical marijuana dispensary than grow it at home because of the concern of attracting dangerous criminals to their home and family. 5. In order to reduce the incentive for corruption and keep the cost of the medical marijuana down give preferential consideration to medical marijuana dispensary applicants and renewals that are 501(C)(3) corporations or not-for-profit entities that are structured similarly. Meaning that they only compensate principal officers for direct travel expenses for attending meetings. Also give preferential consideration to applicants of this type that pay their employees and managers wages and salaries commensurate to those in the area they are applying for. 6. Because many, if not most, of the people with a debilitating medical condition have very low income, make the following changes: a. Lower the fee for a patients and caregivers registry identification card to \$5. b. Implement A.R.S. Â§ 36-2817 creating a medical marijuana fund and establishing the manner in which donations are made to this fund. c. Since A.R.S. Â§ 36-2817(C) prohibits money in the medical marijuana fund from reverting to the state general fund at the end of a fiscal year, distribute 80% of the projected excess funds at the end of a fiscal year, in equal amounts, to the patients and caregivers, not to exceed the amount paid by the patients and caregivers. Any remaining funds of the 80% of the projected excess funds at the end of a fiscal year after distribution to patients and caregivers will be distributed to the dispensaries in equal amounts not to exceed the amounts paid by the dispensaries.

Our Oncology Nursing staff at [REDACTED] had an in-service on Prop 203 before the vote. Since at least a third of our patients have at least TRIED medical marijuana, we were happy to see that the state seemed to be serious about making this a MEDICALLY controlled substance, not a recreational drug. Now we find that the state is proposing that dispensary licenses be given out randomly. When did this become a lottery? All our nurses, pharmacists and physicians have to meet SOME kind of medical standard, drug certification and ongoing medical education. Even then, we need to be tested regularly. The fact that anybody who fills out the paperwork, leases a building and pays the application fee can sell marijuana is a disservice to patients expecting to be treated like a real patient rather than simply a customer for legal weed! The current medical requirements are too skimpy to meet even the minimum standard of care for cancer patients. Please give some thought to adding more patient and community relevant requirements to the licensing process. A random drawing seems a tremendous mistake!

The patient fee, after the first year should be considerably less than the proposed \$160, or is it \$150?

Why not have the physician, after verifying a condition to recommend marijuana, fill out the necessary forms, collect the fee and forward the information to the state. Keep the process simple....

R9-17-302.B.2.b.ii. indicates that if there is more than one eligible dispensary registration certificate application for a dispensary located in a CHAA, the department shall randomly select one dispensary registration certificate applicant and allocate the dispensary registration certificate for the CHAA to that applicant. Random selection, though indeed an impartial process, does not factor the potential that one applicant might have more to offer than another. The department should consider a simple proposal process by which an applicant can delineate strengths related to and associated with dispensary related activities and the applicant's ability to make a positive impact on the community it serves.

If each dispensary cultivates it's own marijuana and can purchase from caregivers and qualified patients there will be no consistency of quality to say nothing of trying to enforce the rules at 125 sites plus the patients and caregiver sites for those that live 25 miles from a dispensary . I propose that there be a small handful of growing locations maybe 3 or 4 . All dispensaries would buy their Marijuana from these growers at the same price the quality of the various strains would be consistent and the rules concerning Facilities, sanitation , and disposal would be a lot easier to enforce. I think you are asking for trouble by having so many growing sites to oversee.

I think the requirement for a "Medical Director" is a good idea. However, I think there should be a limit to how many dispensaries one Medical Director may be involved with. Regarding R9-17-201, (page 13): I think #10 and #11 are far too vague and should be eliminated. The rules already offer individuals the opportunity to ask to have specific ailments added if they can prove necessity. Regarding #12, I think it is too vague and I believe medication already exists for people suffering from epilepsy. If it is determined that epilepsy patients need medical marijuana, then the rule should say specifically that. Regarding #13, I think it is too vague. If it is trying to permit use for M.S. patients, then it should say that specifically. The wording in #12 and #13 opens the door to much too interpretation. This section needs to be extremely tight to avoid abuse. I think anywhere the rules refer to a Physician initialing forms and documents, etc., it should be changed to require the Physician's signature and date. Example: Page 15, 5. e. through page 16, 5. l.. I think the term "pledging" used throughout the rules is too loose. I believe language should be changed to state that the individual SHALL NOT. Example: Page 17 h.ii.. Regarding page 42 E., I think any dispensary found out of compliance with the department should be closed until the violation is remedied. The way it is written will lead to situations of dispensaries operating while continuously being in violation. There needs to be much stronger incentive to operate within all the rules, all the time. I think all dispensaries should be required to donate a percentage of their gross revenues to substance abuse prevention education and programs in the communities where they are located. I also think if dispensaries are allowed to operate growing operations in communities other than the community where their dispensary is located, they should be required to donate a percentage of their gross revenues to the community where their growing operation is located.

Strict guidelines for physicians writing medical marijuana prescriptions.

I would like to see provisions for Seed Banks. So that MM Seed companies can be in business in the state of Arizona.

How can you have warnings about cancer on marijuana when there's documentaries coming out that show marijuana kills cancer cells without damaging nearby health cells? They're going to soon have a new treatment for cancer made of marijuana. PLEASE before you make cancer one of the warnings watch [REDACTED]

Having so many medical directors seems like it's going to chaos. Patients need to hear the same information at every dispensary through out the state. There should be only one medical director for the whole state or a board of medical marijuana directors. Either way would bring uniformity. Change the medical director to be either one person or a board of directors that serves the whole state.

Take out the CHAA and just go by number of pharmacies per county as described in prop 203. The CHAA does not help patients get medicine! It was not designed to be used for prop 203. Take out the need for a "medical director" as prop 203 does not give you the power to force a dispensary to have one. Make a person applying for a dispensary permit show capital.

The CHAA's have made it very difficult to locate a location that will work within the various overly restrictive city regulations. For example the city of Surprise has 4 CHAA's that it will share with adjacent cities; however out of the 4 CHAA's there is only one location that will work. Therefore, there will be 3 certificates left on the table for that city. Will these be reassigned? Will you ask the cities to work with the CHAA's that have been given? Or will you simply just ignore the fact that these certificates will not be issued based on the city requirements. I have just mentioned one city there are several other cities that I have been researching where the same thing has occurred. Also, with the city requirements they have forced these MM locations in areas which they have not even identified if such buildings exist which they don't I have checked. Other cities have pushed them to areas where there are no buildings or areas that have one building that will work, but has been occupied by a large corporation since the early 90's. If the cities are suppose to make reasonable requirements why are these practices being allowed? Who are policing these cities? What is the plan for the certificates that will not be issued because of these requirements?

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

Include Planned communities in the definition of "public space"

Basically by Removing the lottery system from the selection process. Use only the individual merits in each case before selections are made.

Today was my first visit to this subject. I thought I would investigate the business potential of growing medical marijuana for purchase by legal dispensaries. After reading the 12/17/10 news release by the ADHS I have the following suggestions that will make this what I feel a much more viable program for

all involve. From the new release: Are dispensaries just a place for people to buy medical marijuana? According to the informal draft rules, dispensaries must provide information as well as the medical marijuana. The informal draft rules require dispensaries to have a medical director on call whenever they are open; the medical director is a licensed MD or DO who cannot write recommendations for medical marijuana, but ensures educational materials are provided for patients about drug interaction, safe techniques for use, and information about substance abuse programs. 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 tracks where all marijuana sold was grown and to whom it was sold. I would think that with the requirement of having an MD or DO on staff during the sales hours of medical marijuana will be a HUGH deterrent to people interested in growing for distribution AND operating a dispensary. I don't think it has the business potential to justify the cost of all listed above. Why should this be treated any differently than any other controlled substance? Drug manufacturers are not involved in the dispensing of their products to the public. Pharmacies do not have MDs or DOs on staff during the sale of controlled drugs. I can understand the security requirements of growing facilities but to mix them with the dispensaries is totally unnecessary. The solution possibilities: 1. Allow the dispensing of the product at the offices of the willing MDs and DOs that are licensed to buy the product directly from the growers IF you can demonstrate the actual NEED for this restriction. If this is not part of the actual LAW then number 2 is the answer. 2. Simply allow pharmacies to dispense the product just as they do all other controlled substances and allow the pharmacy companies to buy directly from the growers. It seems to me you are trying to put the emphasis of control all rolled into one entity. Most people interested in pursuing this business have no interest in growing, dispensing, and employing MDs or DOs. I also think that it is highly unlikely that there are many practicing MDs or DOs that are interested in turning their existing practices into a growing facility and having their offices looking like a high security prison. The control requirements are already in place in the pharmacies for controlled substances and there should be no reason for it to be dispensed with MDs or DOs on staff. The job of providing educational materials for patients about drug interaction, safe techniques for use, and information about substance abuse programs should be the job of the prescribing MD or DO as with ANY controlled substance. The REAL concerns should be with the security and control of the grown product since this is a new situation and is not being produced by drug manufacturing businesses that already have safeguards in place. Being new to the study of all of this (as we all are) maybe this has already been discussed and changes have been made to the above copy and pasted draft info I have provided. If not I think it is likely a pipe dream of actually taking place or if they do are likely doomed to fail. The use of marijuana under a doctors prescription doesn't seem to be that big of business in Arizona as it appears the safeguards are in place for its abuse as it is in California where it IS a MUCH bigger business due to said abuse. To me, the restrictions for the legal dispensaries will limit how many there will be throughout the state and will provide for the more wide spread legal growing for personal use that will be very difficult to police. The potential for abuse and illegal use of marijuana beyond the illegal drug problem the state already has will increase. [REDACTED]

Limit the number of patients to 100 that a physician can recommend medical marijuana to

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

I believe that the rules for doctors having to have an intimate Dr./Patient for 1 year is absurd. I've suffered from severe chronic pain for years, yet, I have not found a doctor that has the nuts to do any recommendations. Instead, I get sent to a pain management doctor to be put me on 90 mg of methadone (divided in 3 doses), Soma 4X a day Zanax 2-3 times a day...and that's perfectly OK with DHS.

if being a felon to big of a stigma to get over, even only having one prior felony, you can emplant a probationary period for dispensarie's officers and caregivers, my proposal for this would be for felons with a single conviction dispensary would be inspected twice a month and to renew registry card would be twice a year for the first year...after succsfully completing this probationary year the person would be eligible for sigle year renewal and yearly inspection as a normal caregiver or dispensary officer. the renewal fee for the frist year would stay the same making for felons \$2000 a yr renewal fee, being a single time felon i say collectivly our price we must pay to prove ourselves. Thank you again [REDACTED]

might be good to give the already---nonprofits a better chance at becoming a dispensory. if the non-profit is already running a business type set-up--maybe they should be considered ahead of the ahead of the rest. thank you, [REDACTED]

A "doctor" should not be able to have more than 50 medical marijuana patients in a year and any increase in this rule must be approved by AZ DHS.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

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this draft rule can very easily be fixed...have the excluded felony rule state that any one with 2 or more prior felony convictions is ineligible to be a part of the medical marijuana industry...give the people who have made a mistake in thier past a second chance, a way to show them selves, and the city and state that convicted said person that if they wanted to, and have the inspiration and motivation to, show even though once covicted and only once convicted, anyone can change for the better...for the people who have 2 or more felony convictions, they have already had a second chance to change ones behavior that led them to the conviction in the frst place, therefore do not deserve the oprtunity to take part in the medical marijuana industry. my reasoning behind this is i was convicted of a felony when i was 19 years old. over 6 years ago...ive served my 6 months of time in ten city and even completed my probation early...as with the othr gentleman that spoke today 2-17-11 i concidered my self a model inmate and probationee, after my time on probation i found a job being a restaurant manager at a little place called [REDACTED] which gave me the skills know how and ability to invest into my own auto cutomization shop until the economy took a turn for the worst. Now if i can own my own custom car shop and not hold a public risk to anyone, even being a convicted felony, why should one mistake in someones past be considered a health risk? being a previous busness owner i have what it takes to open a great dispensary that would qualify to dispense the highest quality medicine possible. So please look into the posibility in changing the rule to allow a

person with no more than 1 previous felony conviction to be apart of this growing industry. thank you

R9-17-101.14. Throughout the rules document you use both the terms "dispensary agent" and "designated agent of the dispensary." Are these interchangeable? If yes, we suggest using the same term throughout the rules rather than changing it. However, in a few places, it seems like these might have different meanings, i.e., the designated agent of the dispensary might have a higher level role than just any "principle officer, board member, employee or volunteer." (ARS Â§36-2801).

Limit the number of patients a physican can recommend for medical marijuana to no more than 100 patients per year.

Most of the people I know that are in serious pain rarely go to see a Dr. due to lack of funds. I know may people that are food servers, construction workers, etc. that do not have health benefits or enough money to regularly see a dr. I think some of the restrictions that allow dr.s to recommend Medical marijuana are extreme. I can go into a clinic or a dr. for the first time & get multiple controlled substance prescriptions without even trying. Getting a safer alternative like Medical Marijuana should be no different.

I went to see a new Dr. about some back pain I had been having. He prescribed me muscle relaxers, narcotic pain pills, & anti-inflamatoiesy. All of which are toxic, can cause damage if used long term, & can kill me if over used & two of which are extremly addictive. When I asked if he would recommend Marijuana in the future for such pain he laughed, & said there is "no way". He said the state will make it too hard to recommend to patients & will not be worth his time. He said there is not problem with prescribing the current medications, even though they are much more dangerous. Reading over the current draft rules I get the feeling as if you are talking about something else besides marijuana. It seems to be treated as if it is extremly dangerous, & addictive & not even medicine. It is medicine & should be treated that way. Yes, it needs precautions but not the current limitations. Dr's should never be afraid to recommend it.

Increase time-frames for dispensary application process \*see below This will allow for a special use permit and necessary build out to meet design requirements.

You have no exemption for independent companies such as testing companies or labs to become agents unless they're affiliated with a dispensary, which most don't want to -- nor should they -- do since they're independent companies with no particular affiliation. There are companies out there like [REDACTED] that should be able to register with the state as legitimate independent testing, inspection services. I would think that the state would want independent testing and inspections done on cultivation sites.

Quit treating MEDICAL marijuana as a dangerous radioactive explosive device! Do not make it harder for patients to get than much more dangerous drugs. Make the fencing for outdoor cultivation less restrictive & costly. DO NOT harass or threaten doctors that recommend patients to use marijuana. Treat Medical marijuana as a MEDICINE & not a street drug thati is kind of legal ran by thugs. Marijuana is MEDICINE in Arizona now, the way it has been used for thousands of years. It is safer than the hard addicting drugs that are prescribed constantly & should be treated as such.

A "doctor" should not be able to have more than 30 medical marijuana patients in a year and any increase in this rule must be approved by AZ DHS.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

My name is [REDACTED] and I represent [REDACTED] a prospective dispensary in the [REDACTED] CHAA. I am thankful the department of health increased the residency requirements to 3 years. I want to suggest these applicants show 3 years Arizona tax returns as proof of residency. As a third generation Arizona native I believe this requirement will deter out of state investors and expose straw buyers who have tax returns with minimal income for the past 3 years but somehow can come up with thousands of dollars to start a dispensary. At previous meetings I heard people with concerns regarding the requirement of including a physical address of the proposed dispensary in the initial application. I do not oppose this requirement. If a prospective dispensary is not now actively working with leasing agents, landlords, city zoning, a zoning attorney and surveyor and if that prospective dispensary has been unable to secure a location by May 1st they should not be applying at all. If a physical location is not required as part of the initial application prospective dispensaries would lock up a CHAA and potentially never perform. Our group has identified our location, signed a lease with an option to terminate if an approval is not granted and in the meantime we are working on buildout plans and engineering so when DHS gives us approval June 30th we are ready to buildout and start cultivating our first crop and take patients 90-120 days after. This leads me to another concern. Opening and operating a dispensary and cultivation warehouse will be costly. Many people who do not have the proven track record in business management will fail for a variety of reasons. Initially the largest factor will be the lack of capital. For this reason I recommend DHS include a hard cash requirement of \$500,000, and proof of funds to be provided during the initial application. This will not only identify the ability to perform, but identify the source of the funds which will cut down on the criminal element. Another area I believe DHS needs to clarify is the ability to submit multiple duplicate applications. From my understanding I can submit 20 identical applications in the [REDACTED] CHAA as long as they each accompany a \$5000 Check and I would get 20 separate entries into the lottery. If DHS does not address this I will be doing just that and I will expect 20 separate entries to raise my chances in the [REDACTED] CHAA I am applying in. If this isn't the case please save me \$95000 in application fees and clarify how multiple applications will be dealt with. Also in order to provide transparency to the process, I suggest a system be set forth for the procedures of the lottery. For example applicants should be present to accept if their name is drawn, and a runner up in case the first dispensary cannot perform or if more investigation confirms the winning applicant falsified their application. My next comment has to do with the lottery option itself. I spoke with Mr. Humble at the Maricopa Bar Association continuing law education class a few weeks ago. He expressed that his main reason for choosing the lottery was to stay out of litigation with dispensaries who were not chosen during a qualitative awarding system. My suggestion to the board is to have a requirement for an application to be complete include an attestation promising that the applicant will not pursue legal action against DHS for the choice they made in the selection process. Finally I am a disabled veteran of the USAF and deal with extensive nerve damage. I strongly believe firsthand knowledge of pain and the relief medical marijuana can give a patient is essential to the success of this program. In other words if a principal officer of a dispensary does not know what it's like to live with debilitating pain I'm afraid their main motive will be for money and not driven out of care and

compassion for the patients of Arizona. Â For this reason I propose dhs add a requirement that one or more of the principal officers be a medical marijuana patient card holder. I'm excited about Arizona's program and I strongly believe with the right people in the industry we can have a model program for other states looking to adopt there own medical marijuana law.Â Thank you

Change the materials that can be used for growing outdoors for patients & caregivers. The current materials are very expensive & unnecessary. It will force patients to grow indoors which is not as earth or body friendly. It forces you to use a lot of electricity & chemical fertilizers instead of growing under that sun the God wanted it. I read in the proposition where greenhouses can be used, but I do not see that mentioned in the rules. I think greenhouses should be listed in the rules. Let the grow sites & dispensaries be chosen by a way other than a random one. I think you should review the applicants & make a set of standards & grade them so you can choose who does or does not get the licenses. Maybe choose people that have been residents of the town the longest, or have the backing of the town or city where they want to open up. You could also see how well the security plan looks. I think we need the BEST people to get the dispensaries, not just random ones.

Vendor access must be given without any sort of waiting or approval period. Dispensaries and Cultivation sites will need to use the services of plumbers, electricians, HVAC techs, firemen, etc. It is not clear in the draft rules exactly how Dispensaries and Cultivation sites may allow access to these contractors. In fact it appears in the rules that only patients and agents may enter..

I do not think that dispensaries should be chosen randomly. I think the overall business plan, location, town or cities feelings, security/safety plan should be considered & chosen based off of that.

1.RE: On-site advertising, specifically dispensary store-front building/lot. Has consideration been given to acceptable wordage. "Dispensary" is acceptable and recognizable as to the service/product it provides to those in need of those services/products. Given the controversial and emotional subject matter, I believe words such as marijuana, pot, head-shop, etc. are not necessary and SHOULD NOT BE ALLOWED, . For instance, should a parent driving with a child have to explain what pot/marijuana means when passing by a dispensary store front that says "Pot Dispensary" or "Medical Marijuana Dispensary"? 2.RE: The requirement that a dispensary shall have a Medical Director. "Medical Director" should include Licensed Pharmacist. I am a pharmacist, licensed in Arizona since 1984. My practice involves retail and limited care servicing skilled nursing facilities. If I managed a dispensary, filling orders directly provided a patient from a physician, my normal day to day functions already satisfy requirements placed upon that physician. Examples include drug utilization reviews, education, etc. The need for a physician, PA, etc. is redundant. Sincerely, [REDACTED]

The draft rules do not articulate enough instances of "Public places" in the Definitions. Actually, it would be better to articulate where marijuana CAN be consumed rather than were it CAN'T be consumed. It should be allowed ONLY in the confines of a private residence (not outside if an adjacent living structure is within 500 feet) or a marijuana consuming establishment.

I think it is insane that a caregiver or patient makes the investment to grow their own medicine if they are 25 miles from a dispensary, then if one opens near them they have to purchase it from the dispensary and then their grow room is worthless???!!!!! It is expensive to grow indoors or out for that matter. The medicine is going to be expensive. If i cant afford it than I am out of luck, even though I can grow it myself so I don't have to buy it. That's crazy. If a cancer patient could make his own medicine, would'nt you allow it? Or make them go pay for it even though they can make it for free???!!!!!!!! Come on guys.

Reverse the order of issue of patient cards and dispensary certificate / approval to operate. It just makes more sense to get the dispensaries open first, then allow patients to qualify after dispensaries are open. Assuming a dispensary is awarded an Approval to Operate on July 1 2011. The dispensary will not be able to sell legally acquired / produced medicine available for about 90 to 120 days or Oct 1 2011 based upon normal growth cycle. If DHS begins approving patients in August, that will be a better order of events for the overall management of the process.

Limit the number of patients a physician can recommend for medical marijuana to no more than 200 per year.

The ONLY people who are happy about the lottery process to choose who receives a dispensary are those who have done nothing else to warrant their chances of receiving one. This is not simply a license to run a business, this is a license to help those with serious medical conditions. Please consider a 3rd party to assess the applicants and get rid of the lottery system. Or at least pair down the potentials not just by a complete application but by assessing the group of individuals choosing to apply. Looking at what these individuals have done for the community, how their occupation might contribute to making our system even better and lastly how they will continue to contribute for years to come to both the community as well as the population of people requiring the support of this medical intervention.

█ comments: 1. Reconsider the rule to allocate dispensary registration certificates geographically by CHAA. It was/is our expectation that dispensaries would primarily be located in cities and towns in response to market demand, i.e. at convenient locations where the majority of customers are concentrated by population. Rural residents typically travel into cities and towns to shop anyway, and it would be no different for dispensaries. For the same reasons that we don't have Safeway stores out in our remote rural areas, i.e. that it is not worth the expense to build, stock, and staff such a store in a remote area, dispensary operators will likewise not choose to locate in such areas, and dispensary licenses will go unallocated. Also, the CHAAs include Tribal lands and the Tribes are not expected to participate in the program so those licenses will go unallocated. Since Arizona's population is not distributed evenly across the state, but concentrated in the urban centers, the urban centers are where the dispensaries should be. If the CHAAs do remain in

the final rules, there should be a provision for reallocating licenses for which there is no demand, and that reallocation should not be confined within a limited jurisdiction, but more flexible state-wide. 2. R9-17-101 -- Provide a definition of "public and private school" from which a dispensary must maintain a minimum 500-foot separation to include a "public or private preschool, kindergarten, primary, secondary, or high school" but not to include community colleges, universities, adult education, dramatic, dancing, music learning center, beauty colleges, or anything and everything that might include some sort of instructional program. 3. R9-17-107 Time-frames -- Clarify somewhere in this section the time-frame between an applicant being issued a dispensary registration certificate and the amount of time they have to obtain an Approval to Operate. Section R9-17-321(2)(c)(ii) implies that they have one year, but it should be made more explicit under "Time-frames." A sufficient amount of time is necessary for engaging an architect, preparing plans, obtaining a building permit, completing the work, obtaining inspections and a Certificate of Occupancy, and obtaining the final Approval to Operate. If one year is the intent, that is sufficient, but it needs to be more explicit. 4. R9-17-303(B)(5), -304(3), and -306(B)(3) require a dispensary applicant to submit a sworn statement by the applicant certifying that their proposed dispensary location is in compliance with local zoning regulations. We strongly recommend that this be revised to require that the applicant obtain and submit a "Zoning Verification Letter" from the local jurisdiction certifying that the proposed location is compliant with local zoning. Other State agencies require such zoning verification from local jurisdictions already, e.g. ADOT requires it for proposed auto sales lots, Office of Manufactured Housing requires it for modular homes, etc. There is too much risk of an individual applicant misconstruing or not fully understanding local zoning for them to be responsible for the certification without verification by the jurisdiction. 5. R9-17-318(A)(1)(a) allows edible food products to be prepared at the dispensary with the applicable food establishment permit. We recommend adding a provision to allow preparation of edible products to also be permitted at an off-site cultivation facility with appropriate food establishment permits. 6. Include provisions for ADHS to inform local jurisdictions (i.e. counties, cities, and towns) about all dispensary applications that are submitted for their respective jurisdiction and the particulars of all such applications so that the jurisdiction will be aware of the market demand for such facilities and will be able to plan accordingly. Thank you for the opportunity to comment.


I am concerned about out of state medical patients being arrested in Arizona. [REDACTED]

A "doctor" should not be able to have more than 30 medical marijuana patients in a year and any increase in this rule must be approved by AZ DHS.

A "doctor" should not be able to have more than 30 medical marijuana patients in a year and any increase in this rule must be approved by AZ DHS.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

I believe that the direction contained in the draft regs regarding random selection of dispensaries is NOT in the best interests of local communities and risks the establishment of a dispensary that is at odds with local custom and culture. I believe that dispensaries should be locally owned and accountable to the community they serve - they need to have "some skin in the game" so to speak, and I do not believe that random selection will ensure this. Please consider removing random selection of dispensaries from the regs - or at least give local communities a choice about whether or not they might choose to use this approach or not. Thank you.

FEES It would appear that the ADHS is intending to impose fees that are not in compliance with the law or the implied intent of the law. These rules are governed by 36-2803. Rulemaking 5. (b) NONPROFIT MEDICAL MARIJUANA DISPENSARY APPLICATION FEES MAY NOT EXCEED \$5,000. See the following: DRAFT 01/31/11 R9-17-102. Fees A. An applicant submitting an application to the Department shall submit the following nonrefundable fees: 1. Except as provided in R9-17-302 (F), for registration of a dispensary, \$5,000; The intent of this fee is to generate enough revenue to cover the cost of approving the individual dispensary applicant from application through approval AND oversight of the approved dispensary for that year; and that by retaining \$4,000 of this fee from the non-approved applicants (R9-17-302 (F)); this could be considered excessive taxation, as the cost to simply review and disapprove should not exceed \$1,000. R9-17-102. Fees A. An applicant submitting an application to the Department shall submit the following nonrefundable fees: 3. To change the location of a dispensary, \$2,500; AND 4. To change the location of a dispensary's cultivation site, \$2,500; The proposed fees for relocation of a dispensary and cultivation site at \$2,500 each would be excessive and are not authorized in the law. This is a clear overstepping of authority and will most likely be challenged in court. My opinion would be that a \$1,000 fee to cover actual costs by the department would not be perceived as excessive and would be much less likely to lead to legal action.

Hours of operation should be identical to Walgreen's

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

Dear AZDHS Comments on 203- 1.31.11 Draft A nice social consequence could be less turmoil in Mexico. The IRS disallows deducting operating expenses in MM operations. This will force operators to stay a small operation, cultivate and dispense. This should keep the businesses from scaling as the tax burden will crush them! R9-17-102- Reduce the fee for the patient. Unfair to punish the sick. R9-17-302 Limit/mandate one application per individual per CHAA Otherwise multiple applications buy greater odds from the State; the State should not accept payment to influence the outcome in commercial ventures. R9-17-303 B g iii & iv MAJOR ERROR including these. Not germane to Prop

203- The State should not guide decisions on a simplistic and uninformed basis. The Secretary of the Treasury owed Back taxes. R9-17-306 The draft is silent on dispensary transfer of ownership. Big problem area there. I'd disallow transfer for first 3 years. This lets the bad actors flush themselves out. In California there is no tourism aspect of the MM dispensary. Only the card holder is allowed into the shop. Please ensure my kids do not have the opportunity to gawk at a Head Shop selling pot. And come to think of it- please restrict dispensaries from Head Shops and adult entertainment venues. To do otherwise is really dumb and will open AZ to further national criticism.

The random drawing of licenses is not fair. There are so few licenses that groups that can afford to submit multiple applications will have a far greater chance than the people who simply want to provide a high quality service at a fair price. This is supposed to be a medical service, not a for-profit headshop lottery!

By having the application process be more about viability, and ability to run and maintain a strict business, than random choice. So that a more qualified applicant has a better chance than a less qualified.

Allowing a lottery to take place for the assignment of dispensary licenses is not the way to ensure that proposition 203 is being fully enforced and protected. By not screening the applicants all the way to the final assignment of licenses, undesirables will infiltrate the system that AZDHS has stated they wanted to be secured. To ensure that the dispensary licenses are being granted to the most qualified, I believe a grading system needs to be implemented, that takes into consideration; a business plan, a security plan, ties to the community and financial strength. With the technology today there has to be a way to ensure the security and safety of the patients, the dispensary and the operators of the dispensaries. Arizona can be on the forefront of this industry if we choose to do it correctly. We are under the microscope of the whole country and what we do next is critical to us moving forward in a positive light. I believe that other states will want to follow in our path, if we do it correctly.

I think that medical marijuana must be regulated and dispensed under the same rules that other prescription medications and controlled substances are done. That being from a pharmacy not a dispensary. If it is truly for medical reasons, then the same policies and procedures must apply. If not, the whole process loses credibility. Why is the wheel being re-invented for this substance? Is this not unnecessary additional cost to a state already in financial crisis?. Thank you. ██████████ Tempe, AZ

Please eliminate the lottery for dispensary's. Each landlord should have the right to properly vet each and every potential tenant at their properties. A lottery obviates this right.

I am sitting in "The Great Hall" and can see I will not get the chance to be heard. Therefore I will use this method in hopes I will be heard. First I would like to note that I did not vote YES on Proposition 203. Before Arizona voters had their chance to vote on Prop 203, several meetings and debates were conducted. One of those meetings was the SECRETARY OF STATE'S TOWN HALL meeting which took place in Phoenix, Arizona September 22, 2010 at 7:00 p.m. At this meeting were

discussions in favor of Prop 203 and against Prop 203. Both sides presented compelling arguments. Supporting Prop 203 at this meeting was Mr. [REDACTED] who is Treasurer for the [REDACTED] [REDACTED] who said: Right now, there are already thousands of patients all across Arizona, who are already using marijuana. WOW!!! Here it is the middle of September and the person they have supporting Prop 203 comes out and says there are thousands of patients breaking the law! Not hundreds, but thousands! Here in Arizona, possession of any amount of marijuana can be prosecuted as a felony, but yet there were thousands of patients willing to commit a crime in order to get the medication they needed. When I heard this the question I had was, where are these patients getting their medication? The most obvious tells me they were either supporting Mexican Drug Cartels or they were growing it themselves. I personally hope they were growing it themselves. Anyway, speaking against Prop 203 was Mr. [REDACTED] who is a Representative of [REDACTED] [REDACTED] and his argument against Prop 203 included this statement: In California, where just within the last year, you've had three different dispensaries involved in murders, because of the criminal element that gets invited in the neighborhoods. In fact, the Associated Press on March 18, 2010 reported: SAN FRANCISCO "Patients, growers and clinics in some of the 14 states that allow medical marijuana are falling victim to robberies, home invasions, shootings and even murders at the hands of pot thieves. There have been dozens of cases in recent months alone. The issue received more attention this week after a prominent medical marijuana activist in Washington state nearly killed a robber in a shootout " the eighth time thieves had targeted his pot-growing operation. And later that year after this article was published, I found several crimes surrounding medical marijuana facilities in California:

1. On Dec. 15, 2010, at 9:35 p.m., (Los Angeles) West Valley Area officers responded to a radio call of a shooting at a medical marijuana clinic located in the 8200 block of White Oak Avenue. Detectives searching for three suspects responsible for a robbery and an attempted murder.
2. June 24, 2010 at 9:15 pm (Los Angeles) An employee was slain during a robbery attempt at a Hollywood medical marijuana dispensary -- the second killing of the day at a city marijuana store.
3. June 24, 2010 at 4:15 pm (Los Angeles) An employee was slain during a robbery attempt at a Hollywood medical marijuana dispensary

Anyway, the reason I bring up both the Pro and the Against Prop 203 here is because for me, I would rather see the patients growing their medicine rather than subjecting them to this crime. To support this Mr. Will Humble who said on February 1, 2011: limiting dispensaries to specific areas also eliminates the possibility of clusters of pot shops, a magnet for crime. So these "pot shops" as Mr. Humble calls them are "crime magnets", but under the latest draft rules, patients in Arizona will have no choice but to get in their car and drive up to 25 miles to visit one of these "pot shops" to purchase their medication. This burden I feel violates the patient's right to privacy. The question before us today is not whether to allow medical marijuana or not. The voters have already told us what they want. We are here today to answer the question of how do medical marijuana patients get their medications safely and at a cost they can afford. Under the current draft rules I do not believe many will be able to afford this medication. As reported just recently by our local news station channel 3 and referenced here today, the average cost for medical marijuana in Colorado is \$400 per ounce. Under Arizona law patients can have 2.5oz every two weeks for a total estimated cost of \$2,000 a month for a weed that grows in the wild! And this does NOT take into consideration Arizona's proposed sales taxes which is already being addressed. Let's take Chandler's sales tax rate of 8.8%. This \$2,000 now becomes \$2,176. And this does not factor the 300% tax as proposed in House Bill 2557! Simple first year business school tells me that with only 124 dispensaries in the entire state of Arizona that the supply and demand is going to increase the price of this medication to limits much higher than found in other states. The worse thing about this is that those who need this medication the most, are likely to not be able to afford it and will seek their medication elsewhere. By not allowing the patient to grow his own

medication, I believe Arizona is going to find an increase in illegal drug traffic simply because of economics. The patient is allowed to use it, but the patient can not afford it. As reported by [REDACTED] in September of last year, there are thousands of patients already using marijuana by the recommendations from their doctors. How is forcing patients to purchase at a dispensary going to help? I believe these patients are going to continue to be illegal and therefore your implementation of the Medical Marijuana Act will end up being a bigger failure than other states and only end up hurting those people who need it the most. I know Mr. Will Humble has been on record stating that growing your own has risks like fire and other crime, but what I understand is that these people are growing in closets or other risky areas to avoid detection. My research does not show an increase in crime or an increase in fires by those who are legally growing for medication purposes. And Mr. Will Humble said earlier this month that "pot shops" are "crime magnets". So why force the sick to purchase their medication from a crime magnets? My research also shows that Many medical marijuana patients prefer not to share their medical condition or how they treat their condition with their neighbors either. By forcing these patients to purchase from a dispensary, you are forcing them out in public with their neighbor or boss watching them enter the dispensary. Not to mention the possibility of some gang member waiting in the parking lot when he exits the store. When you walk into a pharmacy nobody knows what you are purchasing. But as soon as you walk into a dispensary, everybody knows exactly what you're doing there. And when you leave, you might just have 2.5oz of high grade medical marijuana with you. This is a risk I do not feel the state of Arizona can place on people. By allowing patients to grow their own medication I believe you solve a couple of problems. One, the patient can now afford their medication. And two, you lower the cost of medical marijuana for those who do not wish to grow. I know Mr. Humble has said he believe people who grow are going to be people who sell, but I do not believe that. Why would a medical marijuana patient sell illegally? If he was going to do that he would already be doing it. You not allowing a patient to grow will not change this fact. Plus, selling medical marijuana is a Class 2 felony under the law. That's the same as manslaughter and is punishable up to 25 years in prison. Who in the world would take that kind of risk? I'll tell you who. It's the person who is already breaking those laws and NOT the medical marijuana patient. Anyway, I hope you consider making a change here for the good. The way things are going now I can see this will create more problems than solve problems and Arizona will be known as the model to avoid. Allowing patients to continue personal cultivation will allow patients inexpensive, safe and legal access to the medication, that for many, can be life saving.

1 dispenser per 100 independant pharmacies

A major issue of concern to me and all others that drive on AZ highways is that the AZ rules do not seem to recognize the fact that marijuana seriously impairs the ability to drive a motor vehicle. Globally, marijuana use is currently involved as often as alcohol in traffic injuries, accidents and deaths [see references below]. While the draft rules focus on the compassionate use of marijuana for the "chronically debilitated" there appears to be a serious disconnect with the fact that such "chronically debilitated" people will smoke the drug and get into their cars/trucks/motorcycles etc and get onto the neighborhood streets, roads, and highways in AZ and pose a serious risk for the rest of the driving public. Is this a reasonable approach for the AZ Dept. of Health?? To focus on care for a few and to put the majority of AZ citizens at risk for permanent injury and death?? I don't think so and I don't believe that the AZ Department of Health has fully considered these consequences. In my opinion, as a condition of eligibility, individuals applying for the marijuana program should be required to

relinquish their drivers permits as long as they participate in the program.

AZ cannot tolerate establishment the "drug docs" that are prevalent in places like Colorado. These "docs" set up shop and make millions of dollars processing "med MJ" claims for headaches, backaches, joint pain, etc. You know their M.O. and we can't allow it to happen in AZ. I was disappointed that this draft reduces the accountability of physicians compared to the original draft. I would like to see a requirement of 8 hours training for all caregivers as part of the licensing process to become a caregiver. As a school employee, I have some real concerns about med MJ in relationship to our bus drivers or anyone who transports children. We need restrictions on people who transport the children or the elderly to protect them from riding in a vehicle with a driver who is "high" on medical MJ. This also applies to rapid transit drivers who drive county/city busses. I don't want be a passenger with a "high" bus driver.

A "doctor" should not be able to have more than 30 medical marijuana patients in a year and any increase in this rule must be approved by AZ DHS.

Reduce the cost and complex process. These are sick people. The rules should permit growing of small quantity by all patients to reduce the cost. The limited dispensaries and costly fees are going to create monopoly situation and excessive cost for the patient.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

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It seems that the draft proposal for dispensing medical marijuana has many unknown for the process of prescribing/ dispensing: 1- How is the actual prescription written? Does a doctor provide a written prescription (with their name, address, DEA number, etc.) to a patient? Can he/she call by phone or use a fax? Are there "refills" allowed? How long are the prescriptions good for? 2- How does the dispensary process such a prescription? Is there need for a label, with patient's name, direction for use, etc.? Should they keep an electronic records? 3- Is there a mandate to screen for patient's concomitant prescription and non-prescription drugs, patient education and consultation? If so, who is going to provide such service? The irony is that medical marijuana is being accepted as a medication, yet none of the safeguards for its safe and effective use have been overlooked or compromised. In fact, marijuana use poses many more challenges than other well-studied drugs. Whereas there is plenty of evidence for a therapeutic benefit of this compound, it is not a completely harmless drug, good under all circumstances. For instance, it can cause tachycardia, hypotension (making folks prone to falls/ hip fracture), hallucination (which may be additive to other drugs and/ or medical conditions posing threat of self-harm or harm to others), and the list can go on. As for any drug, having a potential therapeutic benefit does not mean an optimal therapeutic outcome. For the latter, individualized professional care remains a pre-condition. The solution to a multitude of problems raised above has already been tried and tested. Why not treat medical marijuana as a medication drug (a de facto schedule V for example, based on DEA classification) and dispense primarily through pharmacies? There are many advantages to such approach: 1- no loopholes in the prescribing dispensing process. 2- patients will have access to clean, professional medical care (instead of "back alley" dispensaries); their concomitant medical conditions and medications can be screened and they can receive full benefit of consultation on proper use and education of potential side effects. They will also be afforded professional help contact, should there arise a problem. 3- a computerized medication processing system can also yield labels (helping with use and also preventing diversion) and an easily traceable track. Unfortunately, many pharmacies may be hesitant to be associated with stigma of marijuana; on the other hand many are willing and able to fulfill this mandate. Short of limiting the permits for dispensaries to pharmacies only, the least that the Department of Health can do, is to make sure that enough permits are issued to pharmacies for safe and effective use of medical marijuana. The spirit of use of medical marijuana calls for a therapeutic use for appropriate medical conditions and it deserves to be implemented as such. Respectfully [REDACTED]

Have an initial 30 day period for Dispensary Applications to be submitted, before making licencing determinations

Rules need to include notification to Federal agencies for placement on list of those prohibited from buying or possessing guns due to known drug use. Almost no restrictions on the patient's growing of marijuana. At least what is sold to dispensaries should be tested by a certified laboratory as to quality. This protects other users from a tainted weak or unfit drug.

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LOCATION LOCATION LOCATION! Location of the dispensary owner/operator is as important as the location of the dispensary. The towns/cities dispensary will directly impact its citizens and community. The persons running it should be members of that SAME community and directly affected by the manner in which it is run. Saying you will give back to a community outside where you reside and actually living in and being a member AND INVOLVED IN that same community are two very different things. Owner/operators living in the city where their dispensary operates creates ACCOUNTABILITY, and personal interest in the health and well being of its citizens because they are our NEIGHBORS, FAMILY, CO-WORKERS, AND FRIENDS. WE CARE!!! PLEASE KEEP "CALI-RADO" OUT OF OUR BEAUTIFUL ARIZONA!

I don't think the selection process should be random. The states goal seemed to have been to be better than those states that already have medical marijuana, by trying to learn from their mistakes. Your random selection will not ensure that the "best" and "most qualified" will be running dispensaries. Since you are not requiring a medical professional to "dispense" the drug, I would think you would want to choose who it will be, not just someone who can fill out an application (or pay someone to do it for them). You call it a drug, you restrict it like a drug, yet you want to pass out permits randomly?? Give permits by merit, so the state does not set itself up for failure.

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Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year

Under section R9-17-315 (C) please clarify if the "audit" is an audit prepared by an independent CPA performed un generally accepted accounting principals in which an accountants letter is submited with the report or if the intention is for the designated individual prepare monthly inventory control reports that are "auditable" according to generally accepted accounting principals. .

The rules could be improved by creating more control and accountability for caregivers, such as registering the location of their home grow operations. I believe that accountability for caregivers falls under the intent of the law as the law provides for oversight of every other aspect "dispensaries, doctors, transportation and patients. The Marijuana Policy Project is a well-funded and organized group attempting to legalize marijuana in the US. When you draft the final rules, please be careful to weigh the comments that decrease control of marijuana in Arizona as comments posted on your website may not necessarily come from Arizona residents, taxpayers or registered voters.

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PLEASE reconsider this lottery system to hand out dispensary licenses. We know several groups of people applying and were always thankful of the original guidelines because we knew a couple of these groups would not receive a license, and rightfully so. You have so carefully (up to this point) handled the details of establishing a dispensary for the people of the state of Arizona---- do not be bullied now by those who want to simply "make the money" from this endeavor. Their threats of

lawsuits has created this decision for a lottery --that does not seem to have thought through very well. This is an incredibly serious business and other states will look to us in the future as they move forward. Arizona has the ability to be the leader but not by choosing our dispensary owners by lottery! Think this one through, return the right to establish a dispensary to those with the merits to carry it out in the safest most professional manner, keep the communities safe by knowing the history of the applicants and make sure they can show some sort of recent past or longstanding contributions to our communities. Consider a third party group (from out of state if necessary) to assess the applicants. DO this right.

Ensure that the number of patients a physician can recommend for medical marijuana is limited to no more than 100 per year.

Please do not institute a lottery for dispensary certifications. This will only cause extreme quality issues across the field. A lottery will only create a lower standard in applicants, service, facilities, medication, and agents. A lottery is the worst thing that could happen for AZDHS and law enforcement. Monitoring the lower standard lottery applicants will become a nightmare for the county law enforcement as well as for AZDHS officials who are forced to take on the added burdens of babysitting a playing field marred with unqualified/untrained agents, wasteful operations, and facilities that are lacking regulations. Allowing a lottery would be like throwing in the towel just before winning the fight. Patients should be allowed to be certified by medical cannabis physicians and still be able to choose their own primary care physicians and specialists. It is unconstitutional to make patients be treated for issues like cancer by a single physician because they prescribe that patient medical cannabis.

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A "doctor" should not be able to have more than 30 medical marijuana patients in a year and any increase in this rule must be approved by AZ DHS.

A "doctor" should not be able to have more than 30 medical marijuana patients in a year and any increase in this rule must be approved by AZ DHS.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

I have great concern that you are considering handing out dispensary licenses through a lottery system. I understand your concern about being fair and the threat of lawsuits by not being fair but the

outcome of NOT choosing high quality applicants seems to be a poor decision and a form of (legal??) gambling really--essentially those with money could submit 10 applications to stack the draw of a random pull!!! It seems that up to this point you have looked out for the good of the entire program by setting high standards and formalizing the process of attaining a license to dispense. Without assessing the initial applications to determine the merit of the individuals coming together to run a dispensary it appears that the threat of lawsuit of "being fair" is a way to manipulate this system. "Fair" would constitute putting the dispensaries in hands of the right people so AZ leads the cause for the nation. "Fair" would be granting a license not to those who just want to get wealthy but to those who already have a sense about this business, about the health of individuals that could be affected and to those who care about their community and have shown this through the work they do. I am very worried that a college kid, or someone with a lot of money but no sense of community could win the lottery. Please reconsider this lottery, it IS still your choice.

i think that the effort to spread out the dispensaries is commendable but using the chaa is not going to work. if you force a dispensary to some outer lying area and there is not enough patients to support it, the owners are forced into banruptcy. simply put, poeple living in rural areas are going to grow it anyway.

Be elimating the lottery and accepting the best of the best applicants, If the dept of health doesn't have enough money to grade the applications, we as applicants would be willing to pay more to be judged on our merits than on just minimal requirements. Have a seperate license for despening and a seperate license for cultivating 125 despensaries 125 cultivation sites.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

Rules are too stringent on dispensary location and moving location.

I believe there should be a restriction inserted into the rules limiting the number of recommendations that a physician can issue each calendar year for medical marijuana. I would suggest limiting that number to 100 or less than that per calendar year per physician.

Please do no allow alternative medicine (Naturopathy, e.g.) to refer or advocate for their members to be included. They cannot prescribe narcotics and they will use every excuse to provide their members with this alternative. Some of their inherent beliefs are foreign to allopathic and osteopaths medicine because of their restricted licenses. There should be very punitive laws for anyone obtaining marijuana under false pretenses or sharing their supplies with friends for recreational purposes - an inevitable happening. These pemalties must exceed the liberal marijauna possession laws now on the books. Do not in any way restrict employers from prohibiting employees from being on premesis after testing positive for marijuana. Impaired judgement goes with this use and the excuse that testing can detect use for several days does not mean it wasn't a hour before work. There

are serious implications for many industries requiring a clear mind for judgement. People needing this drug should not be in the workplace for most industries. Try to realize that many diagnoses are subjective and cannot be proven by clinical testing or evaluation, There include "chronic pain syndrome", "chronic myalgia", "generalized myositis" or whatever other title they may be given. This will be the real gimmic to obtain marijuana without an identifiable condition. God help the "real doctor" who has to make that decision. Any center that dispenses marijuana without absolute documentation of serious disease and pain not ammenable to common management alternatives should not only lose the license, but be heavily penalized in a court of law.

I would like to see an explicit inclusion of Idiopathic Peripheral Neuropathy as a qualifying patient condition. Article 2 #10 specifies non-specific chronic or debilitating pain, which neuropathy would qualify, but having an explicit inclusion would result in, in my humble opinion, less subjectivity for patients such as myself in qualifying for the program. I understand the specific process by which items can be added to this list, I wanted to make the request specifically prior to the end of public comment deadline.

#### DO WHAT THE VOTERS VOTED FOR

The Office of Legal Affairs of the Drug Policy Alliance urges that Â§R9-17-106, "Adding Debilitating Condition," be modified to delete or amend subpart (7) of Part A of that section. This section of the proposed regulations currently states, in relevant part, that a person must submit an application to add a debilitating condition containing, inter alia: (A)(3) the name of the medical condition or the treatment of the medical condition the person is requesting be added; (4) A description of the symptoms and other physiological effects experienced by an individual suffering from the medical condition or the treatment of the medical condition that may impair the ability of the individual to accomplish activities of daily living; (5) The availability of conventional medical treatments to provide therapeutic or palliative benefit for the medical condition or the treatment of the medical condition; (6) A summary of the evidence that the use of marijuana will provide therapeutic or palliative benefit for the medical condition or the treatment of the medical condition; and (7) Articles, published in peer-reviewed scientific journals, reporting the results of research on the effects of marijuana on the medical condition or the treatment of the medical condition supporting why the medical condition or the treatment of the medical condition should be added." To require persons who seek to add a debilitating condition to submit articles, published in peer-reviewed journals, concerning research regarding the efficacy of medical marijuana for a particular condition erects an unreasonably high burden that, at least for the foreseeable future, will rarely, if ever be met because of the refusal of the federal government to permit the vast majority of such research to be undertaken. While marijuana has demonstrated exceptional promise as treatment for many disorders and conditions, published peer-reviewed research regarding its medical efficacy has long been curtailed by the federal government's monopoly on the production of research marijuana and its long-standing refusal, with few exceptions, to sanction marijuana-related research. In fact, marijuana is considered to be the most difficult drug in the country to study (see AMICUS CURIAE BRIEF OF THE MARIJUANA POLICY PROJECT AND RICK DOBLIN, PH.D. IN SUPPORT OF THE RESPONDENTS, *Gonzales v. Raich*, 545 U.S. 1 (2005), at p.18, available at [REDACTED] (visited February 16, 2011.) One recent (and continuing) example of federal efforts to thwart medical marijuana research is the federal government's continued denial of a request by [REDACTED] of the [REDACTED]

██████████ to cultivate different strains of marijuana with varying levels of THC and other cannabinoids, for use by researchers to investigate the clinical significance of different genetic strains of marijuana. Because the federal government authorizes the production of only one strain of low potency marijuana – a strain that many clinical researchers have found to be inadequate -- a federal Department of Justice Administrative Law Judge expressly found that “that there is currently an inadequate supply of marijuana available for research purposes, that competition for such purposes is inadequate” and that ██████████ registration to cultivate marijuana would be in the public interest. In the Matter of ██████████ Department of Justice, Drug Enforcement Administration, ██████████

██████████  
██████████

Notwithstanding this finding by an impartial arbiter, the federal government has refused to follow the judge’s recommendation and continues to deny ██████████ application. Because of the obstacles to medical marijuana research erected by the federal government, Arizona’s draft regulations regarding adding new debilitating condition are overly onerous and make it unlikely that patients petitioning to add conditions will be successful. In this regard, it is notable that the vast majority of other medical marijuana jurisdictions require only that there be some scientific evidence supporting the palliative effect of marijuana, not “published” “peer-reviewed” evidence or its equivalent.. For instance, in Rhode Island, the petitioning patient need only submit “Any literature supporting the addition of the condition to the list.” In New Mexico, the petitioning patients must submit information as to “the proposed benefits from the medical use of cannabis specific to the medical condition, medical treatment or disease sought to be added to the existing debilitating medical conditions listed under the act” and “any additional supporting medical, testimonial, OR scientific documentation.” [capitalized emphasis added] Moreover, some patients may suffer from rare conditions or from conditions for which extensive research has not been conducted or for which there is not a generally accepted view among experts regarding marijuana. These patients should not be penalized if there is some evidence that marijuana will help alleviate their suffering, but there has not yet been extensive research or analysis by the medical community to prove so. For these reasons, the Drug Policy Alliance strongly urges the Department to amend the proposed regulations to not require persons who seek to add a debilitating condition to submit “[a]rticles, published in peer-reviewed scientific journals” supporting their request.

The Debilitating conditions do not include and mental conditions (e.g. psycho-affective, bi-polar, anorexia, ect.)

Hi, my name is ██████████, I appreciate you all listening to the public's comments and making changes based off what we want. I have some suggestions that I think would help improve the program and please the people who initially supported and voted to pass prop 203. If there are any problems reading this, please let me know, and I can submit the department my comments in a more readable format. My e-mail is ██████████, my phone number is ██████████ ----- PAGE 35: R9-17-303 - A. "Each principal officer or board member of a dispensary is an Arizona resident and has been an Arizona resident for the two three years immediately preceding the date the dispensary submits a dispensary certificate application." - YOU NEED TO CLARIFY WHAT A RESIDENT IS. I SUGGEST YOU CHANGE IT FROM "...is an Arizona resident and has been an Arizona resident..." TO "...is a

permanent Arizona resident and has been a permanent Arizona resident..." ALLOWING PART-YEAR RESIDENTS MAY LET IN OWNERS WHO HAVE NO INTEREST IN THE LOCAL PATIENT COMMUNITY. IT WILL ALSO OPEN THE DOOR TO OUT-OF-STATE DISPENSARY APPLICANTS TO SPREAD INTO ARIZONA (MAY OR MAY NOT BE A BAD THING, BUT DEFINITELY DOES NOT SUPPORT THE PEOPLE OF ARIZONA). PERHAPS EVEN CHANGING IT TO "Each principal officer or board member of a dispensary has held permanent Arizona residency for the three years immediately preceding..." TRUE CITIZENS OF OUR ARIZONA COMMUNITIES WILL GREATLY APPRECIATE THIS KEEPING ARIZONA'S PATIENT'S MONEY IN ARIZONA'S ECONOMY. ----- PAGE 46: R9-17-312 - A. "A dispensary shall appoint an individual who is a physician to function as a medical director." - PROPER MEDICAL OVERSIGHT AND MAKING SURE PATIENTS ARE EDUCATED ON THE SAFE AND HEALTHY WAY TO USE THIS MEDICINE IS VERY IMPORTANT. WHAT I DO THINK IS ABSURD IS REQUIRING THAT PERSON TO BY A PHYSICIAN. THE DESCRIPTION OF A MEDICAL DIRECTOR (R9-17-312 A) IS BASICALLY ONE WHO DOES SOME RESEARCH ON CANNABIS, THEN WRITES "EDUCATIONAL INFORMATION" AND CREATES PSEUDO-SCIENCE SURVEYS THAT PATIENTS MAY NEVER READ, OR PARTICIPATE IN. THE ROLE DOES NOT EVEN REQUIRE OVERSIGHT, JUST AVAILABILITY VIA PAGER AND A ONCE-A-YEAR COMMITMENT TO CREATE "EDUCATIONAL INFORMATION" FOR PATIENTS THEY MAY HAVE NEVER SEEN. WHY NOT OPEN THE DOOR TO A CERTIFIED PHARMACIST OR A REGISTERED NURSE WHO WILL BE THERE, ON-SITE, TO PROVIDE OVERSIGHT AND GUIDANCE TO PATIENTS? SURELY THEY ARE QUALIFIED AND MORE LIKELY TO ACTUALLY BE AVAILABLE AND ACCESSIBLE TO PATIENTS FACE-TO-FACE. BESIDES, THE PHYSICIAN THAT RECOMMENDED USING CANNABIS TO THE PATIENT SHOULD BE THEIR GUIDE ON PROPER USE. I SUGGEST YOU CHANGE IT FROM "...an individual who is a physician..." TO "...an individual who is a physician, certified pharmacist, or registered nurse..." (YOU COULD ALSO ADD OTHER PROFESSIONS THAT YOU BELIEVE WOULD BE SUITABLE). IF YOU DO NOT ALLOW DIFFERENT TYPES OF INDIVIDUALS TO BE MEDICAL DIRECTORS, THEN I THINK YOU SHOULD NEED TO MAKE SOME SERIOUS CHANGES R9-17-312 C & D, WHICH UTILIZES THE POWERFUL RESOURCE OF A PHYSICIAN AND ACTUALLY REQUIRE THEM TO BE AT THE DISPENSARY. DOING THIS WOULD BE IRRATIONAL BECAUSE THERE ARE HARDLY ENOUGH DOCTORS THAT ARE WILLING TO WRITE RECOMMENDATIONS, LET ALONE, ANOTHER 125 FOR EACH DISPENSARY. I HIGHLY SUGGEST KILLER TWO BIRDS WITH ONE STONE, AND ALLOWING OTHER TYPES OF INDIVIDUALS TO FILL THE ROLE OF MEDICAL DIRECTOR. ----- PAGE 32: R9-17-302: "Dispensary Registry Certificate Allocation Process" - IT IS NOT TOO LATE TO COMPLETELY BACK AWAY FROM USING THE CHAA MAP TO DISTRIBUTE DISPENSARIES. I DO NOT SEE ANY BENEFITS FOR PATIENTS, CAREGIVERS OR DISPENSARY OPERATORS BY USING THE CHAA SYSTEM. THE POPULATION DATA IN THESE CHAAS HAS VERY HIGH VARIANCE, WHICH WILL DESIGNATE HUGE DISPENSARY FACILITIES IN THE HIGH-POPULATED CHAAS , WHICH WILL BE PROHIBITED TO EXPAND BY LOCAL ZONING REGULATIONS WHICH SPECIFY A CERTAIN ALLOWED AMOUNT OF SQUARE FOOTAGE OF FLOOR SPACE. SMALLER CHAAS WILL HAVE DISPENSARIES THAT WILL FAIL BECAUSE THERE AREN'T ENOUGH PATIENTS AROUND TO SUPPORT IT. WHEN A DISPENSARY GOES DOWN, THE 25-MILE HALO DISAPPEARS AND GROWERS MAY FLOCK TO THAT AREA, DESTROYING THE POINT OF GEOGRAPHICALLY CONTROLLING WHERE PEOPLE CAN GROW. YOU CAN IMAGINE WHAT KIND OF PROBLEMS AND LEGAL-BATTLES THIS WILL CREATE. INSTEAD, I SUGGEST YOU FOLLOW THE INITIATIVE, PROP 203 THAT SAYS THERE ARE TO BE NO MORE THAN ONE DISPENSARY FOR EVERY PHARMACIES. YOU CAN BREAK THE STATE DOWN INTO ZONES USING COUNTIES. YOU CAN EASILY FIND OUT THE NUMBER OF PHARMACIES IN EACH COUNTY, THEN ALLOCATE THE NUMBER OF DISPENSARY CERTIFICATES ACCORDING TO HOW MANY PHARMACIES ARE IN THAT COUNTY, DIVIDED BY 10. LOCAL ZONING REGULATIONS FOR DISPENSARIES AND CULTIVATION SITES ARE ALREADY ESTABLISHED AND STRICT ENOUGH TO RELIEVE YOUR CONCERNS ABOUT "POT SHOPS" POPPING UP AROUND SCHOOLS, PARKS, OR PLACES WHERE CHILDREN MAY BE. PATIENTS IN RURAL AREAS WHO

DON'T HAVE ACCESS TO GETTING TO A DISPENSARY CAN DESIGNATE A CAREGIVER TO SUPPLY THEM WITH THEIR MEDICINE. OR, IF THE LOCAL ZONING PERMITS, THE PATIENT COULD ORDER MEDICATION FROM A DISPENSARY AND HAVE IT DELIVERED TO THEM, OR THEY COULD GROW THEIR OWN MEDICINE. THERE WILL BE NO PROBLEM FOR PATIENTS IN RURAL AREAS TO GET ACCESS TO THIS MEDICINE. PLEASE BE AWARE THAT LOCAL ZONING REGULATIONS MENTION THAT DISPENSARIES MUST BE A CERTAIN NUMBER OF FEET AWAY FROM OTHER DISPENSARIES. THIS STOPS A BUNCH OF DISPENSARIES TO POP UP ON EVERY CORNER, LIKE CALIFORNIA AND COLORADO. LOCAL ZONING REGULATIONS ARE MADE TO KEEP THE PUBLIC SAFE, RIGHT NOW, LOCAL ORDINANCES ARE BEING EXTREMELY SAFE WHEN IT COMES TO DISPENSARIES AND CULTIVATION LOCATIONS. I ASK THE DEPARTMENT TO RELY ON THE POWER OF LOCAL ZONING REGULATIONS TO CONTROL WHERE THE DISPENSARIES WILL BE DISTRIBUTED, AND STICK TO PROP 203, ALLOCATE DISPENSARY CERTIFICATES BASED ON THE NUMBER OF PHARMACIES, USING EACH COUNTY AS ZONE. ----- PAGE 35: R9-17-303 - B. "To apply for a dispensary registration certificate, a person shall submit to the Department the following:" - I SUGGEST YOU ADD "9. Proof of sufficient capital to open the dispensary, in the form of a bond or bank statement." - DISPENSARY APPLICANTS SHOULD HAVE SUFFICIENT CAPITAL TO GET THEIR DISPENSARY OPEN, ACCORDING TO THEIR BUSINESS PLAN. THIS WILL DECREASE THE AMOUNT OF TIME QUALIFYING PATIENTS WITH ID CARDS WILL HAVE TO WAIT TO OBTAIN MEDICINE FROM A DISPENSARY. IT WILL ALSO PROBABLY DECREASE THE AMOUNT OF APPLICATIONS, WHICH WILL DECREASE THE AMOUNT OF RANDOMNESS IN THE LOTTERY. ----- PAGE 37: R9-17-303 - B. "5. 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;" - THE DEPARTMENT MAY DEDICATE A LOT OF TIME AND RESOURCES GOING THROUGH AN APPLICATION, WHO HAS A SIGNED STATEMENT SAYING THEY ARE IN COMPLIANCE WITH LOCAL ZONING, BUT, IN REALITY, ARE NOT. AN EASY SOLUTION TO ELIMINATE THIS POSSIBLE WASTE OF TIME AND RESOURCES IS TO CHANGE THE LANGUAGE TO "5. A statement signed and dated by a local city or town council employee, certifying that the dispensary is in compliance with local zoning restrictions;"

continues negotiations between growers and Regulators.

GET WITH THE PROGRAM AZDHS (WILL HUMBLE-DIRECTOR), AND STOP ACTING SO STUPID! HELP THE PATIENTS OR DON'T HELP US AT ALL! Within R9-17-202 Paragraph F; section 5; is subsection e, which DISCRIMINATES against qualified patients from obtaining a Registry ID Card. AZDHS is requiring a patient-doctor relationship that currently is not feasible in today's reality, as physicians are not willing to give medical marijuana recommendations, and the only way to get a medical marijuana recommendation is to see a medical marijuana physician. Yet, your new draft rules require a recommending medical marijuana physician to assume responsibility for management and routine care of the qualified patient, when in today's reality the recommending medical marijuana doctors only want to see these qualified patients for their marijuana related issues, not their 'management and routine care' of their debilitating condition and physicians don't want to or can't recommend medical marijuana to their patients. This is a MAJOR ISSUE with some qualified patients i.e. Disabled U.S. Veterans. Their VA Medical physicians can't write them a medical marijuana recommendation and they can't see a medical marijuana physician for management and routine care, because it won't be covered by their VA Medical Benefits. HOW AZDHS, CAN YOU REQUIRE SOMETHING WHICH DOES NOT EXIST! HOW AZDHS, CAN YOU EXPECT YOUR CURRENT DRAFT RULES TO STILL WORK IN TODAYS ENVIRONMENT. IT IS A CATCH 22.

By requiring a dispensary applicant to show liquid ability to operate, and carry the cost of the

dispensary through the first year of operation should be an important component in deciding what a "qualified applicant" is. Without this, the person who receives the Dispensary registration certificate may have more good intentions than ability to be in full compliance with the regulations set forth in the draft rules. In addition diversion of medicine to cover cost may become a consideration of those who don't have the capital to carry the organization through the first year. With tight time frames, and strict regulations, the ability to pay for and fully comply with the laws, must be taken into consideration. Lack of capital will cause lower allotments for security, qualified medical directors, and allow operators who may be more likely to divert to obtain certificates.

I think it's a mistake to allow law officials to impose their prejudices on patients. Prohibition does not reduce demand. Don't make us criminals for finding relief in a plant that does not include the the side effects of pharmaceuticals. Please respect the professional opinion of the doctors.

ARTICLE 1. GENERAL R9-17-101 Definitions 15. b. CHANGE: 10 foot walls to 6 foot walls.(they are most common to Home Owners Association rules and most if not all HOAs prohibit walls greater than 6 feet. STRIKE: "that prevent viewing of the marijuana plants" CHANGE TO: "that prevent viewing of the marijuana plants from street at normal eye level". ARTICLE 2. QUALIFYING PATIENTS AND DESIGNATED CAREGIVERS R9-17-201. Debilitating Medical Conditions ADD: DIABETES ADD: HIGH BLOOD PRESSURE ADD: ANXIETY and DEPRESSION

We have concern with a requirement on page 35 of the Medical Marijuana draft. Item B-1-b requires the physical address of the proposed dispensary. This seems unreasonable to expect an applicant to rent or purchase any such property prior to securing a registration certificate. Suggest this be amended to read the same as R9-17-34 on page 38. This allows the person holding the certificate 60 days to secure a physical address. This should apply to the cultivation site and dispensary. Our due dilligance concerning application has taken our group to California and Colorado to inspect dispensaries and cultivation sites. Here is what we found: An abundance of both dispensaries and cultivation sites - some good, some not so good. In both states one could assume current operators plan to apply for certificates in Arizona. Are you aware that multiple out of Arizona residents plan to apply for multiple certificates using existing residents as shills. Like in many things there is clean money and dirty money. On each of our visits we were asked to partner with them. (We declined). AZDhS should select the most qualified applicants. Random or lottery type selections would seem not to be in the best interest of the program.Should qualify by application, business plan and personal interview. AZDHS should establish a heavy fine for any misrepresentation in acquiring a certificate. Be fore warned that there will be multiple applications for specific locations by residents and non-residents. Number of locations should be determined by population. Maricopa County has 60% of the states population and would seem to warrant 60% of the locations. What are the specific zoning requirements for the cultivation site and the dispensary. It is not legal to purchase plants or to transport across state lines. Where does AZDHS expect certificate holders to secure seeds or plants? Suggest you provide a period of time for such purchase and transport so this can be accomplished legally; otherwise, the start up will be outside the law.

**\*\*UPDATED\*\***RE: R9-17-202 Paragraph F., section 5., subsection e.: Please remove entire subsection e., as requiring patients to see their recommending Medical Marijuana physician for "management and routine care" would cause them financial distress. i.e. Veterans with VA Medical Benefits that

need to see their Medical Marijuana doctor for a recommendation, but cannot see them outside of their regular VA Medical team, due to it would not be covered financially for them. This is why requiring Patient Applicants for the new Registry Identification Card to see their recommending Medical Marijuana physician for "management and routine care" would DISCRIMINATE against Veterans, as well as anyone who is financially distressed and only wants to see a Medical Marijuana physician for the Recommendation, but keep their original doctors, as well.

RE: R9-17-202 Paragraph F., section 5., subsection e.: Please remove entire subsection e., as requiring patients to see their recommending Medical Marijuana physician for "management and routine care" would cause them financial distress. i.e. Veterans with VA Medical Benefits that need to see their Medical Marijuana doctor for a recommendation, but cannot see them outside of their regular VA Medical team, due to it would not be covered financially for them. This is why requiring Patient Applicants for the new Registry Identification Card to see their recommending Medical Marijuana physician for "management and routine care" would exclude Veterans, as well as anyone who is financially distressed and only wants to see a Medical Marijuana physician for the Recommendation, but keep their original doctors, as well.

Abandon 'reform' for repeal, that is to say, TABLE the Rules as unconstitutional extensions of the unconstitutional laws of Prohibition. REPEAL all marijuana laws; And, we demand use of the 10th Amendment to deny Federal enforcement of the illegal drug laws in AZ. Recognize the ultimate un-enforce-ability, the inexpediency of it all.

1. The CHAA areas seem to contradict the spirit of the proposition. I thought there were supposed to be 1 for every 10 pharmacies? The current CHAA maps don't effectively take into account population and I think it will be a hardship for patients in some of the larger areas that only have one dispensary.  
2. Randomly picking the dispensary makes sense based on your staffing and time limitations. However, I think that the qualification process for the dispensaries should be more rigorous. They should have to show financial solvency and I think it would be a good idea if they had to present their idea to a panel (maybe 5-10 minutes) so that you can weed out those who are figureheads for out-of-state corporations and those who have no idea what they are getting themselves into  
3. I think that this should be kept to Arizona residents and that all dispensary agents and board members should have to be residents for at least 1 year.  
4. I think anyone applying for a dispensary should have to disclose if they are affiliated in any way with another dispensary (i.e. out-of-state owners coming here to do the same)

Severe headaches and migraine headaches should be included in the rules

The one area that I feel MUST be improved and changed is the patients right to grow his own medication. As reported by MSNBC and just recently by our local news station channel 3, the average

cost for medical marijuana is \$400 per ounce in Colorado. Under AZ law a patient can have 2.5oz every two weeks for a total estimated cost of \$2,000 a month for a weed that grows in the wild! And this does NOT take into consideration Arizona's proposed sales taxes which is already being discussed. Let's take Chandler's sales tax rate of 8.8%. This \$2,000 now becomes \$2,176. And this does not factor in the proposed House Bill 2557 of a 300% tax! Simple business 101 tells me that with only 124 dispensaries in the entire state that supply and demand is going to increase the price of this medication to limits much higher than found in other states. The worse thing about this is that those who need this medication the most, are likely to not be able to afford it. By not allowing the patient to grow his own medication, Arizona is going to find an increase in illegal drug traffic simply because of economics. As reported by ██████████ in September of last year, there are thousands of patients already using marijuana by the recommendations from their doctors. What? You mean to tell me there were thousands of patients illegally buying and growing medical marijuana back in September? What make you think by forcing these patients to purchase at a dispensary is going to stop that? So all these needy patients are going to continue to be illegal and therefore your implementation of the Medical Marijuana Act was a failure to those people who need it the most. I know Mr. Will Humble has been on record stating that growing your own has risks like fire and other crime, but that's likely because these people are growing in closets or other risky areas to avoid detection. My research does not show an increase in crime or an increase in fires by those who are legally growing. And Mr. Will Humble also stated earlier this month that "pot stores" are "crime magnets". So why are you forcing me to purchase my medication from a crime magnet? Many medical marijuana patients also prefer not to share their medical condition or how they treat their condition with their neighbors either. By forcing these patients to purchase from a dispensary, you are forcing them out in public with their neighbor or boss watching them enter the dispensary. Not to mention some gang member waiting in the parking lot for me to exit the store. When I walk into my pharmacy to purchase my medications, nobody knows what the medication is. In fact, I might be going to CVS to pick up an aspirin or to simply purchase a gift card. But the second I walk into a dispensary, everybody who sees me enter knows exactly what I'm doing there. And they know that when I exit, I'll have up to 2.5oz of high grade medical marijuana. This is a risk I do not feel the state of Arizona can place on me and my family. But allow patients to grow their own medication and you solve a couple of issues. One, the patient can now afford their medications. Two, the cost of medical marijuana is decreased because the patient is now the dispensary's competition. I don't know what the big deal is. I know your objective is that people who grow are going to be people who sell, but who are you kidding? Why would a medical marijuana patient sell illegally? If he was going to do that he would do it even if you didn't allow him to grow. You not allowing him to grow will not change that fact. Plus, selling is a Class 2 felony under the law. That's the same as manslaughter, punishable up to 25 years in prison. Who in the world would take that kind of risk? I'll tell you who that is. It's the person who is already breaking those laws and NOT the medical marijuana patient. Anyway, I hope you consider making a change here for the good. The way things are going now I can see this will create more problems than solve problems. Let's face it, you are already allowing everyone to grow at least until there is a dispensary within 25 miles of their home. Why make them purchase later from some business they may not feel comfortable visiting? Believe it or not, there are a lot of medical marijuana patients that don't want dispensaries in their neighborhoods either. In fact, there are many potential medical marijuana patients that did NOT vote yes on Prop 203.

1. I would limit the number of applications that any person can have any interest in, without exception. If there are large pools of persons, joining together to make many applications, I would require all names to be listed, all Members and Directors to be named, and unchanged for a period of

time, except for cause. I would fail to license or revoke the license of anyone who violates the X number of applications rule, not just void the rights of the offending applicant. I realize that the State needs to fund the program, but allowing the wealthy stuff the ballot box is almost as bad as the "pseudo-merit based selection process." I say "pseudo" because if anyone makes the effort, they can pump up their application for a dispensary by promising all sorts of programs, charitable giving, ancillary services, extra security features, etc. Are these promises really going to be enforced? I highly doubt it. If these extra services are important to the consuming public, a sufficient number of dispensaries will provide them to obtain and retain patients. To cure any deficiency suffered from having random-based applications selected, see #2 below. #2 I suggest that the State place more definite requirements upon dispensaries, regarding record keeping, security, if necessary, and to attempt to obtain, monitor and record, with patient consent, a whole range of data that could be used to study drug interactions, effects of marijuana on hundreds of physical and mental ailments and abilities. Who knows maybe we'll prove that marijuana is horrible and the voters will repeal the legislation. The dispensaries could be required to devote a certain number of hours to various types of programming, The State could provide literature, etc. There are lots of creative ideas out there. The application procedure should not be a test to see who can promise the most.

What happens when the D. caregiver want to go on vacation or quits. The patient is then without one until another suitable caregiver can be found. There needs to be a provision for alternates in case of these types of emergencies, such as above or what if the caregiver dies? The patient and caregiver have to go through a long process.

As with any new and a lot of the existing laws. Everything is too wordy! Make it simple... But good luck on that.

I firmly believe by adding another license incorporating either a growers, or cultivation license to your current list of registry cards is your strongest possible move. This will hereby remove any doubt that dispensaries will not be able to provide medicine adequately and efficiently within the first year and any time thereafter. I also feel it is not only our duty to provide cheap medicine, but medicine held to the highest possible standards excluding growth hormones and pesticides. Growers should strive for the pinnacle of quality not only cultivating marijuana but doing so while preserving both THC, and CBD content.

Here are several concerning issues I have with the rules that I do not believe are directly addressed in this form How will it be managed when an officer suspects a patient of DUI under the influence of marijuana? Will users be advised not to drive within a certain time period of using the drug? What is my recourse if I am involved in an MVA where the other driver is under the influence? Will there be a contraindication for asthmatics or COPD patients? Will they be instructed to only use oral forms? Are there any proper RTC studies of efficacy for any of the indicated diagnoses? How am I as a physician supposed to know how this interacts with other medications I prescribed? Will other controlled or sedating substances be contraindicated, such as opiates, benzos, or alcohol? Will there be a registry, like the state pharmacy database, where physicians can see if their patients are getting medical marijuana? As physicians, should we refuse to prescribe other sedating medications if a patient is using marijuana? Since the physicians that run these dispensaries agree to take on management of these diagnoses, will they be prescribing other medications; i.e. narcotics for chronic pain patients? Is it appropriate for one physician to be prescribing narcotics and another prescribing marijuana? Why have all the rules about continuity been taken out of the rules? Shouldn't there be

some form of continuity established if a patient is being prescribed an addictive substance?

As I read through the 2 drafts, I was disappointed to find no licensing for the farmers of Arizona in which to include this herb. The herbs, fruits and vegetables that we currently grow are in high demand to naturalist looking for this type of alternative growing. You make no provisions for "cultivation sites" or horticulturists like me. I am not interested in dispensaries, and would like to continue what I am doing to include this healing herb. To serve my community and help people achieve organic results to their debilitating medical conditions. Your current rules do not allow the farmers of Arizona to easily and legally provide this service to the people. R9-7-316 Product Labeling and Analysis Finally, my question to the board is "elf smoking marijuana causes cancer, why is cancer the number one disease listed in which qualifies one as a patient? As per article 2 R9-17-201. What is this statement saying to the patient? You have already been diagnosed with cancer, we approve this marijuana for your condition so you can get some more! The statement is contradictory.

Nurse Practitioners should be able to recommend MM. If Homeopaths can do it, a medical professional grounded in real science should have the same privilege.

allow all patients to grow their own if they have the knowledge

I attended the open session on 2/25/11. Please consider what one person addressed..... You do not monitor pharmacies with this much control and a medical doctor is not on call at a pharmacy; however, you are requiring a doctor with a dispensary. It doesn't make sense. There are many medically licensed medical individuals that can monitor the medical training that is required. Why does it need to be a medical doctor?

R9-17-202 and other F. f. Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient's medical use (because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary;) All qualifying patients should be allowed to cultivate marijuana plants for personal use regardless of distance to nearest operating dispensary. Given that the average cost per ounce is estimated to be between 250 dollars up to 400 dollars this rule creates an unfair and unproportional burden on those living within the 25 mile radius. The State Attorney General seems to gloat over the fact that State and Local taxes can be imposed on purchases made from dispensaries, yet if I grow and consume my own there is no tax? So I am told that I have to purchase and pay taxes while others can grow and use...how is this not an unfair tax burden? I am also amused with how the State Attorney General seems to take pleasure in "putting it to" those individuals that must prove they are chronically ill and with debilitating disease. WaaHoo, lets pilfer the weakest and sickest of our citizens...God you have to love politicians! So how about this, if this rule winds up staying as written, how about we take the taxes generated from the purchase of medical marijuana and subsidize the cost of medical marijuana so those living within the 25 mile radius can afford their medical marijuana.

The whole allocation of license by Community Health Analysis Area (CHAA) is cumbersome, illogical while adding no more control to the licensing process. It should be deleted and left to the cities to allow operations since the individual cities have (or will have) ordinances to control the sites available for dispensaries or cultivation areas within their own jurisdiction. The boundaries of a CHAA in

conjunction with the cities ordinances may preclude any medicinal marijuana operation in that CHAA. It should be the state regulations which control the licensing process and dictate regulations for licensing, inventory control, etc and perhaps allocate licenses based on population by County. For example, a new regular pharmacy has to be licensed by the state and follow the regulations, but the state does not tell that pharmacy that they have to locate within a certain designated area. That is a zoning issue.

1. Discontinue the Lottery System. It encourages graft and organized crime money to enter our State. It takes resources to open a "clinic type business" just as it does to open any business. Why would the "BEST and BRIGHTEST" want to invest many thousands of dollars in capital expenditures to buy only a LOTTERY ticket. Successful people do not stay successful for long doing that. It almost looks as though someone has already "gotten to" DHS officials on this one. VERY POOR IMAGE for you. USE A MERIT BASED SYSTEM only!!!! 2. Discontinue the CHAA method of allocating dispensaries. Leave that up to the cities based on their set back requirements. One Licensee per CHAA discourages competition and will increase the prices for those with a medical need who cannot afford it. The LAW does NOT give the DHS the right to do it this way. 3. Discontinue or clarify the "one entrance rule". Deliveries should not be through that door, and what if there is a fire blocking that one entrance. Poorly written, and probably not your intentions.

I think you need to add back the wording that dispensaries grow 70% of the medical marijuana that they sell. Having large, monopolistic farms supplying multiple dispensaries would not be helpful at all to the local economies of each city/town that has a dispensary. I think more well paying jobs would be created in total, and are desperately needed in each local area, by having each dispensary grow its own medical marijuana. For example if a large "farm" opened in Phoenix, but supplied product to smaller towns or even rural areas, the jobs/taxes/etc would be skewed to Phoenix rather than the smaller town/cities/areas. In addition, the high risk of criminal activities that might occur during transportation of the medical marijuana from the large farms to each dispensary just seems too risky.

The draft rules could be improved by deleting the proposal to use the CHAAs as a method of distributing the dispensaries. There is way too much discrepancy in the population of the CHAAs. For example one has a population of 182 and it gets a dispensary? I feel that the best method is to use the same formula that determines how many there are to be in the state. Each city should be allotted one dispensary for every ten pharmacies in that city. R9-17-303 should be amended to read Each principal officer, board member, or PERSONS WHO HAVE ANY FORM OF OWNERSHIP IN THE DISPENSARY is an Arizona resident and has been an Arizona resident for the three years immediately preceding the date the dispensary submits a dispensary certification application. Without the amended wording out of state investors can own a dispensary and hire the principal officer to run the dispensary and obtain the license for them. You will lose control if out of state people buy in. Their motive will be to turn Arizona into another California. Let's keep this for Arizona residents only. I question the impartiality of the AMMA. Their franchise approach with high capitalization creates a situation in which only their rich backers will be able to apply. I favor the Mom & Pop approach. Don't rule out the small investor like the AMMA wants. The recommending Doctor should be the one doing the patient education not the dispensary. No medical director should be required at the dispensaries. They're not required at pharmacies so why at the dispensaries.

The regulatory process for adding a covered condition is clumsy, onerous and open to lawsuit. Who is to decide whether a condition qualifies? Do we set up a whole new branch of ADHS to act as pot

police??This is not what you were hired for. It should be up to an independent group of medical professionals serving in that specific capacity to recommend and add conditions. The entire process should take weeks,not years. these are dying people many of them and they should not have to wait over a year to have some possibly unqualified party decide their fate. This provision has lawyers salivating.. and there is really no reason for ADHS to take on the job they are not qualified for. Only medical professionals should be involved in these calls.

Eliminate the Medical Director per dispensary, form a small members board for the entire State to facilitate the educational materials. Doctor - Patient relationship should and will be the primary medical responsibility in the entire process. Many Doctors are not willing to associate themselves with the mmd enterprise for fear of losing their license, Doctors in Navajo County are posting signs in their waiting rooms that will not be certifying, recommending, etc. med marijuana period and not to ask...

The draft rules need to reflect patient needs better and stop being so fear based and reactionary.The 25 mile distance needs to be defined as by roadway. These are handicapped people and truly can't fly across a mountain to get their medicine.I understand that the 25 mile in a direct line serves to keep patients from growing. But you need to consider their economic and physical condition. Inb the states where rural patients grow their own there has not been a problem with muggings or security..so why is it a problem here for rural patients to save thousands each year by growing their plants? We see this as deliberate intent to circumvent the law passed by the voters. It appears to be a conspiracy with law enforcement to try to create a system where home growing is not allowed. The 25 mile direct line definition serves to do that,as does the CHAA system. The CHAA system will only serve to create dispensaries that fail,and holes in the plan..How does that serve anyone? You need to look at the fact that by overregulating and acting in fear over the choice the voters made regarding medical marijuana you are turning this perfect small business opportunity into a game which can only be entered into by the rich.

The AzMMA only says that one 'can' go in each county, not even that one 'has' to go in each county. This unlawful attempt at dispersing the dispensaries in such a way as to eliminate almost every possible patient or caregiver from growing their own medical marijuana, goes against the letter and spirit of the law and is evidence of the Department's willingness to subvert the will of the voters. Whatever your fear is, it should be abated. The law only allows caregivers to grow for 5 patients. The caregiver will not be as you have said, a 'legal dope dealer', though I guess you don't mind the dispensaries being giant 'legal dope dealers'? In case you folks didn't read the law, it only allows the caregiver to provide medical marijuana to the patients that have signed him or her up as their caregiver. There is no incentive to divert, as all gains would be lost if ever caught, and you would not be able to participate in the MMJ program again.

Grow facilities should be able to supply to all dispensaries.

How can the draft rules be improved? By eliminating all this constant fingerprinting stuff. After all, we won't be doing anything illegal. Guys, the passage of prop 203 makes it legal to have and smoke marijuana if you have a card. Our fingerprints do not change. There's really no point in this every six months ridiculousity, Except that you are trying to make us feel like and be treated like criminals.

I have re-read the draft and have some comments and questions. Is the purchase of medical marijuana, if substantiated by receipts, going to be deductible as a medical expense on Schedule A of the Federal Tax Return or as an add in for the State of Arizona? How about the annual registration cost of \$160? Will there be any price breaks for those of us living on SSDI for the purchase price of this medication? How can anyone on SSDI and Medicare who also pays for other medications going to afford this? Is this only an option for the rich? Please look at the amount of taxes and the registration cost and the price of medical marijuana and consider those of us who desperately need relief from severe and chronic pain when opioids such as oxycontin, morphine, fentanyl patches are covered by insurance even though they do not help the patient and have ended up being counter-productive in the long run. If a person has severe and chronic pain that a pain specialist can document all attempts at relief including the ineffective use of opioids, does that person really need to pay another \$160 each year. Is this a money making effort by the government, the dispensaries, doctors, or is it an actual compassionate care act? We already have not had a cost of living raise for SSDI since 2008 even though rent, utilities, food, medical premiums, medical copays etc have gone up. If you have any true concern for the patients please explain how anyone can afford this unless they have a lot of disposable income?

My main issue with the draft rules is the selection criteria if more than one person applies for a dispensary registration certificate. A lottery system awards individuals with the resources to buy many \$4,000.00 lottery tickets and does nothing to quantify the individual's intent or ability to run a successful dispensary. At the 2/15 public hearing I heard people suggest means testing as a way to score the applicants. This leads to the same results. The size of someone's bank account has no bearing on what that person brings to the table when deciding who should receive a dispensary registration certificate. The type of dispensary we all want for Arizona is one who's goals are providing compassionate and knowledgeable care to the patients that come into their place of business, provide goods at a reasonable cost, and repay the trust placed in them by the people of Arizona to follow all the rules and give back to the community. Since these attributes can not be determined by a luck of the draw or credit check I suggest that when there are multiple complete applications the principal officers be interviewed by a panel of experts who can assess and score the applicants in their understanding of the proper use of medical marijuana, what strains are most effective for the ailments listed in the legislation, proper growing techniques, and how they intend to ensure compliance with the rules of the legislation. Running a first class dispensary will require knowledge, heart, and a lot of hard work, not good luck or unlimited funds.

Lowering the cost of the ID's, I live on SSDI and am afraid I can't afford the card. My doctor may or may not commend this for me but in case hdoes I want to participate in the program, lowering the cost will help a lot of people.

I do not feel a medical director is needed.

the bill said greenhouses and you have taken it out, can we trust you??

When I heard that the price of medical marijuana was to be set at \$400/oz with a 300% tax, my heart broke. There are those of us who are trying very hard to live within our means on social security disability with chronic illness and chronic pain that could never afford to use a medicine that is this

expensive, when other pain medication has been counter-productive. The pain specialist I see for chronic pain only wants to see me once a year for monitoring of my condition because it would be a waste of medicare monies to see me more frequently when my condition has been "permanent" in his eyes for at least 10 years. Please consider your requirements for monitoring by a doctor more often. I am a responsible 51-year-old woman trying to engage in life on a very fixed income. Please don't punish me because you are afraid others will scam the system (they will always be able to obtain it illegally). Those of us who rent a room in another's home to keep our expenses down cannot grow their own pot (can't afford equipment, can't do that sort of work, and don't have locked area for plants... so that is not an option for us. Purchasing this medicine is our only option. And is there any hope for a truly compassionate care option where those of us on SSDI who aren't rich can obtain it? You will be encouraging a black market on marijuana if there is no affordable medical marijuana from dispensaries.

I appologize if this is not the place to make this comment. I was at one time in my life a user of marijuana and at that time considered myself a heavy user compared to most. I was very surprised to see the amount that will be given out. An ounce of marijuana when I was using in the 1970's would last me a month or more and stayed high almost constantly. It has been reported that the marijuana grown today is many times more powerful than that grown in the 70's. It seems to me that 2.5 ounces of marijuana every 2 weeks is a very large amount. I would recommend drastically reducing the amount and suggest maybe 2.5 ounces every 6 months or even every year.

LOTTERY. One major concern after it is all said in done and there happens to be a number of approved applicants in a single CHAA is the consideration of a lottery system. This entire concept is not the right approach to, "give it to chance" especially if Arizona wants to do this the right way and become a model of how to do it (run a MM program) for future states, as you know there will be many many more. The plain fact is with these impossible CHAA restrictions it allows for such a small amount of possible locals and beyond that everyone fighting for them which in the end makes it about money and not service. It is important to remember that the patients/clinets are looking for accesibility and affordability. The lottery approach along with the unlikley allowance of viable locations within a set CHAA makes the earlier points of ill-success. It creates much disapproval, frustration and makes the state of Arziona look ill-prepared to handle the needs of the public that voted, approved and wanted this. SOLUTION: Say there is a number of approved applicants in one CHAA. The locations are approved as meeting restrictions to run a dispensary. Instead of a lottery and chance, have the applicants present to a dual board committee comprised of every day citizens much like a blind chosen jury for a court of law plus a panel of specific City officials and ADHS key personal to make a final vote based on presentation that includes specific expectations from business canidate. These logistics can be worked out later but should include the Why's and true purpose of running a dispensary verses just allowing "Chance" to choose the worgng business owner who may have no passion to help or reason to supportother than the Cash sign in front of them. This is how ad agencies pitch to a new client to get their business knowing they are not alone and must show passion, knowledge and expereince to win them over. Why should this be any different especially when this is a huge step in the State of AZ and WILL be spotlighted for all to see. Lets choose correctly and create model businesses and growers that deserve to impact the state and become a shining example of HOW TO DO IT! and DO IT RIGHT.

move the requirement of "Address of Dispensary" from the certificate application to the application to operate a deispensary

Issue: R9-17-302 B.2.b (pg 33) D.1.b.; D.2.b.; D.4 (pg 34) Draft dated 01/31/11 - Random selection of applicant that receives dispensary registration certificate. Comment: leaving to random chance which applicant is selected does not select the best applicant, just the luckiest. Solution: select the applicant whose charity/cause best serves that CHAA community. Issue: R9-17-302 F. (pg 35) - 80% of application fee is not refunded to dispensary applicant not selected. Comment: 80% not returned is excessive. 50% of fee is more than enough to cover review cost. Solution: Return at least 50% of application fee.

Let state ran pharmacy give out. Make it a level 2, and PT would have to get monitor every 30 days.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year

The random selection (lottery) is neither fair to applicants or beneficial to the patients. People who can afford to buy more lottery tickets (application fees) will have a greater chance of winning the big prize (a license). You need a different way to select which applicant will best serve the needs of Arizonans. Medical marijuana was not approved as a retail commodity, it was approved as a medical product. Applications should be judged on who has the best plan to provide the best medical service, not who was lucky enough to get their name pulled out of a hat!

I support solid standards and appropriate rules and regulations. I strongly believe that dispensaries should be awarded on merit not chance. The lottery is a potential disaster and may reward the least qualified applicants and eliminate serious, highly qualified applicants. In sitting through the meeting yesterday, at ASU, I heard a lot of emotional comments, that, for a large part, were really just saying that we should have no rules, Essentially they were wanting legalization of marijuana with no or minimal rules. They wanted dispensaries to be given to minimally qualified applicants. A recipe for disaster. When the voters approved the Arizona Medical Marijuana Act last fall, they did not vote to legalize marijuana...they voted to legalize medical marijuana...with appropriate rules and regulations. In summary...eliminate the lottery idea. Choose applicants based on quality, professionalism and fiscal soundness.

As far as choosing a dispensary in a particular location where more than one application is submitted, the quality of product provided should be taken into consideration rather than a random draw. For example if the product is tested for its quality by chemical levels, pesticides (or lack thereof), or if one is offered as certified organic vs. not then the higher quality should be chosen.

I'm submitting this input as a private citizen. In no way am I representing the [REDACTED] or the [REDACTED] position. That being said, I firmly believe that the lottery system of selection for the qualified MMD operators is a huge disservice to the communities looking to establish quality, caring

provisions of palliative services in Arizona. A selection of locally qualified providers could be facilitated by County Health Services based on criteria established to meet the communities needs. Much more responsible providers will be awarded as a result. Sincerely [REDACTED]

Im submitting this input as a private citizen. In no way am I representing the [REDACTED] or the [REDACTED] position. That being said, I firmly believe that the lottery system of selection for the qualified MMD operators is a huge disservice to the communities looking to establish quality, caring provisions of palliative services in Arizona. A selection of locally qualified providers could be facilitated by County Health Services based on criteria established to meet the communities needs. Much more responsible providers will be awarded as a result.

2 items that could be improved are: The limits on possession: 2 and a half ounces every 2 weeks NOT adequate for individuals who ingest their medical marijuana in ways besides smoking. People who choose to not smoke but instead eat or drink their herbs would require much more. Also, people may prefer to buy in bulk at the end of harvest season and then store their supply for the year, instead of relying on costly indoor cultivation for year-round small purchases. Limitations on cultivation to areas NOT within a 25 mile radius of a dispensary: Ridiculous. Absolutely retarded. So, because there is a grocery store down the block, I should only ever have to buy tomatoes from them and not grow my own? Everyone is registered with their cards, designating whether they cultivate their own or not, what should it matter if there is a dispensary 25 miles away or a mile away? Perhaps if people who register to cultivate are subject to similar inventory and accounting procedures as a dispensary? Should people have to flee the city just attend to their medical needs in an affordable way? This needs to be fixed.

Patients residing more than 25 miles from a dispensary can grow their own marijuana. Currently it shows that caregivers for these patients may grow for the patient. The rule should specify that caregiver should not be allowed to grow marijuana if they live within 25 miles of a dispensary. AZDHS has certain requirements that caregivers must follow, including application processes and fees. Caregivers should also be required to undergo a minimum of 8 hours of training on medical marijuana health and safety issues.

I believe common areas within neighborhoods in HOA's should also be prohibited areas for smoking medical marijuana.

don't put patients names on a list for police and others to use. marijuana is not a narcotic, don't invade patients privacy! you don't put names of people using other pain medicines. move this process along faster, people should be starting the growing process ASAP!

Allow this medicine to be sent to patients via US post, UPS, Fed-x or delivery service. If the rules allow wholesale farming, allow patients to get at cost direct from Farmers, Wholesaler's. Shipping to patient would be a great method for this, protecting farming locations. Set a max. fixed price for the cost of this medicine

The rules do not address Infusion operations. Will there be background checks for employees of infusion operations? The Draft Rules of January now have the CHAA areas which while it might

eliminate the allowance of growing capabilities, it does not accommodate the demographics that a business person might require in making such a Huge investment. I wish that DHS would put back the Grow requirements of a Dispensary. Maybe not 70%, but a Dispensary should grow their own marijuana. If there is not a measurement of at least 120+ dispensaries, then how will any of us know that MJ is not being bought from the Cartel. With DHS requiring Dispensaries to grow it, data can be obtained to see what is real and reasonable cultivation.

February 16, 2011 Arizona Department of Health Services To Whom It May Concern: [REDACTED] is a company organized in Arizona on a not-for profit basis. [REDACTED] and [REDACTED] are two of the members of this company. [REDACTED] is dedicated to serving the patients within Arizona. Our members have extensive healthcare experience and believe that we will be able to meet the needs of Arizona's medical marijuana patients. Below are our comments related to the most recent draft of the rules prepared by the ADHS: 1) R9-17-302.B.b. "the Department shall randomly select", through discussions with realtors and other potential dispensary applicants it appears that dispensary applicants with significant funds are planning on submitting multiple applications. This is a direct reflection of the dispensary selection process being random. This is not fair to those of us with the funds necessary to submit one application but not multiple. Please change this rule to be based on merit as determined by an independent party or some type of scoring system. If the Department does not change "random", will the Department cross check applications for individual owners on multiple applications? 2) R9-17-302: D.1. b. - What is the process for random selection of certificates for multiple applications within the same CHAA. 3) R9-17-306 A. "A dispensary shall not change the dispensary's location during the first three years after the dispensary is issued a dispensary registration certificate." What if the property is destroyed by fire, or the landlord backs out of the deal? This section needs to be changed to after the full approval process, not after the issuance of a registration certificate. 4) R9-17-302.F. "the Department shall return \$1,000 of the application fee to the applicant. Why will applicants who do not receive a certificate only be refunded \$1,000? This seems like a significant cost to a qualified applicant for no return. 5) Community Health Analysis Areas (CHAA's) "The CHAAs do not follow the population very well. The Phoenix metro area should have 83 dispensaries based upon the population base. However, there are only 40 or so CHAAs within the metro area. This should be spread to more dispensaries. 6) Community Health Analysis Areas (CHAA's) "There are CHAAs within certain cities where there is no zoning available for a dispensary. Will the allocation of these CHAAs be moved to another area? 7) R9-17-307.B.1.g.iii "Has not provided a surety bond or filed any tax return with a taxing agency" Does this mean that a surety bond is still required if taxes have been filed? If so, who is the surety bond to and for how much and for what purpose? 8) R9-17-307.B.4. "A report of an audit by an independent certified public accountant of the annual financial statement required in subsection (2);" Why require an audit by a CPA. It seems like a financial report filed with the Department in a Department required format (that could be verified by the Department, if you so choose) meets the need of the Department at significantly less cost to the dispensary and as a result less cost to the patients. 9) R9-17-315.C. The comment related to performing an inventory every 30 days should be changed to once per month. Businesses normally track inventory with the end of each accounting period, not an arbitrary every 30 days. 10) R9-17-320.D. "Commercial devise" What comprises a commercial device? How does a dispensary know whether we are using a commercial device? 11) R9-17-107.G.1.b. "The written notification is not a denial and is not considered a final decision of the Department subject to judicial review;" What exactly is a judicial review? [REDACTED] would like to thank the Department for the opportunity to comment on these rules and commend the Department for an excellent job of putting together reasonable rules in such a short period of time.

Sincerely, [REDACTED].

AZDHS please consider in your rule making. The cost of patient card. Other mmj States average patient card cost is aprox. 55.00 25-mile rule. Here is the reason for the 25-mile rule "to give a market to the dispensaries in the community so they'd be viable" This was said by [REDACTED] the spokesman for [REDACTED] the crafters of prop 203 14 other States allow patient cultivation, the percentage of patient cultivation incidents to number of cardholders is negligible. The cost of patient cultivation will be in the hundreds of dollars annually. The cost from dispensaries will be many thousands of dollars annually per patient, this is a huge financial penalty to the patient. Many patients will not have access to this medicine for that reason. Cultivation of marijuana is not toxic to people, pets or the environment, there is no valid reason to not allow patient's to cultivate for themselves. Please remove the 25-mile rule from the rules. Thank you

1. A great way to better qualify applicants for dispensary and cultivation before a possible lottery, is the credit ratings of all owners. It is measurable by an independent outside source and is numerical.
2. The three year resident rule is excellent. But, [REDACTED] is already advertising for three year AZ residents as managers. All owner's, who own over a certain percentage should be required to meet this rule. Not just hire a local person, with little or no control, to get around this requirement. If owned by another legal entity, then all (or majority) partners, members, ownership, or director's should meet this requirement.

RE: R9-17-202, Paragraph F, section 5, Please clarify what type of Physician Certification will the AZDHS deem appropriate. Also, Please clarify the 90 day rule regarding signed Physician Written Certification, as some Physicians Written Certifications are valid for up to 12 month. Having a patient to go back to their doctor for a Written Certification, if they have a signed Written Certification dated greater than 90 days prior to submission of the qualifying patients application will be burdensome for some patients and prevent them from obtaining the medicine they need in an expeditious manner.

Hospitals should be required to stock it for patients prescribed medical marijuana. If it is effective for them at home, why should they be deprived of it in the hospital?

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.

R-9-17-302 B-2b. Random selection of dispensaries is a terrible, terrible idea. This implies that all applicants are equally qualified. It gives equal weight to an application from a group of potheads as to a group composed of medical professionals and social workers. Surely, the Department can find a method to select dispensary applicants based on qualifications. Additionally, the random selection process favors well-funded (i.e. funded by the out-of-state marijuana industry) corporations that can afford to submit multiple applications in multiple CHAAs. A small business owner, who will only submit a single application, ends up losing to the odds. R9-17-302 B-1. While I am not against the idea of cities and towns having an opportunity to comment on the distribution of dispensaries in their jurisdiction, this is poorly written. There is no indication of timeframes in which a city may make the request. Further, the rule makes no provision for providing information on reallocation to potential or current dispensary owners. Additionally, this may come into conflict with R9-17-306 which does not

allow a dispensary to move in its first three years. There must be limits on when Cities may ask for re-distribution. Then, the information that a dispensary has been reallocated to another CHAA must be announced widely, fairly, and with sufficient time for a potential dispensary applicant (or, in the future, a current dispensary owner) to find a new location if necessary.

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 is allowed to issue 126 licenses. Yet Â§R9-17-302 seems to act contradictory to A.R.S. Title 36 Chapter 28.1. Draft Rules Â§R9-17-302 breaks Arizona cities and towns into a CHAA map. This makes little sense when related back to the State's interest in delivering one medical marijuana dispensary per 10 pharmacies in the State. Furthermore its language pertaining to a lottery system if two applications are received in the same CHAA is irresponsible at best. This will turn the application process into a gambling lottery instead of a responsible application screening process. It also will allow lottery winners to sell their winning ticket to the highest bidder. The goal should be to consistently provide high quality product to sick patients. We feel that the language of that rule should be deleted, permitting one dispensary per CHAA and Lottery drawings for dispensary application permits. This would make the State's regulatory task easier, less costly, and less vulnerable to potential law suits over a Lottery system.

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Stop taking direction from ██████████ and keep Arizona drug free! 10% of the population thinks crack cocaine should be legal, and 10% thinks mint tea is dangerous. Put the patients first, that's why we voted for this and you know it. Trying to force a gravely ill person to drive an hour each way to reach a monopolized dispensary that is 25 miles away (if they could fly!) is not the intention of us voters and you know it! Then they will be forced to pay 50 times what it would cost them to grow their own in a little garden, and that's what's going to make you feel like you accomplished something? Unless you live under a rock, you realize that marijuana will be decriminalized nationwide within another decade or so. Trying to keep things as restrictive and overbearing as possible for just a few more years will only cause this to happen sooner out of necessity! The inbred nitwits that worry about what other people have in their urine should be the last ones you suck up to and blindly follow! Please listen to the requests of the patients, that's who this is for! These are the Arizonans you should be trying to best serve right now. Not the people who choose to believe that a plant is more dangerous than pharmaceuticals! How many pharmacies were robbed by desperate and violent criminals here in Arizona in the last week? That's the real problem, what are you doing about it? Oh you're too busy making sure cancer patients have to jump through more hoops and red tape to procure a non-toxic and non-physically addictive plant! The only reason why anyone would ever rob a dispensary is the probability of there being some cash (like 90% of all businesses) and the street value of the marijuana, why is the street value elevated? Prohibition! You won't see marijuana "addicts" committing violent crimes to get a fix, that's what your "safe" drugs cause to happen here every couple of days. Oxycontin doesn't require two Doctors to be consulted before it is dispensed, Oxycontin doesn't have a warning label warning of cancer, but it's more likely to cause it than cannabis! ADHS, can you smell what you're stepping in when you're following the fools that choose to ignore the fact that marijuana

is a much safer medicine?! If marijuana was half as dangerous to its users and society as "they" would have you believe, it would then be 10 times more dangerous than it actually is! That would place it somewhere between aspirin and cigarettes! Why are specifically trying to cause valid patients an undue hardship to obtain cannabis and treating it like enriched plutonium?

in section 30.2806.03 we believe as Veterans that there should be a sliding scale recommendation for patients renewing there cards to fee lower then now are out. Thank you

A physician cannot recommend medical marijuana to more than 100 patients per year.

I believe the draft rules could be improved by having the draft in its regular form and a sort of dummy's guide explaining the whole draft rules rather simply but is stated that this form of rules cannot be used in court. Just something that would help generate clear understanding for those who don't understand lawyer lingo. I also believe the draft rules would benefit if the conditions anxiety and depression were added. I am S.M.I. suffering from both and have been on medicine for years marijuana is the only medicine that calms me down and doesn't have harmful side effects.

Rheumatoid arthritis has been shown in numerous studies to benefit from the use of Medical Marijuana. It can cut down inflammation and pain as well as other symptoms related to the disease and more importantly, potentially slow the diseases progression. In addition, MM is also helpful in alleviating some of the side effects that some of the traditional and necessary treatments for RA can cause. Although this is a disease that would certainly fall under the severe and chronic pain category in the rules, I think legitimizing the benefits that RA can have from MM would be a great service to many patients. Thank you.

Add PTSD and insure no taxation what so ever as the law says and if a taxation is introduced it should be recycled back into the system to help impoverished individuals receive assistance.

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My concern is that nurse practitioners (NPs) were excluded as authorized providers to certify patients for use of medical marijuana. The inability of NP's to provide this service to their patients will be a detriment to quality of care as well as continuity of care, causing many patients to seek care away from their current provider. Nurse practitioners are primary care providers for many patients with qualifying diagnoses who can benefit from this treatment and should be allowed to maintain ongoing treatment with their provider should they choose to pursue this avenue of treatment. In addition, professionally, it is within our scope of practice. In the state of Arizona, we are licensed to practice independently. We have the same prescriptive authority as physicians and it is well within our scope of practice to evaluate, diagnose and prescribe treatment. It is well-known that nurse practitioners are highly skilled, trained, and effective providers of care. Respectfully, [REDACTED]

Rules for Caregivers are lacking: 1. What is the application process for caregivers? 2. Will there be a limit on the number of patients served? 3. What paper work will caregivers need from the patients they serve? 4. What paper work will the caregiver need on their person when delivering? 5. Must caregivers purchase their supplies from an Arizona Dispensary?

See changes below \*\*\*\*\* ( ) \*\*\*\*\* R9-17-303. Applying for a Dispensary Registration Certificate  
A. Each principal officer or board member of a dispensary is an Arizona resident and has been an Arizona resident for the two three years immediately preceding the date the dispensary submits a dispensary certificate application. B. To apply for a dispensary registration certificate, a person shall submit to the Department the following: 1. An application in a Department-provided format that includes: a. The legal name of the dispensary; b. The physical address of the proposed dispensary; Change to proposed CHAA c. The name of the entity applying; d. The name of the individual designated to submit dispensary agent applications on behalf of the dispensary; e. The name and license number of the dispensary's medical director; Remove, this required in application to operate

R9-17-312 Is a can of worms. Before a patient enters a dispensary they have been seen by their physician who has certified the need for Med. Marijuana. A doctor on site has not followed a patients history and a doctor on site may not specialize in the many different cases that will walk into a dispensary. The system would be better served with notices posted with issues and concerns to contact your doctor if suffering from adverse side effects. Their physician is in a closer loop than a medical director would ever be. It seems that having a medical director or doctor on staff for the Dispensary is a conflict of interest. Although the intention may have well meaning. It seems that the director is in place in case someone comes in from the streets and wants a bag of weed... That will not happen City ordinances are already blocking general public access to the product area of a dispensary. IE:Peoria Zoning 14-9-5 2.f states "The product offered for retail sales to medical marijuana cardholders shall be inaccessible to the public entering the medical marijuana dispensary. All product provided for retail sales shall be located behind a counter staffed by a nonprofit medical marijuana dispensary agent as defined by A.R.S. ss36-2801

The CHAA addition would be a complete disaster. The dispensary zoning needs to incorporate population. Combining neighboring zip codes to reach about 50,000 patients per dispensary zone would be the best way. The CHAA system could work if you combined small CHAA zones and gave multiple dispensary licenses to the larger CHAA zones, but population still needs to be considered.

I think that dispensaries will be greatly hindered with the 198 plant limit. I also believe the allowed amount of medication should be increased from 2.5 to 4 ounces. I believe that schools should not be able to discriminate on patients.

How dare you impose on the relationship of a doctor and their patients. There is no reason why a doctor should be treated like a criminal for writing recommendations. I do not know how you intend

to investigate doctors who write over 100 prescriptions, but I will guarantee a huge lawsuit if you try and get your hands on my medical records.

The procedures for adding a debilitating medical condition as described in R9-17-106 are much more restrictive than the spirit and text of Proposition 203, and will have the effect of needlessly preventing the addition of genuinely debilitating conditions. Recall that many debilitating conditions are rare and thus attract a scarce amount of scientific medical research, let alone peer-reviewed studies regarding marijuana: --- R9-17-106-A-7: This section should be deleted or changed to call for peer-reviewed literature reporting either that the condition is chronic and debilitating, with symptoms that qualify per R9-17-2019 to 13 OR that marijuana provides a therapeutic or palliative benefit for the condition --- R9-17-106-C: Delete, this restriction is not contained in the Proposition, and in fact is a restricts the ability to propose a qualifying condition ten 12ths of the time, i.e. only one month in six. This is unduly restrictive; while it might easily impede the ability of patients suffering from debilitating conditions to put forth proposals, it does nothing whatsoever to help enable the use of medical marijuana for those who would benefit from it as provided for in the law passed by voters (i.e. the findings listed in Section 2 of Proposition 203). The physician requirements are improved compared with the first draft, but, perhaps unintentionally, became unduly restrictive for certain cases: R9-17-202-F-5 (and similar provisions in R9-17-204): Section G implies the recommending physician has made the diagnosis. Other sections imply the physician directly confirms a pre-existing diagnosis. This is not feasible in many cases including the conditions allowed by the law (for example, Crohn's Disease or AIDS) where the diagnosis and physical checks are commonly made by specialist physicians and the primary care physician relies on the diagnosis of the specialists. It should be clear that the recommending physician may rely on the diagnosis made by other physicians. This also covers the cases where diagnosis is invasive, involves risk to the patient, highly expensive, or requires the scarce resources of specialists; it is expected that patients may change primary physicians from time to time for various reasons and requiring a re-confirmation of diagnosis is an undue hardship. Also note that this would prevent an undue waste of scarce medical resources available. Dispensary locations: The proposed method of defining allocation for dispensaries is unreasonable, the allocation should be by county population (or population assessed by some other district). The law as approved by Arizona voters calls for an allocation of dispensaries by number of pharmacies, following the spirit of the law would thus provide for a similar distribution of dispensaries. As drafted, the rules seem to encourage a distribution of dispensaries covering the broad geography of Arizona, which is a poor fit to the circumstances of our State where there are a small number of population centers including most residents of the State, and large areas containing very limited population.

I have a very big problem with the CHAA system. I live in CHAA area 55 in Paradise Valley. My CHAA area has only 15,000 residents, but due to the CHAA system, we will have a dispensary. The 4 CHAA areas adjacent to my CHAA area have between between 90,000 and 198,000 residents, but they have one dispensary as well. There is no reason why one dispensary area should have 15,000 residents, while another has almost 200,000. This CHAA system needs to be removed and replaced with one that is based off of population.

Sir I find it reprehensible that [REDACTED] and his group of WEALTHY investors can still have ANY influence over the MM Rules! AZHDS is required by LAW to put forward as a FAIR and BALANCE Plan for every Arizona citizen to have a chance of obtaining a dispensary license!!! I ask you HOW will we

the average citizen wishing to go into to this business be able to compete in the open market when [REDACTED] puts forth WHAT the RULES should be to tip the scales towards his investors? Sure we all have a few hundred thousand dollars laying around that we should pledge without any respect to the financial ramifications if we are unsuccessfully at obtaining a license. [REDACTED] HAS SAID IT!!! The game is only for the well to do and Ã©lites of his club!!! What more evidence do you want were he stands representing the wealthy of which few are from Arizona???

I want a chance at obtaining a dispensary license but should I have to cash-in my 401â€™s and annuities at server penalty costs or ask an investor to place hard money into an account before I even know if I have a dispensary license???

THIS IS WRONG, WRONG, WRONG on the part of AZHDS to even entertain to require this nonsense dictated by the elite on how the MM game is going to be played in ARIZOINA!!! Iâ€™M A CITIZEN OF THE UNITED STATES OF AMERICA AND A TAX PAYING RESIDENT OF ARIZOINA and I want a FAIR outcome to this messâ€¦ LET IT BE A LOTTARY with all participants knowing that successful applicants MUST qualify under REASONABLE license requirements without having to gamble there financial security away in IRS penalties just for a ticket to play. NO SIR, I AS A CITIZEN DEMAND A REASONABLE HONEST CHANCE. Thank You

1. R 9-17-305 A. A dispensary may not transfer or assign the dispensary registration and certificate. This equates almost to a "taking" of a person's business. What it sounds like is that an owner can build a business and then be unable to receive any compensation for the business that has been built nor can the owner leave it to heirs in the event of death. Perhaps your intent is not to allow someone to profit unreasonably from the restricted benefit of having the good luck to have a been drawn for a certificate. I agree but without some reasonable guidelines, this regulation is extraordinarily punitive. Surely you can come up with some criteria that allow for a reasonable transfer or assignment so an owner to be reasonably compensated for the business that owner has built. Maybe transfer contingent on retirement, illness, death, other hardship situations and for compensation based on some common business valuation or transfer within the entity itself providing that new owner meets criteria but for reasonable compensation.

2. These regulations are so cumbersome that it probably will be impossible for the Dept. of Health to adequately police the compliance. Is all of it really that necessary to avoid abuse? Why cannot you license growers and bakeries, for instance, separately instead of creating a monopoly in these areas for the owner of the dispensary. Seems to me that would make compliance oversight much easier.

3. The use of the word "non-profit" basis has everyone confused. What is the point? Every accountant I talked to is baffled by the use of this word of art that in this context is meaningless b/c the organizational base is not that of a non-profit corporation-- nor should it be. GET RID OF IT... That verbiage leaves lots of room for challenge and litigation. SIMPLIFY. You are just creating a mess.

4. Change the wording that says marijuana cannot be used in a public place to it can only be used in the privacy of one's home. This eliminates issues of properties like townhouse communities that are private so they don't have to struggle with their own enforcement issues. Tighten this up.

Social anxiety disorder [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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I disagree with your plan to "award dispensary registration certificates as described in R9-17-302... If more than one complete and compliant application is received for a dispensary for a particular CHAA, the Department will randomly award the certificate." In [REDACTED] we have worked to establish ordinances and P&Z regulations that work for our community, as well as an RFP process to select the company best suited to provide services to our citizens. In response to our RFP, we received 8 submissions with great variation in the proposals' plans for community involvement, start-up investment, and business experience levels. We had a committee of municipal professionals (including our city manager and police and fire chiefs) review all the applications and select the proposal best suited for [REDACTED]. We would not be well served by a lottery or randomly awarded certificate for a dispensary. Please allow local leaders to make decisions on the local level for what is best for each community that is awarded a dispensary. We have tremendous community variety in our great state and committed local leaders who are able to handle this part of the decision process. Thank you, [REDACTED]

**How can the draft rules be improved?**

[REDACTED]

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• CHAA areas do not make sense. We should stick to the original plan and have one dispensary for every ten pharmacies. OR go by population in each CHAA ? Have just one per CHAA will create a monopoly which will result in less quality of service and medicine. It will also make sick patients drive too far to buy medicine ! • Applying for a dispensary license – randomly picking the dispensary will be a huge mistake. We should hand pick the most qualified people to ensure quality of health care. We understand there might be a situation where two qualified candidates are applying for the same spot, and that's when random picking can be a solution. BUT we need to narrow down the process. Applicants should have a business plan, financial proof ( to show they can pay for what they are offering in their business plan) and be given a 5 minutes presentation time or face to face meeting to show and explain who they are, their concept and ability to make it happen. • Applying for dispensary – R9-17-303 B g1 – ADD : "Or is affiliated with any other dispensaries anywhere else". This will show who is really a local group and who isn't. • R9-17-303 viii – Add – " or has served as a paid consultant to the department of health in regards to medical marijuana.

Given the expected flood of dispensary applications, it's safe to say that the entire selection process will come down to a random drawing. Arizona has a chance to show the rest of the country how to run the best managed, highest quality medical marijuana program in America. To make this a lottery system is further proof that this is just a money making scheme for the state and a few lucky applicants. Let the local hospitals opt out of the process and have them judge each duplicate application through their own internal review board. Remove all names to blind the process.

limit the distribution to pharmacies Award the AZDHS permit for MM distribution facilities by a

lottery. To get into the cell phone business the US Govt collected \$500k for each lottery ticket and the rulings were one application per applicant. That price is absurd for this issue, but it would get the commitment from the applicant and generate enough \$\$ for a State of AZ medical professional team to act as the dispensary medical director. remove the requirement for a med director per dispensary- Walgreens doesn't have one and they dispense narcotics. Something to keep someone's Mom from puking as she works thru her Chemo treatments should't be handled differently- that is a chilling effect, not the purpose of the law and not the solution for better serving the patient. The State should handle that role- otherwise the quack md community is going to have responsibilities no one wants them to have.

As I mentioned at the League presentation, perhaps an anti-monopoly clause could be inserted for producers, than no one producer supply more than 20% (or 10%) of total AZ usage. I understand that fees must reimburse AZ Dept of Health expenses to create this structure, and applaud that you provide for remote areas being sustained by sales to urban areas. But please make some provision for poor rural areas to get started by perhaps giving them time to gather the fees from sales and giving them time (or even forgoing) high-tech, expensive security measures that may not be as necessary in remoter areas of Arizona. It would be fair to only require what standards pharmacists are held to in R9-17-303 B 1 G and 307 B 1 g ( and elsewhere). That an officer or board member owing a parking ticket (or whatever) disqualifying them seems excessive.

As I understand it, the individuals responsible for selling marijuana in our neighborhoods will now be chosen randomly? The state has given up on making the best possible choice but has chosen to avoid lawsuits by picking applicants from a hat? A doctor, pharmacist and a nurse from the Mayo Clinic (who seem to have done a lot of work to make sure this stuff stays limited to medical instead of recreational use) now have the same chance to get a license as my next-door neighbor's kid? His parents won't even let him drive their car (he's had two under-age DWI's) but the chiropractor who does his mother's botox is partnering with him (daddy's paying the application cost in the hopes of getting junior out of the house). PLEASE FIX THIS SYSTEM BEFORE IT'S LAW!!!

R-9-17-101 #7 AMOUNT OF DISPENSARIES SHALL NOT EXCEED THE PROPOSITION INDICATOR OF 124 TOTAL, LICENSED WITHIN THE STATE OF AZ, PLACING LICENSURES ACCORDING TO PER CAPITA NEEDS, SO AS TO AVOID SATURATION OF AN AREA WITHOUT PATIENT NEED INDICATED (i.e Maricopa county may have more than Yavapai county) #11 ISSUED ONLY TO THOSE THAT MEET THE RESIDENCY REQUIREMENT, AZ RESIDENCES WHO PROVIDES PROOF OF RESIDENCY IN THE STATE FOR 2 CONSECUTIVE YEARS, WITH AZ ISSUED STATE ID OR MVD LICENSE TO COMPLY WITH CURRENT REGISTRY PHOTO REQUIREMENTS #15 WITH INDICATION PROVIDED OF THE SQUARE FOOTAGE INDICATED AS NEED TO MEET THE AMOUNT OF CULTIVATED PLANTS, WITH PER CAPITA REQUIREMENTS (LARGE BUILDING FOR MAJOR OPERATIONS, SMALLER FOR SMALLER AREA OF PATIENTS) R9-17-102 #1 (NON REFUNDABLE) FEES OF \$1000 FOR APPLICATION REVIEW; UPON APPROVAL OR DENIAL PROVIDED WITHIN 14 BUSINESS DAYS FROM THE DATE OF RECEIPT OF THE APPLICATION BY THE DHS. IF APPROVED AN ADDITIONAL FEE OF \$4000 FOR ISSUANCE OF LICENSE. #7 NO FEE FOR FIRST AMENDMENT OR CHANGE IN REGISTRY CARD WITHIN A 12 MONTH PERIOD OF ISSUANCE, SECOND CHANGE OR AMENDMENT WILL INCUR A \$10 FEE R9-17-105 3D) NO PASSPORT IDENTIFICATION WILL BE ALLOWED AS THIS MEDICATION REGISTRY IS ALLOTTED TO ONLY AZ RESIDENTS R9-17-106 5) THE AVAILABILITY WILL BE BASED ON TRADITIONAL MEDICAL DIAGNOSTIC TOOLS INCLUDING BUT NOT LIMITED TO; CASE HISTORY, X-RAY, MRI, BLOOD TEST REMOVE ITEM #6 AND #7 R9-17-106 REMOVE ANY AND ALL TIME FRAMES FROM APPLICATION WITH OR FOR MD

REVIEW. IF BASED ON THE CHANGE IN R9-17-106 5- LISTED ABOVE; TRADITIONAL MEDICAL DIAGNOSTIC TOOLS WILL INDICATE NEED, RATHER THAN LENGTH OF TIME WITH ASSIGNED PHYSICIAN OR WHEN SEVERITY OF ILLNESS DIAGNOSED IS EXACERBATED WILL DICTATE MEDICATION RECOMMENDED BY LICENSED PHYSICIAN. R9-17-203 MEDICAL MARIJUANA WILL BE DISALLOWED FOR THE FOLLOWING EMPLOYMENT DEcriptions: CDL LICENSE HOLDERS INCLUDING; BUS DRIVERS, HEAVY EQUIPMENT OPERATORS, PILOTS OF PERSONAL, COMMERCIAL AND PRIVATE PLANES, LAW ENFORCEMENT OFFICIALS INCLUDING; POLICE OFFICERS, PROBATION OFFICERS, JUDGES, CORRECTION OFFICERS, PHYSICIANS, NURSES, LICENSED SUBSTANCE ABUSE PROFESSIONALS, DAY CARE WORKERS, TEACHERS; BOTH PUBLIC AND PRIVATE GRADES K-12, CARE GIVERS, AND BEHAVIORAL HEALTH CARE WORKERS. EMPLOYERS IN THESE FIELDS MAY BE ALLOWED TO REQUIRE RANDOM URINALYSIS FOR MEDICAL MARIJUANA WITH SUSPENSION OR NON HIRING PRACTICES ABOVE AND BEYOND HIP-PA MANDATES. R9-17-203 3 B 5) TRANSPORTATION OF CERTIFIED PROVIDERS WILL BE AUTHORIZED OUTSIDE OF THE 25 MILES RADIUS FOR CARE WITHIN A 100 MILE RADIUS OF DISPENSARY TO AVOID THE NEED FOR QUALIFYING PATIENTS TO ENGAGE IN CULTIVATION OF PLANS FOR PERSONAL USE. OUTSIDE OF A 100 MILES RADIUS TO NEAREST DISPENSARY WILL REQUIRE..... R9-17-204 A I REMOVE EMAIL REQUIREMENT R9-17-204 A,4-C, G, H i, ii, iii -PHYSICIANS WILL BE REQUIRED TO PROVIDE DOCUMENTATION BASED ON TRADITIONAL MEDICAL DIAGNOSTIC TOOLS INCLUDING BUT NOT LIMITED TO; 12 MONTH CASE HISTORY, X-RAY, MRI, BLOOD TEST, BUT DOES NOT HAVE TO HAVE ESTABLISHED A 12 MONTH RELATIONSHIP IF THE DIAGNOSTIC TOOLS INDICATE IMMEDIATE NEED FOR MEDICAL MARIJUANA.

So you're passing out dispensary licenses based on a LOTTERY? Patients can get medical quality if they have either unlimited options (more than 124) or a system that selects applications based on high medical standards. By doing NEITHER, you have severely limited the ability of Arizonans to make the best possible choice. Make the choice on QUALITY, not CASH!!!

I would like to see the dispensing of the marijuana be done under the guidance of medical person, much like the methadone programs were. This would allow for observation of those using the marijuana ensure that it is dispensed properly and hopefully limit abuse and misuse. I am concerned that under the proposed guidelines there does not appear to be any enough initial monitoring and control to assure compliance of these dispensaries and their personel.

As a [REDACTED] I am confused by your intentions. Caregivers are the only option for patients like me and anyone else on disability. None of them will be able to afford the 2-3 hundreded % markup of dispensaries. If your intention is to make these meds only available to the rich, you are doing a good job. I do not have an extra \$1000 a month to spend on anything and without my meds I can guarantee hospital stays of 2 to 3 days on a regular basis. I have gastroparesis which essentially reverses your digestive track and causes uncontrolable vomiting, after 6 months and at least 3 stays in the hospital a month my doctor illegally recomended marijuana. My medical records prove the efficiency of the medication in my almost total lack of repeat visits to the hospital afterwards. Your plan clearly supports big buisness, taking the compasion out of the equation and that is what WE voted for. It seems to me like you have an under the table deal with Phillip Morris or RJ Reynolds, promising them a monopoly on the market. You are creating this monopoly and you should be ashamed that you are personaly making these meds unavailable to the patients who really need them. Not to mention your plan encourages the black market. I would love to hear your take on this situation. Please email my husband's email address:

I would suggest a three step process. 1) I believe that a pre application registration and Non refundable \$5000 deposit submitted by April 1 may decrease the number of applications submitted on May 1 and allow for a more merit based selection process to be analysed and properly graded.. 2) A score should be predetermined that would allow for quality applicants to be included in the random drawing within all the CHAA's. The score should be based on strong fundamentals of a business operation. Some individuals and groups have been working on a plan and educating themselves since the election results and before and could certainly provide a better business model than people who have decided to get into the lotto and see what happens. Randomly awarded licenses could present greater risks of business risks in the future. I think this is what the Department is trying to avoid. 3) If a CHAA receives no application with the minimum standard score required, the license should be offered to the highest statewide application score not awarded a license though the random process of selection. The merit system should be continued until all licenses are awarded.

Our parent group was approached several months ago by a group wishing to open a Dispensary in our community. We were persuaded to support these individuals after they presented a rather detailed plan involving a multi-specialty medical advisory board, community education forums, research contracts with local hospitals and universities, a registered pharmacist and a charity program for hospice patients. Several of these programs were added in response to our own suggestions. When Mr. Humble posted the link about psychosis and marijuana use, one of their medical people responded to our questions IMMEDIATELY. We were impressed. In an update meeting with this group we were told that the state has decided to NOT evaluate Dispensary applications on merit but will simply do a random drawing among applicants who have completed all forms, provided a business plan and paid the application fee. How is this ensuring that our community has the best possible medical supervision of a law designed to regulate a medical substance? Our guess is that the State is worried about lawsuits over any subjective judging on their part. We feel that it is the responsibility of the State to provide EXACTLY that kind of oversight. Either contract with an out-of-state firm, local university or third-party review commission. Or make the requirements QUANTITATIVE rather than QUALITATIVE (i.e. submit a plan for community outreach, submit a plan for charity care, submit a plan for physician education etc.) Good suggestions could even be used in future revisions of the State plan. Please reconsider the random drawing!!!

Part A Medical marijuana patients are required to be under the care of a physician. I believe that the need and expense of a physicians services, as outlined below, by the dispensary are unnecessary and unneeded. Other professional individuals can competently provide the services outlined in the proposed code. In rural areas this requirement will impose a significant burden and encumber operations. R9-17-312. Medical Director A A dispensary shall appoint an individual who is a physician to function as a medical director. Part B Below is rules for revocation. It appears that there is no where to legally obtain start up seeds or plants since there is currently no sources within the state that supply legal Medical Marijuana. The current proposed code has the effect of preventing interstate commerce that violates federal statutes. C. The Department shall revoke a dispensary's registration certificate if: 1. The dispensary: a. Operates before obtaining approval to operate a dispensary from the Department; b. Dispenses, delivers, or otherwise transfers marijuana to a person other than another dispensary in Arizona, a qualifying patient, or a designated caregiver; c. The Department determines that the dispensary did not implement the policies and procedures or comply with the statements provided to the Department with the dispensary's application; or d. Acquires usable marijuana or mature marijuana plants from any person other than another dispensary in Arizona, a qualifying patient, or a designated caregiver; or Remove the requirement

for the Medical Director to be a physician. Leave decisions of operation and administrative compliance up to the Non-profit organization. Several states that border Arizona have developed the quality of their medical marijuana. The quality of Medical Marijuana produced will be linked to the genetic development plants. The dispensary should be allowed to obtain the strain of medical marijuana it chooses without restriction as long as source is disclosed as described in administrative code.

You need to limit the number of "recommendations" a doctor can prescribe to 100! It is the ONLY way the AZ DHS is going to have any control this industry. Otherwise we will have those in the medical profession abandoning their profession to become "POT DOCS" like those in California.

Make it so ANY patient can grow their own medication. Insurance will not cover marijuana and it will be far too expensive to purchase from a dispensary.

The process is too complicated for both patients and dispensaries. It takes about thirty seconds for a physician to write any prescription. Pharmacists, or even drug manufacturers do not have to climb a mountain to offer their services. If we want patients to use dispensaries rather than street corner drug dealers, we need to make things easier. Monitor and regulate us, but please do not make it so difficult for everyone involved. All of the unreasonable rules and regulations are only serving to further the stigma connected to medical marijuana, making it even more awkward for patients who need and would benefit greatly from the use of medical marijuana to try to obtain it.

possibly adding Chronic Pain stipulations: Has to have been treated for more than 2 years with documentation attesting this Has to have been treated by at least two health professionals, again with documentation

Add other medical professionals in being able to prescribe marijuana

The concept that it is a "random" drawing for each CHAA seems ridiculous and doesn't serve the public interest. Why not create a "blue ribbon" panel with a cross-section of government and private sector. Also, add to the application that applicants understand the selection process involves subjective criteria and that they waive the right to sue the State.

Part B. of R9-17-301 is ridiculous! That is like making everyone principal officers! Not every member or manager etc wants to be associated as a "Principal Officer" Let the bylaws decide what they want to do and who they want to be principal officers.

Why are cultivation sites tied to dispensary's? Farmers are not pharmacists and vice versa. It seems like the state should really pursue two different licenses for these businesses. Each one should be licensed and regulated individually. Let one group regulate the cultivation industry and let another group regulate the dispensary industry. If a non-profit wants to do both, that's up to the non-profit. Don't force a non-profit into becoming farmers when they just really want to be on the front line talking and helping people. Personally I feel that the state could be much more effective in

helping people and could raise a lot more revenue if both parts of the business are taxed separately. This might take a complete rewrite of the rules. Sorry, I just now have been reviewing the rules, however I feel it would be much more effective.

People who suffer from other conditions that are treated with narcotics or other controlled substances i.e. valium, xanax or the like should be considered qualifying patients as well. The benefits of medical marijuana use in people needing these types of medications can not be ignored.

We are against rules making prospective dispensaries have a certain amount of money to be able to apply for a permit. There have been suggestions that dispensaries would have to have \$200,000 or \$500,000 to be able to apply. There are deep pocketed, wealthy interests that are trying to turn the idea of nonprofits into profit making machines paying high salaries to those who operate them. They are trying to monopolize the medical marijuana industry even before it gets started. Many of these groups have stated they will open chains of dispensaries throughout Arizona. The truth is that dispensaries can be formed and operated with far much less capital than they suggest. Many are willing to work at a nonprofit as volunteers or for small salaries. Expensive growing equipment does not have to be purchased outright, many manufacturers of growing equipment will supply equipment for a down payment and monthly payments. Some dispensaries won't even use indoor growing equipment, they'll use cement block walls with heavy metal mesh roofs as suggested in the draft rules. The truth is that some dispensaries will do it for far less than \$100,000. We support the drafted lottery system as one way to avoid these wealthy groups from becoming monopolies.

Instead of creating a limited number of Marijuana growers (dispensaries), reverse the model. 1. In the present rule, caregivers are allowed to have up to five patients. Make it 100 or more patients per caregiver. 2. Dispensaries are now allowed to grow up to 70% of what they intend to sell. Make it 25%-30% or even 0%. Allow the caregivers to grow the majority, 70%-75%. Then allow the caregiver to be compensated from the dispensary for the Marijuana. The caregiver must then compensate their patients from the sale of the Marijuana. 3. Allow caregivers to grow the plants for their patients regardless of whether the patient resides within the 25 mile zone. Do not allow a dispensary to setup a new location that has an established caregiver place of operation that is already outside the 25 mile zone. Note: The new process would be: The patient is assigned to a caregiver. The caregiver grows the patient's Marijuana. Once it's ready for market, the caregiver sells it to the dispensaries. The caregiver's patient receives a payment or voucher (from the caregiver) based on the sale of the patient's Marijuana, which then can be used for their personal purchases. All payments and transactions are recorded and monitored by the state. This is a win, win situation for all concerned, everybody benefits, everyone makes (or saves) money and the tax base is consolidated. The end effect is that there are fewer people to manage, more visible supply lines and visible, auditable tax streams.

I am a board certified Neurologist, and I have been working in the Valley for eleven years. ALS is not a painful disorder, in fact pain and sensory symptoms are exclusion criteria for the disorder...how did this end up on the list? I have never seen an ALS patient require pain medications except for unrelated, coexistent conditions. There is no good study out there confirming that marijuana decreases seizure frequency, in fact there are some that suggest it may worsen seizure...how did "seizure" end up on the list? Who suggested that and what was their argument for its use...I'd love to see it. "Cancer"...so if I have a little basal cell on my nose I can get a bag of weed legally? See how

loose that is? How about being specific, as in pancreatic cancer, liver cancer, brain cancer causing intractable nausea, bone cancer, metastatic cancers, lymphoma, leukemia, persons undergoing chemotherapy with intractable nausea not responsive to usual prescription anti emetics? Get a Boarded, respected local oncologist to give you some input. How about tying it to specific stages of specific cancers? A stage one breast cancer patient should not need marijuana, it would be unusual for them to require any pain medications...may not even get chemo. A stage four...well give them whatever they want as they are typically in a living hell. There is a world of difference between the two situations. Be specific. The blanket statement that marijuana will be authorized for any condition causing muscle spasm, chronic pain, etc....way too vague. My back hurts after I drive a long time, in fact I'm sore right now that does not mean I need access to dope. Do not turn this into a big joke as in CA. Make use of this substance tied to specific valid diagnoses otherwise the shysters (read pain management docs...not all but an awful lot) out there will just find an excuse to give it to anyone that they see, and begin running "mills" as in CA. Fibromyalgia is a disorder of disuse, the last thing those patients need is another excuse to sit on the couch and eat all day. In some of these disorders listed there is more harm than good to be done by feeding them marijuana. Weigh risk and benefit. I think your criteria / qualifying diagnoses at this point are way too loose.

Get rid of the random process to choose dispensaries.

Is there any way to "spread out" the locations of dispensaries so that "home grown" locations can be minimized? I am worried that remote/rural areas will be exploited, and they will be "overgrown" with home growers, and difficult to monitor.

i think that 25miles to grow is way to far it should be 10-15 miles

1) A authorized caregiver needs amnesty from drug testing by employers and law enforcement. Although the caregiver is not authorized (unless they hold their own registry card) to use cannabis they will fail a drug test from being in the room where cannabis is smoked by a registered user and from handling the cannabis in preparation to be used by the registered card holder. It should not cost a caregiver their job or detainment by law enforcement. 2) The State is missing an opportunity to make more money! There should be distinction between a cultivating dispensary license and a distribution dispensary certificate. A company may want to cultivate only and contract with multiple distribution dispensary store fronts or non profit agency who want only to distribute to registered card holders, but not cultivate.

de·bil·i·tate verb \di- bĭə- tāt-dē-de·bil·i·tat-ed·bil·i·tat-ing Definition of DEBILITATE transitive verb : to impair the strength of : enfeeble — de·bil·i·ta·tion \- bĭə- tāhən\ noun See debilitate defined for English-language learners » Examples of DEBILITATE The virus debilitates the body's immune system. <the heart surgery debilitated the college athlete beyond his worst fears> Origin of DEBILITATE Latin debilitatus, past participle of debilitare to weaken, from debilis weak First Known Use: 1533

Eliminate the crazy half-baked idea of using CHAAs to try to disperse dispensaries physically around just to eliminate almost all patients and caregivers from being able to grow. What are we so scared of here guys? A caregiver won't be a 'legal dope dealer' as you guys and some law enforcement think. For one thing, a caregiver can already only have 5 patients. He is limited in plant number by his patient number. 60 plants is not really a lot. He or she will have to have at least 10 or 12 of them as

moms to provide variation of strains. Then they have to be grown long enough(maybe months) to be big enough, some of the plant count will be just small clones etc. It would take a lot of planning and time and skill to keep 5 patients supplied with only 12 plants per patient. The caregiver can only supply his or her patients and diverting to anyone else is already not allowed in Prop 203. I don't think you have any legal basis for this dispensary dispersion. Zoning by towns and cities has already placed many restrictions on dispensaries and how close they can be. The law gave them the right to establish reasonable zoning for dispensaries, not DHS. So you want no small growers and the dispensaries will become walmart size ops with thousands of plants. What about the patient on a fixed income who can't afford to pay 400 an oz. Maybe as a caregiver i can supply him at 200 or even less. =====

I apologize please see comments above. Thank you.

Issue 3: prohibitions against consuming medical marijuana in smoking form. I suggest including a rules statement—or enacting legislation—clearly stating that medical marijuana smoking is not exempted from any other state laws regarding smoking. Rationale: Medical marijuana users may attempt to seek exemption from non-smoking legislation under Prop 203 law. Arizona has taken a position recognizing the dangers of smoking and second-hand smoke; marijuana smoking and its second-hand smoke are many times more dangerous than tobacco. For clarity and to avoid ambiguity, such statement would provide clarity and forestall future challenges or conflicts where marijuana users claim protection and exemption from anti-smoking legislation under medical marijuana law. what a blooming idiot^^

Issue 5: provide a rule or legislation general statement that protects bystanders from any harm resulting from the consumption of marijuana by cardholders. I suggest a catch-all rules statement and/or law saying, “Medical marijuana cardholders who are currently consuming marijuana are prohibited from performing employment or other acts in which their intoxication or smoking may jeopardize the health, safety, or welfare of other persons or cause material damage in the course of their duties or actions. Any such abuse of a medical marijuana authorization is tantamount to immediate revocation of the medical marijuana authorization and will make the cardholder’s consumption of medical marijuana subject to the same penalties and prohibitions under existing statutes governing the general use of marijuana.” Rationale: Prop 203 and the draft DHS rules don’t appear to go far enough to protect the rights of those who might be harmed by medical marijuana users either in the workplace or in public places. A general statement like this would indemnify bystanders or property interests from abusive medical marijuana users. did this guy^^ even bother reading the law?? ===== I strongly suggest the following addition to Arizona Department of Health regulation R9-17-311: 7. Marijuana may not be dispensed in its raw form or in any form that can easily be used by smoking it. Marijuana should only be dispensed in forms that can be taken orally, such as in foods or mixed with oil or butter and made into capsules, or rectally, as in suppositories. The dispensary will keep records listing the form in which the marijuana is dispensed. Marijuana for medical use cannot be transported in its raw form. It must be turned into a dispensable form within 100 feet of the place where it is grown. All marijuana dispensaries must post a warning that can be easily seen by anyone purchasing medical marijuana. The warning states: “Marijuana smoke contains known carcinogens and has been determined to be carcinogenic by ADHS. Medical marijuana can only be dispensed in forms that are taken orally or rectally. Smoking marijuana obtained for medical use is considered illegal diversion and can be prosecuted. Possessing raw marijuana and smoking marijuana are still illegal under Arizona law.” ^^huh? These three comments were in the last comments from the proposed draft rules. Even though the writers of those comments are the biggest idiots on this comment page and they obviously didn't bother reading the

law or doing even a modest amount of research, the DHS seems to have included most of what these 'people' wanted. What they really want are all users of marijuana regardless of reason to be locked up in jail or worse. ===== This law requires for the state, and that means you DHS, to take notice of the many studies disproving the things you want to put on the label. Marijuana does not cause cancer or heart disease or lung infections. It is a very valuable tool in the treatment of cancer however.

Should include more specific regulations regarding security, partnership and compliance with laws and zoning and participation with police

Add language and rules around the requirements for obtaining a permit for dispensary usage

Provide more information about the qualifications for the business, like if they have to be a non profit

I am confused about how you can select people for permitting on a random basis. Is this just a way to narrow down the list, or is this a screening method? Seems odd that something this important would be left to randomness

Take out anything about random selection for dispensary permit

Please make costs low for the patient by (1) keeping dispensary costs down (2) keep application fees down (3) don't require a doctor for a dispensary (4) keep delivery costs down. Thanks. The patient should always come first.

provide regulations around the company who will be obtaining the permit by defining all criteria required and take away anything that may indicate random selections

create a better screening system for those who will be receiving permits

take out anything that is random for the permitting process. This implies that companies receiving permits will do so arbitrarily and not through a thoughtful and thorough background check

Beef up the selection process for the way you choose the people for permitting

1. We would ask the Director to consider a local preference instead of a straight lottery system if there are more than one applicant in each CHAA area. Preference should be given to local companies who have demonstrated Medical and/or Agricultural business viability, success and good standing and have been in business in the State of Arizona in those respective areas for a period of not less than 10 years. It is important that this business have strong community ties to ensure legitimacy and support the economic health of the State and communities in which they are located. 2. We would ask the Director to increase the application fees from \$5000 to \$25,000. This is not an unreasonable request

as it is no more than the cost of some liquor licenses. 3. If the application fee is increased to \$25,000, we would ask the Director to refund \$20,000 or greater of the application fee in the event an application is not awarded. 4. We would ask the Director to increase the number of awards per CHAA to 500 over a 5 year period. 5. We would ask the Director to consider when applying for a Dispensary Registration Certificate to withdraw the request to include the exact physical address of the proposed Dispensary and instead disclose the specific CHAA for which the applicant is applying. The physical address of the Dispensary will be required when applying for approval to operate a Dispensary. For an applicant to locate a suitable premise, sign a lease with the landlord, and then at a later date be informed by the Department that an allocation for a Dispensary Registration Certificate was not granted is in my opinion a hardship to the applicant and to the prospective landlord.

I would like to question the rule that requires that a patient must live more than 25 miles from the nearest dispensary to be permitted to grow their own marijuana. I am a 65 year old man on social security and the cost of medical marijuana will put a burden on my finances. I have arthritis of the ankles with chronic pain and a chronic allergic condition that prevents me from taking almost all pain management medicines. Of the very few I can take the damages to other parts of the body from these drugs prevent me from taking them. I would ask that you reconsider the 25 mile rule, or allow for people to submit for a waiver to the rule.

I would like to see verbage relating to frequent unannounced inspections by authorized agents to ensure all safeguards of regulatory compliance are being implemented. The dispensaries should be carefully watched. The database should be monitored for potential abuse. What safeguards are in place to prevent a person to receive their supplies in one county and then travels to another? Is the database accessible to all countries at all times?

no comment

R9-17-318. Edible Food Products Adding medical marijuana to an edible food product does not adulterate the edible food product. -Does adding another chemical agent such as marijuana to an edible food product, adulterate the food product?

I am concerned that the 1-31-2011 draft rules, make mention of DHS conducting periodic inspections of MMD's and advising dispensary agents of any violations that are observed by DHS. I am concerned, however, that there is no chart of sanctions, or specifics regarding the sanctions DHS will impose on those agents and dispensaries who are out of compliance. The recent rules are also silent as to how DHS will communicate with law enforcement. It appears revocation of a qualified patient, caregiver or agent may occur if these individuals are caught selling marijuana on the street, but how will DHS receive that information and how timely will that be? Additionally, I believe the inability for DHS to

share addressing information with law enforcement creates an officer safety issue. Experience reflects that individuals who grow marijuana at home, will go to great lengths to protect their crop (and cash). Law enforcement officers nationwide have witnessed first hand that growers often booby trap their premises and are frequently armed. This results in the necessity for officers to utilize high risk tactics when serving search warrants at these locations. In order to effectively protect themselves and the public, Officers will need to have a way to determine whether information regarding possible marijuana cultivation constitutes a "legitimate" grow under Proposition 203, or an illegal grow prior to serving a warrant.

I am a disabled Vietnam veteran, I am home bound on a fixed income. I believe the state should consider this and allow Veterans Hospital Doctors diagnosis to be accepted for a medical marijuana card. I have 4 of the 5 requirements for the card but my income will not allow me to use the program unless I am able to use the home cultivation program.

1. We would ask the Director to consider a local preference instead of a straight lottery system if there are more than one applicant in each CHAA area. Preference should be given to local companies who have demonstrated Medical and/or Agricultural business viability, success and good standing and have been in business in the State of Arizona in those respective areas for a period of not less than 10 years. It is important that this business have strong community ties to ensure legitimacy and support the economic health of the State and communities in which they are located. 2. We would ask the Director to increase the application fees from \$5000 to \$25,000. This is not an unreasonable request as it is no more than the cost of some liquor licenses. 3. If the application fee is increased to \$25,000, we would ask the Director to refund \$20,000 or greater of the application fee in the event an application is not awarded. 4. We would ask the Director to increase the number of awards per CHAA to 500 over a 5 year period. 5. We would ask the Director to consider when applying for a Dispensary Registration Certificate to withdraw the request to include the exact physical address of the proposed Dispensary and instead disclose the specific CHAA for which the applicant is applying. The physical address of the Dispensary will be required when applying for approval to operate a Dispensary. For an applicant to locate a suitable premise, sign a lease with the landlord, and then at a later date be informed by the Department that an allocation for a Dispensary Registration Certificate was not granted is in my opinion a hardship to the applicant and to the prospective landlord.

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They could be improved by allowing for 3rd party analyses of medical cannabis specimens.

Take out anything related to "Randomly selecting" permit candidates and replace with how you will be screening applicants to ensure a reputable company receives a permit

"common areas of planned communities" be included in the definition of "public place".

The random selection for dispensaries is alarming at best. This is the most important part of the rules and it is being randomly selected? Absurd. A comprehensive rules and scoring list should be incorporated to ensure that an established company with a reputable medical director and board of directors, as well as a very comprehensive physical security plan is put into place.

Take out the part about random selection for permits. This is an important enough cause to take time to find the company that has the best security, best education plan and best medical staff in place.

The lottery system subverts the ADHS plan of having only the highest quality medical-pharmacy type clinic approach to the delivery of medical marijuana to qualified AZ citizen patients. A lottery system INVITES nefarious "financial backing" of persons lacking the resources necessary to effectively open and operate a clinic. It is a "prescription" for inviting ORGANIZED CRIME and "DIRTY MONEY" into our great State. The Lottery method of deciding to whom a license is issued should be DROPPED.

If you are choosing permits for dispensaries at random, how do you know what types of companies are behind these? Shouldn't you be putting together a better process for choosing who will be able to open a dispensary in neighborhoods?

I can't even get a cell phone without going through a verification process and you are going to choose a permit for a dispensary randomly?

The requirement to have a lease signed and location picked before the application is turned in is becoming unfair. So many landlords are now requiring huge non-refundable deposits, the cost is extremely high. Picking the CHAA should be all that is required for the applicant. They should then have 30-60 days to designate a location. An applicant could then pick the best location and have leverage to negotiate with landlords as they would then be the only dispensary in that CHAA. If they can't secure a location, the ADHS could pick from other applicants that applied in that CHAA. Right now, I am aware of 20 plus applicants in all of the large CHAA's in the Phoenix area.

Allow the dispensaries to decide who they want to be principal officers! Let the bylaws stand as they are and not state that everyone listed in section A under R9-17-301 are principal officers.

R9-17-303 - b. The physical address of the proposed dispensary;. Please change this to read desired location or CHAA zone . if the rules state you cannot change physical address for 3 years, whoever is not granted a lic will be stuck in binding lease.

Awarding of the Medical Marijuana Dispensary (MMD) license should be based on merit, experience and quality of both product and services offered. Random selection of MMDs is a disservice to the patients suffering from chronic and debilitating conditions, the voting constituency, and our local communities. The merit system should be based on the ability of each MMD applicant to develop their program based on demonstrated needs, individual community assets and issues, public perceptions, existing and potential resources, the interests of public health system partnerships, and the unique cultural and geographic diversity of each county. Appropriate experience and expertise of key personnel in each of these areas will guarantee a successfully integrated dispensary. This experience shall include: experience running a Non-Profit and working with a board of directors; social service and business experience; experience collaborating with community partners; retail experience; medication monitoring; experience working with patients or individuals with disabilities. Subsequent to discussions with the Coconino County Health Department and Flagstaff City Council we propose the following: 1) An Initial Application Review Panel consisting of County Health Department members, City Government and local Law Enforcement will evaluate MMD applications using methodology established for other entities seeking licensure from the county: 2) The Initial Application Review Panel will make recommendations to the County Board of Supervisors. 3) The County Board of Supervisors will review and make recommendations to AZDHS. Adherence to existing resources will help mitigate the burden of AZDHS in the application review process and ensure that this industry lives up to the expectations of the community.

i would like to see more conditions added to the current list. i think neurosis, depression and insomnia would belong since some people may gain relief from using medical marijuana. i dont think they need a terminal illness in order to improve their quality of life. please understand chronic psychological pain is just as real as physical pain

Instead of a random method for determining which dispensaries will receive permits, create a detailed review structure that focuses on the company, the physical security of the dispensary, growth operations and general business plan strategy. Rank and review in a decisive manner using a more weighted system

I don't understand how dispensary approval can be randomly selected? Does this mean that less qualified applicants will potentially win a permit while other well established companies will not get a chance for a permit due to the way selections are chosen?

Clarity is needed around if the dispensary company needs to be an actual non profit

Don't make the dispensary certificate issuing random. There is no way to put controls around this.

The dispensary certificate awarding is confusing. The rules indicate that the selection will be "random". This poses a serious concern with security, ensuring the company that is building the dispensary is stable and solid and there is a sound business plan and operations strategy in place for the company.

Change the "Must live 25 miles away from a dispensary to grow" rule. If someone happens to live 24 miles away from the nearest dispensary they would have to drive 24 miles who knows how often just to get their medicine. Many people would also like to grow their own medicine because the strain that benefits them most may not be available at nearby dispensaries. The rule should be taken out completely or the distance should be cut exponentially as growing your own medicine may be the only way some people can afford to receive their cannabis. Please take into consideration my request as many will benefit from the change/removal of the "25 mile rule."

The draft rules can be improved by clarifying that common areas located in planned communities be included in the definition of public places.

The draft rules confirm that employers are free to take disciplinary action against employees eligible for protection under the Medical Marijuana Act ("MMA") who are "impaired" by marijuana at work, but go on to state that the "presence of marijuana in a person's system that appears in a concentration insufficient to cause impairment" is not considered under the influence of marijuana. This language creates an ambiguity for employers as it is not clear what a "concentration insufficient to cause impairment" means. ADHS must explain to employers when they can or cannot take action against employees who test positive for marijuana while at work or while engaged in company business.

The proposed product label warning message does not contain accurate information and should be changed. No human death has ever been directly attributed to marijuana itself. - Marijuana is less addictive than caffeine. - There is no conclusive evidence that pure marijuana causes cancer. - There is no evidence that smoking marijuana causes heart attacks. - There is no evidence that marijuana smoking causes lung infection.

Cheapest phentermine online [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Include migraines...They are debilitating, along with the nausea that accompanies them.

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key personnel in each of these areas will guarantee a successfully integrated dispensary. Subsequent to discussions with the Coconino County Health Department and Flagstaff City Council we propose the following: 1) An Initial Application Review Panel consisting of County Health Department members, City Government and local Law Enforcement will evaluate MMD applications using methodology established for other entities seeking licensure from the county: 2) The Initial Application Review Panel will make recommendations to the County Board of Supervisors. 3) The County Board of Supervisors will review and make recommendations to AZDHS. Adherence to existing resources will help mitigate the burden of AZDHS in the application review process and ensure that this industry lives up to the expectations of the community.

██████████ wants the state to limit a doctor to only be able to provide medical marijuana to a limit of 30 patients. This is ridiculous; ██████████ should have absolutely NO say in how a doctor treats their patients. An individual doctor may have hundreds of patients with medical conditions that might require the use of medical marijuana, why limit how many patients can receive the treatment that they need? Let's tell individual doctors that they can only prescribe a maximum of 30 patients for antibiotics. This would make absolutely no sense. Let doctors do their job of helping people to heal in the way that the DOCTOR deems necessary. Let's not limit the power of doctors; they are professionally trained to be responsible and accountable for how they treat patients... LET THEM DO THEIR JOB!!! As for the proposed 'process to revoke doctors licenses': the state medical board already has a process to remove bad doctors from practice. Why should this law be an avenue to harass already stressed out busy doctors? Caregivers already administer narcotic drugs as it is and many of these drugs are more powerful and dangerous than marijuana. We don't want to make it prohibitively expensive for patients to pay for a licensed caregiver, medical bills, and prescription costs if they cannot afford such expenses. Some patients may not be able to get the care they need if they also need to pay for a licensed or specially trained caregiver.

I recommend greater scrutiny of board members/applicants to insure that they are not a front for organizations from California and Colorado. Dispensary license selection process be based upon qualifications and merit (see comment below)

On section R9-17-103 Electronically submitted department formats are preferred, however, completed department format forms can also be mailed-in and accepted as well. On section R9-17-106 , Section B The department should respond in writing to notify the requester of their decision within 45 days. On section R9-17-101, #25 There should be a 25th definition. It should read as follows: #25 A medical marijuana patient's card shall remain valid and shall not need to be renewed as long as the patient's medical condition remains the same. On section R9-17-101, Definitions, # 21, Public places #21 should read as follows: #21 A legal marijuana patient shall not be deprived from transporting his or her medical marijuana medicine on any aircraft to go to any location that also

allows the use of medical marijuana. However, the medical marijuana patient shall not use their medical marijuana while aboard any aircraft.

In order avoid confusion with in the vendor I think that there should be only one or two principal officers, either the director or a board member.

In my opinion it would be most effective to only have one principal officer, that being a board member or director.

I believe that all principal officers should be board members or a director.

The 25-mile rule, patients have no options, only to buy from a dispensary. DHS must impose a low price cap on the cost of medicine. A price cap will also drive off the the dispensary owner applicants that are just in this for the money. Myself and many patients will never be able use this medicine unless some low cost options are set in place.

Please remove medical director idea and replace w/ nonprofit BOARD OF DISPENSARIES. This clearly is not required of ANY other pharmacy or prescription and clearly is meant to burden the costs to sick patients further in an poorly thought out attempt to try and limit patients access and increase price. It seems, sadly, that the dept is attempting to thwart the will of the voters by trying to propose rules that are clearly designed for this purpose. If you want to have another measure passed taking the State further out of the loop and maybe tax free and fee free please do keep it up then. As a life long Republican tired of this abuse of sick people i will be first one to sign and help gather signatures. Also the prosed yearly fees for the card are an outrage. 50 dollars one time with a 4 yr renewal or longer should apply .Just like the drivers license. Your machinations at the Dept are not unnoticed and I believe if you are not more fair and prudent rather then trying to find ways to limit the laws clear intent you will find people calling for a change in leadership and a more liberal law proposed which i do not believe is in the States best interest. Time to accept the will of the people. The operative word being "respect".

In 21 b where public places are defined, common areas of HOAs should be included.

the dr. should be able to subscribe medical marijuana when he sees fit, no patient and dr. relationship.

Only 125 dispensary registrations will be allowed. The rules state that an application for dispensary registration must be accompanied by a \$5000 non-refundable fee. However, where multiple complete applications have been submitted for an area, the registration will be given out randomly. Will those who are NOT provided with a registration be refunded their fee or do they forfeit the fee for the sake of attempting to start their business?

It is clear that Mr. Humble's Department of Health Services continues to ignore the requirements of ARS 36-2803.4 that its rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries..." and the requirement of ARS 28.1 Section 2 to take notice of the numerous studies demonstrating the safety and effectiveness of medical marijuana. It is also clear from remarks by the Director and his staff that he intends to violate the protections of ARS 36-2811.C to persecute physicians who specialize in medical marijuana evaluations. Will Humble, the Director of the Arizona Department of Health Services, has repeatedly expressed his disapproval that some physicians

provide a large percentage of medical marijuana recommendations in other states and his intent to prevent that in Arizona. One departmental indication of that attitude: "Health officials will keep an eye out for physicians who write too many recommendations for the drug that now is legal in Arizona when used for medicinal purposes. Dr. Laura Nelson, chief medical officer for the state health department, said physicians who write more than 100 recommendations within a year would get a second look to ensure they are not falling into the trap of recreational use." Read more: Medical marijuana rules get reworked | Phoenix Business Journal To understand how absurd the 100 patient per year threshold is, consider that a busy family, ER, or pain management physician can easily write more than 100 controlled substance prescriptions in a single day. See also:

Do you think that Mr. Humble's threatening, bullying, and scofflaw behavior just might have a chilling effect on physicians who might otherwise write legitimate recommendations? that such behavior will mean fewer physicians will write a larger percentage of legitimate recommendations? In the recent public comment period hundreds of Arizona citizens reminded the Department that the department has no authority whatsoever to define or re-define the physician-patient relationship, no authority whatsoever to infringe or revoke patients' right to choose if, when, or which physician(s) they choose for their care, and no authority whatsoever to exceed what is allowed by law. The Department continues to ignore the stern and overwhelming public rebuke. The Department's scofflaw behavior de-legitimizes itself. The Arizona Medical Marijuana Act defines the process for qualifying medical marijuana patients. The Act is crystal clear that it is Arizona's physicians, not the Arizona Department of Health Services (hereinafter, "the Department"), who, according to the criteria of the Act, determine which patients are qualified. With regard to patients, the Act provides the Department some authority to design an application, issue state registry identification cards, implement a computer verification process, and to revoke cards in the instance of specified criminal violations, but the Department has no authority whatsoever to determine which patients are qualified or which allopathic (MD), osteopathic (DO), naturopathic (ND), or homeopathic physicians may be consulted or the scope and duration of their duties, how many patients physicians evaluate or recommend, or to otherwise restrict or harass physicians' lawful professional activities. Those are matters assigned to physicians' judgment and patients' choices respectively. R9-17-202 of the 1/31/2011 revised draft regulations on medical marijuana continues the Department's scofflaw efforts to violate patients' rights of choice and privacy and to illegally, arbitrarily, and perniciously re-define physician-patient relationships and physicians' lawful professional activities. Except for sections 5(a), (b), (c), (i), and (k), the only relevant regulations allowed by the Act, R9-17-202 is objectionable in its entirety. The Department has no authority to require or limit the provision of any ongoing care or physician relationship. The Department has no authority to require attestations or statements not already required by the Act. The Department has no authority to add regulations or make definitions that are not authorized by the Act. R9-17-202.F.5(e) is a salient example. The Department has neither authority to force patients to accept care from a particular physician nor authority to force physicians to provide care to particular patients. While patients may be satisfied with some or most of the care provided by their treating physicians and specialists, many of those physicians remain resistant to recommending medical marijuana, so patients may-and do-legitimately choose to see other physicians in circumstances and scope upon which the patient and physician mutually agree, not at all within the purview of the Department. R9-17-202.F.5(e) continues the Department's effort to arbitrarily and unreasonably usurp and infringe upon patient and physician rights. R9-17-202.F.5(g) is another salient example. We are aware that the Director of the Arizona Department of Health Services, met with qualified members of the Arizona Medical Board and was advised that, in the opinion of the Arizona Medical Board, they were not convinced that the Arizona Medical Marijuana

Act required a physical examination since the language of the Act requires a full assessment of the patient's history, but makes no mention of any physical examination at all. It is a dangerous precedent to allow the Department to usurp authority. It may be reasonable for us to wash our hands before meals, but it would be a dangerous precedent to allow the Department to require that. In the same vein, we must not allow the Department to require anything, no matter how seemingly innocent, that is not within their authority. Their draft regulations already confirm the Department's propensity to abuse and usurp authority, even to a cruel and capricious degree. We are not the chattels of the State. We, not the Department, have the right to choose if, when, and whom we seek for medical care. We mean to assert those rights. Even if the Department continues to ignore the enormous body of peer-reviewed evidence of the efficacy and safety of medical marijuana, we will not waive our rights. Even if the Department cannot-or defiantly will not-discern the enormous difference between Arizona's very limited (arguably, too limited) qualifying conditions from our neighboring state's expansive qualifying criteria, we will not waive our rights. Even if the Department continues to act out on its institutionalized nightmares and paranoid fantasies, we will not waive our rights. R9-17-312 is objectionable in its entirety. 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 pharmacies are not required to have medical directors on-site or on-call. For addictive and potentially deadly drugs, such as Adderall, Percocet, and Fentanyl, Arizona does not require patient log books, reporting among physicians, medical directors for pharmacies, the preparation or dissemination of educational materials, querying the Arizona Board of Pharmacy Controlled Substance database, or other of the burdensome and unreasonable requirements of R9-17-312. It is clear that the Department intends to ignore the requirements of ARS 36-2803.4 that its rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." The Department has no authority, as it attempts to do in R9-17-312(E), to prevent a physician from performing any professional duties already allowed by law. Missing protections The Department has demanded unnecessarily detailed information from patients, caregivers, and dispensary principals and applicants, yet has failed to institute any criminal or civil penalties for unauthorized access or dissemination of privileged information. The Department has not provided any criminal or civil penalties for potentially damaging use of privileged and sensitive medical information or for endangering good citizens who may be targeted for home invasion, kidnapping, and theft because they may be presumed to transport or have cash or other valuables. If the Department actually cared about Arizona's suffering and dying, the Department would champion a challenge to the provision of the Arizona Medical Marijuana Act that requires physicians to name the qualifying condition(s) on every patient's recommendation. This requirement is a violation of Article II §8 of the Arizona Constitution right to privacy and should be severable from the remainder of the Act. There is no provision for laboratories to receive and process medical marijuana specimens voluntarily submitted by dispensaries, caregivers, and patients to test for potency, constituents, and potential contaminants or pathogens. Except for elimination of "the 70% rule" and the "1 year/4visit rule" the previous defects are essentially unmitigated in the 1/31/2011 revision, so all earlier criticisms are re-incorporated into this commentary:

[REDACTED]

Change or abbreviate "qualifying patient." This phrase is awkward when you use it 12 times in one sentence, it makes this document extremely hard to read.

A

There is no need to have all managers, board members, directors, ect be principal officers. Principal officers should only be named in the bylaws and for people who are applying for the dispensary certificates. Other people who would be considered a principal officer in the current draft would not want the responsibilities that are linked with the status of being a principal officer. Or the financial burden that being a principal officer involves. That part about everyone in section A being considered a Principal Officer needs to be taken out!

One of my areas of concern is the amount of cultivation sites each dispensary is allowed. Currently 36-2804 B (ii) states "(ii) THE PHYSICAL ADDRESS OF THE NONPROFIT MEDICAL MARIJUANA DISPENSARY AND THE PHYSICAL ADDRESS OF ONE ADDITIONAL LOCATION, IF ANY, WHERE MARIJUANA WILL BE CULTIVATED, NEITHER OF WHICH MAY BE WITHIN FIVE HUNDRED FEET OF A PUBLIC OR PRIVATE SCHOOL EXISTING BEFORE THE DATE OF THE NONPROFIT MEDICAL MARIJUANA DISPENSARY APPLICATION." Federal law prohibits any entity or individual from cultivating more than 99 plants at one location. With state law allowing for only cultivation at the dispensary and one off site cultivation facility, the maximum number of medical marijuana plants a dispensary could have is 198. With traditional growing methods a dispensary could potentially have four harvests per year, 198 plants X 4 harvest per year = 792 plants per year per dispensary. This is based on a 60 day vegetative cycle, 60 day flowering cycle and does not include drying and/or curing the medical marijuana for retail sale or processing further at an infusion facility. Potentially a cannabis plant can produce 6 ounces of dried, cured and processed cannabis under these conditions. 198 plants X 4 harvests 792 plants per year X 6 ounces per plant 4,752 ounces of cannabis per year per dispensary Each patient in Arizona can receive 2.5 ounces of cannabis every 2 weeks or 65 ounces per year. 4,752 ounces per year per dispensary/65 ounces per year per patient = 73 patients per dispensary Arizona is expected to have 100,000 + medical marijuana patients in the first year alone. At full cultivation capacity under the current restrictions Arizona dispensaries can only support cultivation for 9052 patients. This would leave 90,948 patients with no medication available. One possible solution we would like to suggest is having the Dispensaries establish "Caregiver Networks". A "Caregiver Network" is formed when a dispensary applies for and is granted caregiver status of the patients it serves. The dispensaries would acquire the "cultivation rights" of the patients, when a dispensary agent has received "cultivation rights" from the patients and AZDHS, they are permitted to cultivate cannabis for that patient at an additional off-site facility. Each additional off-site facility could cultivate up to 99 additional plants accommodating the needs of 8 more patients. This would also increase employment opportunities and assist a struggling real-estate market in Arizona as dispensary operators would purchase currently un-occupied property across the state I commend the Arizona Department of Health Services in their efforts to draft a set of rules to implement the Arizona Medical Marijuana Act. We understand the importance of this step in the implementation process and submit the following document in an attempt to further strengthen the Rules governing the Arizona Medical Marijuana Act. After all the hard work AZDHS has put in to this program it was truly a disappointment to see a "lottery" suggested. R9-17-302. Dispensary Registration Certificate Allocation Process A. The Department shall review dispensary registration certificate applications and issue dispensary registration certificates according to the requirements in R9-17-107. B. The Department shall accept dispensary registration certificate applications for 30 calendar days beginning May 1, 2011. 1. A city or town that contains more than one CHAA may request the reassignment of a dispensary registration certificate allocation from one CHAA to another CHAA under the jurisdiction of the city or town. 2. If the Department receives: a. Only one dispensary

registration certificate application for a dispensary located in a CHAA that the Department determines is complete and is in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter by 60 days after May 1, 2011, the Department shall allocate the dispensary registration certificate for the CHAA to that applicant; or b. More than one dispensary registration certificate application for a dispensary located in a CHAA that the Department determines are complete and are in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter by 60 days after May 1, 2011, the Department shall randomly select:

I support the decision to make it equal opportunity for all applicants involved however we cannot support the idea that even one of the 124 dispensaries to be allocated is done so by a "lottery" style decision. During a recent radio program Will Humble spoke regarding the anticipated number of applications AZDHS will receive initially and suggested the number to be around a few hundred. Should this suggested "lottery" stand, there will surely be far more than just a few hundred applications. I would like to suggest an alternative option that allows AZDHS as well as the cities and townships in which the dispensaries and associated facilities will reside the ability to choose an applicant. A two step process: Step 1) AZDHS would be required to "pre-screen" all applicants; any applicants meeting the currently suggested requirements would be grouped by CHAA as suggested. Step 2) AZDHS should allocate a time frame in which the cities that are encompassed by the CHAA have to screen the applicants and make an educated choice of applicants based on the individual needs of the cities located in the CHAA. Adding an additional time period for the decision making process at the city level in order to ensure that the most qualified 124 applicants receive permits to operate a dispensary is in the best interest of all parties involved. We also anticipate this to be a warm welcomed alternative based on public response when it was suggested on our social networking sites and associated web sites. One concern that could arise out of such a "lottery" decision was expressed by a AZCSForums.com member and is as follows: "I am a potential dispensary operator and have a question about the lottery. If I am the only applicant in a CHAA area (which would be awesome!) but the city requires a "conditional use permit" to operate any sort of MMJ facility in their city, do I still have to do the public hearing and get the conditional use permit from the city or do I just get to set up shop? Another thing is, what if the city doesn't give me a conditional use permit, do I lose my dispensary permit or can DHS over rule the decision by the city? I just don't want my dispensary hung up in litigation if there is a conflict between the city and DHS. Paying \$5K rent on a building I can't use yet isn't in my best interest." Another post regarding the same concern: "Hey, everyone! Love the forum and the site, lot's of great information on here. I have a question though, if I get a dispensary permit and the cities I want to put a dispensary in are all a conditional use permit required what do I do first? Get a permit from the city? What happens if I get a permit from the DHS and the city says I can't have a use permit? Thanks to all the zoning finding buildings isn't really all that easy and finding landlords willing to rent is even harder when you tell them what type of biz your planning? Any advice is appreciated" This is a good point of concern for some cities as well as potential dispensary operators and should be carefully considered. The AZCS suggested amendments to help eliminate this concern: R9-17-302. Dispensary Registration Certificate Allocation Process 2.b. More than one dispensary registration certificate application for a dispensary located in a CHAA that the Department determines are complete and are in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter by 60 days after May 1, 2011, the Department shall submit pre-qualified applications for review to the appropriate CHAA city councils wherein a final selection of applicant shall be made. With the "lottery" removed the number of applicants will decrease to resemble originally estimated figures of just a few hundred. Under this suggested "Two-Step" process each CHAA in most cases would only receive 1-4 applications to review. Areas of "high interest" such as Phoenix, Mesa, Tempe, Scottsdale will undoubtedly receive more than most cities and thus lengthen the amount of time those CHAA regions would require to complete the decision making process. AZDHS would be

required to allocate sufficient time or a contingency plan for an extension of the allotted time frame based on number of applications received in these areas. . But over all the drafts have been getting more and more user friendly and easier to work with. I commend AZDHS on there ability to listen to the public and make it a group decision in the long run. just remember ITS ABOUT THE PATIENTS!!!! but if the dipensary operators have troubles staying running then patients will be on there own once again. thank you and god bless

The draft rules can be improved by eliminating or drastically reducing the responsibilities of the Medical Director described in R9-17-312. R9-17-312, D...should be changed to: D. A medical director shall not use their position as Medical Director as a means to establish a physician-patient relationship with as a means to provide a written certification for medical marijuana for a qualifying patient.

The draft rules can be improved by eliminating or drastically reducing the responsibilities of the Medical Director described in R9-17-312. I do understand why the ADHC would want a licensed physician to be associated with a dispensary that distributes medical marijuana to qualified patients, but their role should be no more than of a consultant. A patient's physician can provide all the required information about marijuana and other information can be found In-line or be in the form of information pamphlets at the Dispensary The responsibilities of a Medical Directory should be only for the following: 1. Able to be contacted by any means possible for consultation in the medical aspects of Medical Marijuana. 2. Assist in the development and implementation of review and improvement processes for patient education and support provided by the dispensary. .3. A medical director shall not establish a physician-patient relationship with or provide a written certification for medical marijuana for a qualifying patient.

Anyone who has been deemed 100% disabled and receivig SSA benefits will find the issuance of of medicinal card will certainly find the initial / renewal fee excessive being on a limited fixed budget. I respectfully aks if this issue could be reviewed.

keep costs low for patients and dispensaries...no doctor is needed for the dispensary just like no dr. is needed for a pharmacy...don't forget the state wants to tax MJ high which will make costs high...low patient app fees, low dispensary fees, make mj easily accessible for patients in need, don't restrict delivery for those homebound

Remove the no growing within 25 miles of a dispensary law. Make it so anybody who has a card may grow.

Sad to say but we live in Tucson and the dispensaries will be targeting by crime, I don't know if security guards are required in LA but they are pretty much standard. Gang members will be willing to commit armed robbery for the couple thousand there. Having a professional at every location would discourage these crimes. Also the 25 miles rule seems arbitrary, and like it will do more harm than good. How about 10 miles at the most. Caregivers should be given equal oppertunitys to help their patients.

Comments on Draft 01/31/11 Definition of Medical Director: Page 4 (R-17-101. Definitions 15) the definition of "Medical Director" has been crossed out/struck through. I strongly agree the

Dispensaries should have a Medical Director and we should clarify as follows: Page 35 (R9-17-303 – Applying for Dispensary Registration Certificate B.1.e.) notes that when applying for a Dispensary Registration Certificate - the application would require “The name and license number of the dispensary’s medical director” - the question is “What type of license(s) will qualify one to be a Medical Director”? Example: would a medical care provider who is currently a Director of Clinical Research (DCR) qualify? The job description of a DCR clearly mirrors our job description of a Medical Director as outlined in R9-17-312. Page 43 (R9-17-309 Administration A. 3.) notes that “A dispensary shall Employ or contract with a medical director” again the question is “What type of license(s) will qualify one to be a Medical Director”? I suggest the application to Operate a Dispensary include the Resume of the Medical Director and this resume must clearly outline the Medical Director experience as outlined in R9-17-312. Page 46 (R9-17-312 Medical Director – A) Notes – A dispensary shall appoint an individual who is a physician to function as a medical director – what is the definition of Physician? – I recommend we cross out the word physician and replace it with medical director to be consistent. Applying for a Dispensary Registration Certificate: Recommendation to move 2 application items (questions) from Dispensary Registration Certificate Application to Approval to Operate a Dispensary Application: Page 35 (R9-17-303 Applying for a Dispensary Registration Certificate B.1.b) notes that the application will require – “The physical address of the proposed dispensary;” – I propose that do to the fact that the CHAA is the primary concern at this point - this application item (question) be relocated to the application to operate (R9-17-304) – See (Add a Question..below). Page 37 (R9-17-303 Applying for a Dispensary Registration Certificate B.5) notes that the application will require – “...compliance with local zoning restrictions...;” – I propose that this application item be relocated to the application to operate (R9-17-304) – Please note that a number of AZ Cities will not have determined their zoning requirements by summer, 2011. Add a Question to the Dispensary Registration Certificate Application: I propose and recommend that the application for a Dispensary Registration Certificate include the item: “Name of the CHAA where your Dispensary would operate and Name of 2nd choice CHAA where your Dispensary would operate. As opposed to physical address of proposed dispensary. 2012: R9-17-302 Dispensary Registration Certificate Allocation Process C. “In April of each calendar year beginning April, 2012...” D. 1.b & D.2.b – notes “Randomly” I propose we include an Asterisk next to the word Randomly – “Randomly\*” and then in E. add or somehow note - the Department will keep the \$4,000 and apply that to the re-application fee and or give the re- application priority over new applications for a Dispensary Registration Certificate.

It creates an undue hardship to require that all individuals listed in section A of R9-17-301 be considered principal officers. Take section B of R9-17-301 out. It is unethical.

In section R9-17-317 (G)(1)(c)(iii)(2) there is a requirement for a 704x480 resolution for the video cameras. A lot of video cameras support up to 640x480 which is very close to this resolution. Why is the department requiring 704x480? Newer, more expensive models will support 704x480 but I do not see the benefit in light of the added costs of higher-definition cameras. If possible, please adjust this to read 640x480. Thanks

I support the geographic dispersion of dispensaries to help minimize the less regulated home grower operations. I support strong caregiver requirements against home growing and providing proper oversight and training. I support careful monitoring of physicians by requiring a true doctor-patient

relationship with legitimate certifications. I support limiting the number of patients to 30 that a doctor may write a prescription for at any given time.

We request that common areas of planned communities be included in the definition of "public place".

Pick the most qualified people to run dispensary. Instead of lottery limit how many applications a company can apply for.

You should issue Dispensary certificates first come first serve until they are gone. Many health care zones will not be able to open a Dispensary due to costs involved in opening. All Dispensary should be placed in the general population areas of Arizona if there are not at least 10 Pharmacy's in a health care zone then they should not qualify for a Dispensary. We need Dispensary's where the patients live not scattered across Arizona.

Kill the BS 25mile rule if you are authorized you should be allowed to grow it yourself insted of buying off the streets from the sellars from south of the border.

Change the requirements for principal officers! Let the dispenseries decide who should be principal officers. Take out part b in section 301

I support the geographic dispersion of dispensaries to help minimize the less regulated home grower operations. I support strong caregiver requirements against home growing and providing proper oversight and training. I support careful monitoring of physicians by requiring a true doctor-patient relationship with legitimate certifications. I support limiting the number of patients to 30 that a doctor may write a prescription for at any given time.

Let the bylaws say who should be considered principal officers!

I think incorporating the CHAAs to limit or eliminate the number of people who either grow for themselves or who are caregivers growing for their patients is unfair, unwarranted, and discriminating against patients that don't have the economic resources to purchase their medicine from the dispensaries, forcing them to turn to the black market. I think that there was already undue hardship on those that can't afford the dispensary by forcing them to be 25 miles away from the dispensary and any further restrictions only force people to break the law in one way or another. Marijuana literally keeps me out of the hospital from my severe nausea and vomiting. I have to pay \$500 a month for insurance and am on disability that pays \$900/month. As of now I have \$400/month to live on and dispensaries could cost up to \$1000/month if the 300% bill is passed. PLEASE UNDERSTAND THAT THOSE WHO GO OUTSIDE THE 25 MILE MARK TO GROW FOR THEMSELVES OR OTHERS HAVE NO OTHER CHOICE. We voted for that rule to be enforced but if their only choice is taken away, the black

market is who will profit, NOT THE DISPENSARIES. There is no reason to limit the amount of caregivers or cultivating patients. Prop 203 was voted for so that patients in need could be treated- forcing them to buy from dispensaries is against the spirit of helping patients and seems to only help dispensaries which was not what Prop 203 is about.

Grow small plots even if within a zone. Raise the "tax" on card registration.

I support the geographic dispersion of dispensaries to help minimize the less regulated home grower operations. I support strong caregiver requirements against home growing and providing proper oversight and training. I support careful monitoring of physicians by requiring a true doctor-patient relationship with legitimate certifications. I support limiting the number of patients to 30 that a doctor may write a prescription for at any given time.

1. Make medical marijuana easy to obtain for those defined as qualifying. 2. Make it easy for those who have been on pain pills for at least a year to switch to medical marijuana. 3. Make medical marijuana delivery easy (with proper ID) as many patients are shut-ins or have major disabilities and can not travel or do not have caretakers. 4. Many doctors are prohibited from recommending medical marijuana by their clinic or hospitals, so make it simple for a patient to see a 2nd doctor, a medical marijuana doctor. One visit a year is plenty since most of these patients are dirt poor. Do not put too much paperwork requirements on these doctors. Help keep these costs down so a poor patient doesn't have to pay too much to get their recommendation. 5. Do not legislate. This bill was passed to help patients in need. 6. Do not assume the negative. Medical marijuana has far more benefits than pain pills and aspirins which are slowly killing patients. 7. Keep application fees down, especially for the poor. 8. Keep dispensary administrative costs down as the price of medical marijuana will rise to not being affordable if you require a doctor for a dispensary, or have other bogus requirements. Keep in mind that Arizona will also tax marijuana maybe as high as 300%. We don't want medical marijuana just for the rich. 9. Always keep the POOR patient in mind when any rules are set up. 10. Do not force poor patients to continue buying their marijuana off the streets because of costs or rules.

I support careful monitoring of physicians by requiring a true doctor-patient relationship with legitimate certifications but believe that the mendical community needs to be the overseers.

Please include the common areas of a planned community in the definition of "public places" where marijuana smoking is prohibited.

The argument that Will Humble uses that he lacks the budgetary resources to adequately evaluate different applications is spurious at best and reckless at worst. The \$5,000 non-refundable fee per application and Mr. Humble's publicly stated opinion that there will be "hundreds" of these applications translates into millions of dollars that ADHS has available for this task. Failure to use these funds in this manner could be construed a gross breach of ethical conduct and could be basis for legal action taken against ADHS. Much like the city of Long Beach in California holding a "lottery" of sorts for dispensary permits, collecting almost a million dollars, then refusing to award any permits. It could appear that Arizona has found something about California's Medical Marijuana program it wishes to emulate. Randomly selecting among dispensary applications would mean that these funds are used for purposes other than what they were earmarked for in the proposition.

I support the geographic dispersion of dispensaries to help minimize the less regulated home grower operations. I support strong caregiver requirements against home growing and providing proper

oversight and training. I support careful monitoring of physicians by requiring a true doctor-patient relationship with legitimate certifications. I support limiting the number of patients to 30 that a doctor may write a prescription for at any given time.

the random selection between multiple CHAA areas will only guarantee that at least in certain areas this devolves into a recreational program. by not asking questions regarding financial strength, or years of experience, or even past experience with not-for-profit and non-profit and even for profit businesses you guarantee that part of your "random" selection introduces elements which will be detrimental to the total program. look at what is needed to submit a "complete" application, zero requirements on what the business plan entails, no questions regarding past experience, and just the barest outline of what the policies and procedures should encompass. nothing about financial strength, or assets in arizona, or length of time doing business in arizona. basically if you can make a thumbprint, throw together a spreadsheet and remember your name address and maybe your phone number, then somehow accidentally be able to write a check for \$5,000. you have a complete application, and a fair chance of winning the dispensary lottery. is this really the kind of individual you want running this program? i have been doing business in arizona since the 60's. i have the financial resources to lie fallow for the 6-8 months it will take between making an application and actually having medicine in a location. i have canvassed the state talking with mayors, city councils, zoning commissions, police departments, DEA agents, all trying to address their concerns and create a legitimate MEDICAL marijuana program. after doing all of that, after believing that will humble someone who actually wants to have a singular program, i see him destroy it all in the final draft because he is afraid someone will challenge his decision legally. i am disgusted by this lack of fortitude and explicit display of bureaucratic cowardice. you deserve the program you are going to get with this decision.

The definition of "Public place" needs to include the common areas of planned communities. 21. "Public place": a. Means any location, facility, or venue that is not intended for the regular exclusive use of an individual or a specific group of individuals; b. Includes airports; banks; bars; child care facilities; child care group homes during hours of operation; common areas of apartment buildings, condominiums, or other multifamily housing facilities; educational facilities; entertainment facilities or venues; health care institutions, except as provided in subsection (21)(c); hotel and motel common areas; laundromats; libraries; office buildings; parks; parking lots; public transportation facilities; reception areas; restaurants; retail food production or marketing establishments; retail service establishments; retail stores; shopping malls; sidewalks; sports facilities; theaters; warehouses; and waiting rooms; and... Under a. the common area of an planned community IS intended for the use of specific individuals: the home owners and their guests. Under b. specific housing developments are listed: "apartment buildings, condominiums, or other multifamily housing facilities." Planned community HOAs are not included and should be. Thank you for the opportunity to respond.

I am concerned that poor people that live less than 25 miles from a dispensary will not be able to afford their meds. Why can they NOT grow their own at home? Doesnt seem fair to me.. Also I am wondering why PTSD is not covered? The VA said it is helpful and has approved it for relief.

In the recent public comment period hundreds of Arizona citizens reminded the Department that the department has no authority whatsoever to define or re-define the physician-patient relationship, no authority whatsoever to infringe or revoke patients' right to choose if, when, or which physician(s)

they choose for their care, and no authority whatsoever to exceed what is allowed by law. The Department continues to ignore the stern and overwhelming public rebuke. The Department's scofflaw behavior de-legitimizes itself. The Arizona Medical Marijuana Act defines the process for qualifying medical marijuana patients. The Act is crystal clear that it is Arizona's physicians, not the Arizona Department of Health Services (hereinafter, "the Department"), who, according to the criteria of the Act, determine which patients are qualified. With regard to patients, the Act provides the Department some authority to design an application, issue state registry identification cards, implement a computer verification process, and to revoke cards in the instance of specified criminal violations, but the Department has no authority whatsoever to determine which patients are qualified or which allopathic (MD), osteopathic (DO), naturopathic (ND), or homeopathic physicians may be consulted or the scope and duration of their duties, how many patients physicians evaluate or recommend, or to otherwise restrict or harass physicians' lawful professional activities. Those are matters assigned to physicians' judgment and patients' choices respectively. R9-17-202 of the 1/31/2011 revised draft regulations on medical marijuana continues the Department's scofflaw efforts to violate patients' rights of choice and privacy and to illegally, arbitrarily, and perniciously re-define physician-patient relationships and physicians' lawful professional activities. Except for sections 5(a), (b), (c), (i), and (k), the only relevant regulations allowed by the Act, R9-17-202 is objectionable in its entirety. The Department has no authority to require or limit the provision of any ongoing care or physician relationship. The Department has no authority to require attestations or statements not already required by the Act. The Department has no authority to add regulations or make definitions that are not authorized by the Act. R9-17-202.F.5(e) is a salient example. The Department has neither authority to force patients to accept care from a particular physician nor authority to force physicians to provide care to particular patients. While patients may be satisfied with some or most of the care provided by their treating physicians and specialists, many of those physicians remain resistant to recommending medical marijuana, so patients may—and do—legitimately choose to see other physicians in circumstances and scope upon which the patient and physician mutually agree, not at all within the purview of the Department. R9-17-202.F.5(e) continues the Department's effort to arbitrarily and unreasonably usurp and infringe upon patient and physician rights. R9-17-202.F.5(g) is another salient example. We are aware that the Director of the Arizona Department of Health Services, met with qualified members of the Arizona Medical Board and was advised that, in the opinion of the Arizona Medical Board, they were not convinced that the Arizona Medical Marijuana Act required a physical examination since the language of the Act requires a full assessment of the patient's history, but makes no mention of any physical examination at all. It is a dangerous precedent to allow the Department to usurp authority. It may be reasonable for us to wash our hands before meals, but it would be a dangerous precedent to allow the Department to require that. In the same vein, we must not allow the Department to require anything, no matter how seemingly innocent, that is not within their authority. Their draft regulations already confirm the Department's propensity to abuse and usurp authority, even to a cruel and capricious degree. We are not the chattels of the State. We, not the Department, have the right to choose if, when, and whom we seek for medical care. We mean to assert those rights. Even if the Department continues to ignore the enormous body of peer-reviewed evidence of the efficacy and safety of medical marijuana, we will not waive our rights. Even if the Department cannot---or defiantly will not---discern the enormous difference between Arizona's very limited (arguably, too limited) qualifying conditions from our neighboring state's expansive qualifying criteria, we will not waive our rights. Even if the Department continues to act out on its institutionalized nightmares and paranoid fantasies, we will not waive our rights. R9-17-312 is objectionable in its entirety. 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 pharmacies are not required to have medical directors on-site or on-call. For addictive and potentially deadly drugs, such as Adderall, Percocet, and Fentanyl, Arizona does not require patient log books, reporting among physicians, medical directors for pharmacies, the preparation or dissemination of educational materials, querying the Arizona Board of Pharmacy Controlled Substance database, or other of the burdensome and unreasonable requirements of R9-17-312. It is clear that the Department intends to ignore the requirements of ARS 36-2803.4 that its rulemaking be "without imposing an undue burden on nonprofit medical marijuana dispensaries...." The Department has no authority, as it attempts to do in R9-17-312(E), to prevent a physician from performing any professional duties already allowed by law.

Common areas of planned communities should be included in the definition of public place.

The draft rules can be improved by removing section B in R9-17-301. Principal officers should only be stated as such in the bylaws.

I read in the Lake Havasu Herald where the City officials hope for further changes. " preliminary rules released indicate Lake Havasu should get at least one dispensary" The 2010 census shows approx. 44,000 in this town. Part of the rules state that patients can grow their own marijuana if they don't live within 25 miles of a dispensary. ADHS representatives plan to use the CHAA to section off the state into 126 areas. The lake havasu approved a zoning ordinance last week that could allow a dispensary in the business district. City officials are hopeful that one dispensary placed in the location, residents would not be able to grow their own marijuana. With possible complications in regard to zoning and law enforcement and other matters [REDACTED] said he would like to see one thing in the final draft of the law, "I would like to see us be able to tax it" Making changes along the way is relatively easy thing to do. The council could take action with emergency clause to put it into effect immediately." Why put it in the middle of town other than to be able to tax it, why not put it on either end possible the south end where most of the people would have easy access to it and not have to go down town put up with the traffic etc. to get their medicine? Parking and the busiest area of lake havasu. Were talking about people that are in pain, have physical limitations, handicaps, people not well and the Mayor wants us to go to the middle of town to get our medicine. Compassionate caring for Arizonians is the least thing in the city council's mind. Other states have co-ops to keep prices down, and a lot of these people don't have insurance and just getting by in these hard times. I'm 100% disabled veteran, and did not qualify for Agent Orange related disability because they can't find my case papers and have denied my claim from the beginning since most veterans died or have been dying faster than they can complete the claims, you may have heard of the back logs of 8 to 10 years or more. I had letter from 4 doctors saying this was related to Agent Orange and now the city council wants to put the dispensary in the middle of town so they can tax it and make it so a caregiver can't grow it for the patient. Make it so the black market is cheaper, and the stuff coming from the border is grown with pesticides and fertilizers that are poisoning us even further. This isn't what Medical Marijuana is all about. Kids in school can get their pot easier than we can, and pay less for it. The demand is there and the Cartels are making money and killing people along the way. In 06' it passed by a larger margin but the safe guards were not in place for the patients and I don't see things much different. What's the problem with a few extra dispensaries? At least it will be legal and out in the open, and a patient or caregiver should be able to grow a few plants in their closet for their own consumption or take it to the co-op. Check a few states in the surrounding area to Arizona. Just a bit

of common sense.

The bottom line is that the people of Arizona voted and passed prop 203. That being said these laws should be written in concordance to met the patients needs and not be written in a way that incriminates any patients, caregivers, or dispensaries. just right the laws get them in place and as the state of Arizona lets start to see the benefits from this. Like, come on already how did it take us this long we are surrounded by states that have these laws in effect. I am talking in the billions of dollars is what this industry is worth but yet the United States wants to continue to spend money towards fighting this just because it is an illegal plant that for some reason is a schedule 1 drug. Did you know there has never been one recorded death from marijuana and it is proven to help the qualifying patients better than any other prescription drugs we have?(please do me a favor and look up how many deaths are recorded every year from either alcohol or prescription drugs and after you have done this look up the regulations for Liquor stores and pharmacies do they have to go through any of this BS, no i can go right across the street from a school and purchase enough alcohol or prescribed drugs to kill me and many other at one time). Just to throw this out there Marijuana is America's largest cash crop, i mean it is worth more than corn, cotton, wheat etc... OMG what is the problem with this i am pretty sure this will help our state with the current financial status and i believe this will create more jobs for people but what do i know.

The requirement for a Medical Director at the Dispensory level is reckless and could potentially be a liability issue. This requirement borders on practicing medicine without a license. A Dispensory should not be giving medical advice to a patient nor should it require a patient to discuss his or her medical condition, should they not wish to discuss it. This again could potentially be a liability for both the State and the Dispensory. Responsible medicine will require a Physician to discuss the marijuana use and outcomes with his patient. This requirement could be difficult on the patient. Lets not forget that this law has passed and the responsibility of the State is one of implementation and oversight, not to punish the participants or the patient. This law deserves the same respect as any of our existing laws. If the State is going to post related articles please be more professional and at least pretend to be objective. There are great articles and studies that can support both sides of the debate however the bill has passed so maybe you can show some support for the law. Thank you [REDACTED]

Remove the 25 mile restrictions for home caregivers

Principal officers should only be recognized in the bylaws and the people who apply for the license.

Only allow principal officers to be noted in the bylaws. In R9-17-301 section B it says that all of the above would be considered principal officers. Limit the title of "Principal Officers" to those individuals who are applying for the dispensary certificate and others that are stated in the bylaws. State legislation says that principal officers are recognized as those who announce themselves as such in the bylaws.

Common areas of planned communities should be included in the definition of public places.

Add PTSD to the covered issues and confirm no taxation on the backs of the sick to pay for crooked county agendas, debt incurred by illegal aliens in public programs for American citizens as they were formed and legally should be obligated to, and the defense attorneys of our public figures for their

petty arguing.

I feel that section R9-17-321 that states only peoples that have been residents in AZ for 3 years preceding the opening of a dispensary should be changed to a 6 month period allowing for newer residents to take advantaged of a great opportunity to help those in desperate need of a new source of relief from a list of aliments that this medical revolution can aid in.

I feel that section R9-17-301 Part B should be should be changed to allow the individuals within the section should not be considered a principal officer but be allowed to be a board member and/or director.

Please see above--sorry

I realize the ADHS has a lot of responsibilities besides the medical marijuana, but this is going to bring in much more money that it will cost to implement. Even when you give back \$4000 of the \$5000 dispensary license fee, which is the only ethical option! We can clearly demonstrate having invested thousands of dollars and mnay hundreds of man hours into our business and if you stay the course to only offer lottery tickets for one penny more than \$1000 in the form of the application fee, prepare to meet us in court. Without disrespecting Arizonans and charging organizations much more than could reasonably be considered fair, your agency will still compile many hundreds of thousands of dollars that can then be used to prevent teen smoking of any substance, especially the tobacco products. Any 18 year old kid can go out their front door and walk for 5 minutes and buy tobacco for purely recreational purposes with nothing more than an I.D. (if that). Try arguing that tobacco is not much more addictive, dangerous, and deadly than cannabis. That's a fools errand, you can't do it! Just pointing out a few facts that should be obvious, but seem to be being purposely overlooked. There is nothing about forcing dispensaries to undertake the vast expense and undue burden of sourcing and hiring a medical director! ADHS will get sued from thousands of Arizonans for trying to unscrupulously force responsible patients choosing a safer all natural alternative to dangerous pharmaceuticals to pay to consult with two Doctors! Every patient and caregiver will be entitled to join a class action lawsuit due to that expense having to get passed along to them. Not to mention the dispensaries suing you. You will utterly fail to defend the pointless and arbitrary position of why you would ever think the law would allow you to place much more restrictions on a non toxic plant than is called for with methamphetamine and opiates! There is also nothing in the law that dictates that an organization needs to have financial resources in excess of what will be necessary to pay license fees and set up a functional business, I've heard rumors you're going to have an arbitrary threshold of funds available. I don't like competing for a dispensary license with people who don't have the means to actually get up and running, but that's not something you can legally demand. If a group has about \$25k it's feasible they can get a bare bones dispensary limping along. If they can stay in business for 6 months and they reinvest every penny they make, they will probably make it and in this economy I say power to them! I can see why you would opt for the lottery option, it limits liability for your agency and reduces the workload by about 65% or more. I would rather see the best dispensary applicants earn their license in a points based contest like other states have done; but unlike some of the things

that I have commented on that are in a word: ridiculous. I do see why the lottery is viable. Since you are taking the path of least resistance and providing the least amount of service to us in the process I must again implore you, please refund most of the application charges for applications that are not accepted! How can you possibly justify charging Arizonans to pay more than \$1000 to have a maybe 12-15 man hours into reviewing applications for necessary requirements and then to then just randomly picking them out of a barrel. When the notion creeps into your minds that this will create more potheads in Arizona please understand the reality of the situation! 15-20% of Arizonans use marijuana once a month or more NOW( if you're going to believe that the Federal Government is getting accurate numbers about this, if anything they are higher in reality(no pun)), there were that many last year and the year before that and... States that have responsibly and compassionately allowed the medical use of marijuana to become legal have almost all seen lowering teen drug use figures! California where anyone has to admit marijuana is widely accepted as safe and used by people recreationally and to self medicate has seen their teen marijuana use drop below the national average! Understand the fact that alcohol, tobacco, cannabis are all used by people to self medicate for PTSD, stress, emotional and mental problems. In all the other medical marijuana states the percentage of the population that receives it is only 1.9%! that's only about 10% of the regular users! Roughly 90% of users are still going to be using the black market for their needs and you're acting like this is opening the flood gates. You're also scared that some medical marijuana will leak into the black market! OK, well aside from medical marijuana being free of pesticides, molds, mildew, mule hair, and seeds how are the people that would otherwise risk their health with the product of the drug cartel in any more danger? oh they're not! Which brings me to my second point. IF medical marijuana grown in Arizona is leaked into the black market, besides costing the murdering Mexican cartels a few bucks and instead keeping that money here, what is the harm? Oh there isn't any! Criminalizing marijuana has not slowed the demand, fact is that effort has failed abysmally! Despite the fact that a marijuana user is arrested every 38 seconds in America and 90% of those arrests being for only small personal amounts, marijuana use has slowly been rising for decades! That's about as effective as locking up adults for having consensual sex with each other. That would increase peoples health by reducing STD's and reduce children being born and often times ending up on ACHHS and other government aid. You could say it's better for everyone, but that doesn't make it justifiable, and the laws criminalizing the responsible adult use of marijuana are just as archaic and futile! IF medical marijuana does get leaked into the black market here it will not cause an increase in marijuana users, people will just be safer and money will go to Arizona instead of Mexico. I truly hope it doesn't happen as I want this industry to be legitimized and prove it serves a valid and necessary medical need. Please use your brains and stop foolishly believing that the war on drugs has accomplished anything but more harm than good or that some small percentage of medical marijuana finding its way to recreational users (that will get it somewhere else anyway!) would cause any harm to society! Stop listening to the rhetoric and lies from the groups that want to control everyone Else's life while they they are closet alcoholics and pedophiles! I'm serious, these people have issues! Live and let live, life is too short! Can smoking grass make some people less ambitious and be habit forming in a small number of people, yes. Does that mean that because it's not perfect that it's terrible, no. You can't justify having a system that allows and I dare say encourages people getting addicted to pharmaceuticals (including kids) and then say that this is worse. Like everything else in life, this has it's pros as well as its cons! See cannabis for what it really is instead of what hundreds of billions of wasted tax payer dollars have tried to convince and brainwash you into believing it is. The use of alcohol, tobacco, pharmaceuticals, and although much safer than all of those cannabis as well requires individual responsibility. People need to be responsible in life or they suffer. Arbitrarily choosing what things they can suffer from and cannot is not the solution, especially when all the other stuff they at their fingertips is WORSE by any

educated and realistic measure!

A lot of shut ins or seriously ill patients won't be able to travel to get their medical MJ. It is my hope that you will make it easy to have it delivered, of course with proper id.

I have a problem with the process of getting a dispensary and the number allowed. I understand that the point is not to have 1000 places around the state but the 124 are not going to be able to produce enough medicine. I would suggest adding 25 cultivation only licences so the supply is increased, and price stays down so the people go to one of the 124 sales locations and not some black market somewhere. If you take the projected growth of medical users by year 5 or 6 there will be 500,000 of us. That's about 4032 people per dispensary. Also with the process of selectiong who gets the licence, there should be a higher standard on what is a complete application or a rating system.. It seems silly that a basic complete application can get excepted over one that goes above and beyond with theirs.

In R9-17-301 part B should be taken out. Not all people considered to be a board member would want to be known as a principal officer. Managers should not be considered principal officers unless otherwise stated in the operating agreement. This does not comply with Arizona Corporations and LLC's legislative laws.

Since a "written certification" to obtain medical marijuana is not the same thing as a "prescription," other health-care professionals (many of whom will have much more expertise in working with herbs and other natural medicinals than physicians have) should be allowed to provide the written certification. In addition to licensed physicians, I recommend adding licensed acupuncturists, licensed naturopathic physicians, osteopaths, licensed chiropractors, and nurse practitioners to the list of professionals who can provide the certification to a qualified patient. I will use myself as an example. I am [REDACTED] with a forty-year history of debilitating migraines. (A couple of weeks ago, I was in terrible shape for almost twelve hours, and nauseous and vomiting for the first six of those hours.) Prescription pain meds like percocet, percodan, vicodin, and morphine don't work in my case, so I don't use any pharmaceutical products and have treated my migraines with acupuncture, herbs like (feverfew), homeopathic remedies, massage, craniosacral treatment, chiropractic, and so on. I would be interested in trying medical marijuana because I have heard that it will help with the nausea, will help with the ocular auras, and might even help with the pain. But I have no health insurance and therefore no primary-care physician to get a certification from, so with the rules as written I wouldn't be able to get a certification for medical marijuana even though I have such a long history of suffering. This doesn't make sense to me and penalizes those of us who are more "natural" and "green." Everything I've read seems to indicate that medical marijuana is much less dangerous than most prescription medications, so limiting the ability to write a certification to only physicians seems like over-regulation and unnecessary.

I live in a small, planned community in Tempe, in which our homes surround a small common area containing a grassy play area and a community pool. If someone is smoking marijuana anywhere in

that common area, the odor will easily waft into our homes, especially in nice weather. I am concerned that the language in Section 21: "Public Place" ("other multifamily housing facilities") may not cover our situation.

in section R9-17-304 in regards to exact address of thr proposed dispensory. It should not be required that a specific location or site be identified in the application process. This is an undue hardship since the leasing of a building or site is very exoensive and a application may not be successful. A proposed location or site should suffice for the application process. The Medical Director should not have to be a physician but should include a PA or Nurse Practioner as a choice for Medical Director.

the dispencaries need to be able to have a grow opperation on site not defined by the 25 miles away from the dispencary. if our patients sign us up to grow thier medicine we should be able to take care of that on site. it would put a lot more funds to the cities. it would be a better for everyone involved

Nurse Practitioners are able to prescribe narcotics, why are'nt they able to recommend marijuana?

Those of us who are serious about cannabis as an alternative medicine for patients with intractable pain, nausea, etc. need to recognize that a need exists for quality control. This QC could be at either the production level or at the distribution level. Lastly, it could even be available at the consumer level. The draft regulations as written today only make allowance for the DoHS to demand samples for testing. If cannabis is to be treated as a medicinal product for people with illnesses, there needs to be a provision for submitting it to accredited laboratories for voluntary analysis. Patients and providers would both benefit from having this option. With the access to laboratory testing, potency, and possible contamination could be verified. This would benefit all concerned. Third party lab testing would be the best option to make good quality control possible and practical. In California there are at least five such laboratories operating today. There are also facilities in Colorado and Montana, and perhaps elsewhere. Since there are obvious problems with respect to interstate transportation of even small quantities of cannabis product samples, local or regional analysis would seem like a practical option. There are at least two laboratories interested in the possibility of providing analytical services to the cannabis providers of Arizona. However, even with licenses from the DEA in hand, the state regulations, as proposed, do not yet specifically allow for transfer and custody of material samples required for cannabis analysis at an independent laboratory facility. Lacking specific authorization, laboratory service providers would face potential criminal and/or civil sanctions. Without such authorization, few laboratories, if any, would venture to provide these services. Therefore, I suggest that the DoHS move to make specific allowance for bona fide analytical laboratories to possess and analyze small samples of medical cannabis at the behest of any producer, dispensary, or qualifying patient. Thanks for you attention. [REDACTED]

Marijuana is a controled substance and should be dispensed through a regular pharmacy. I do not support geographic dispensaries intended for the sole purpose of dispensing marijuana.

An established system in place to monitor physicians writing medical marijuana certificates. Prohibition agains growing if you live within 25 miles of a dispensary.

I just heard that the so called "Pot stores" will be selected via a random process?? This is not what I

voted for when I voted YES on PROP 203! I thought this would be a carefully thought out process that groups applying for such stores would be chosen based off a set of guidelines, not randomly. I think the time they have lived in the community, past history in the community, the town or cities feelings on the group or individual should play a large role on the selection process.

I dont want to see pot shops all over town, and I think that the idea of putting this out via vending machines is rediculous. No matter how secure even ATM's get ripped off. Why not dispense oxycodone from vending machines?????? Make it 5 years Az. resident. Let this be or Arizonans. Keep investors out in the markets of Cali. and colorado. If we are doing this in Az. let Arizonans help each other

By allowing Cities to designate an exclusive Cultivation for all Dispensaries in their respective City Limits. Some Cities have written Ordinances to apply to their own requirements so this would not be a precedent.

The act should include "Marijuana should be prohibited in common areas of planned communities as well as in common areas of condominiums and apartment buildings."

I support the geographic dispersion of dispensaries to help minimize the less regulated home grow operations. I support strong caregiver requirements against home growing and providing proper oversight and training. I support careful monitoring of physicians by requiring a true doctor-patient relationship with legitimate certifications.

Not enough definitive information about grow sites are they a seperate entity than dispensaries. Is there a seperate fee for application. The state must identify the approved chemicals used to cultivate and prevent unnecessary contanitation of communities.

disabled persons as well as the sick and terminally ill deserve compassion! This is why WE VOTED in a compassion law! These people are most likely to be on assistance from the state or federal government. Therefore we MUST have compassion for the sick and dying poor citizen of our state! These persons in other states pay as little as \$25.00 a year, so why punish the poor by exclusion for lack of funds? This is a compassion law, lets show some from the start. Less than \$17,000 a year income should be FREE and everyone else a compassionate \$40.00 fee the first year \$20.00 after that.

The rules could be improved by taking the RANDOM drawings for a CHAA license to cultivate in case of having more than one group approved for that particular CHAA. The deciding factor in the event of more than one dispensary for one CHAA should be decided by the town council vote for the best candidate to get the dispensary and cultivation site.

Ensure that "common areas" are open areas for medical use of marijuana.

Will, A huge issue that we have not only seen ourselves but are being told about frequently is the squatting that is currently going on in cities. For example in ██████ I know a gentleman that has secured 3 different lease spaces a mile apart to ensure that the city will not issue any further licenses after he gets in and secures his. This gentleman has no financial backing to open a Dispensary but hopes the fact that he will be the only one allowed to pull a permit will allow him to find investors

quite easily. To us, this is quite shady but it seems to be happening regularly. The idea of "pre-registering" with cities seems to be a bit of putting the cart before the horse. If a person who is qualified and has the finance and experience to open and run a Dispensary, cannot find space because it has been acquired by individuals who were quicker on the trigger to secure space, they are going to not be able to submit an application due to the fact there is no physical address for the Dispensary. Can you address this? Some ideas here that could possibly help, we will also post them on the 203 site and our blog as well. Perhaps it would make much more sense to do the following on the application process to ensure fair treatment. 1. Do not require a physical address for the Dispensary but require one be submitted within 60 days of application approval or risk the license being revoked. 2. Require patients to bring verification of a primary care physician rather than requiring each Dispensary to maintain a "medical director". You're setting Dispensaries up for failure and litigation requiring them to malign themselves with licensed physicians. 3. Encourage cities to zone Dispensaries into areas where they can be opened rather than giant open fields that are unusable. example: [REDACTED] 4. Do away with the CHAA format as it will backfire in the end. Especially considering the fact that all of the reservations must abide by Federal Law and many of the small cities in the CHAA map will never actually open a Dispensary because it would not be financially feasible and/or the city has zoned it out completely. (see above example) 5. Decrease the cost to patients for a Card. Albeit many people are involved in this industry because they have green dollar signs dancing in their eyes some of us are in it for a bit more humanitarian reason, the patients. Having volunteered in the Hospice field for years and having had a brother die from a horrible bout with Cancer I have first hand seen the effects and pain easing that Cannabis has provided. These patients in their final days are often alone, homeless many or being supported by family. Regardless, we believe the cost of a license for patients should be in the \$50-60 range 6. \$5000 application fee for Dispensaries seems fair. It being mostly non-refundable poses a question to many people considering that there will be close to possibly 1000 applications. WHY?

PROBLEMS WITH THE DRAFT R9-17-202. B. A qualifying patient may have only one designated caregiver at any given time. (TAKE THIS OUT. USELESS. I HAVE 7 DOCTORS.) F. 1.H The qualifying patient's e-mail address. (INTRUSIVE AND BASELESS) F.2. A copy of the qualifying patient's k. An attestation that the information provided in the application is true and correct; and (F AND K ARE REDUNDANT UNWARRANTED AND NEEDLESS) l. The signature of the qualifying patient and date the qualifying patient signed; (REDUNTANT. IT'S A FORM AND THE PATIENT IS ALREADY SIGNING AND DOCUMENTING) F.2. A copy of the qualifying patient's (SHOULD STATE A COPY OF "EITHER". NOT ALL A THRU E.) 5.E 15 (TAKE IT OUT. DOES NOT NEED TO BE IN THERE) 5. A-N. physician's written certification in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient's application that includes: (ALL THE PHYSICIAN JUMPING THROUGH HOOPS IS A WASTE OF TIME AND RESOURCES) HAVE THEM SIGN OFF THE PATIENTS CONDITION AND KEEP IT SIMPLE. THE DOCTORS SHOULD NOT BE ON TRIAL FOR PROVIDING MEDICINE TO PEOPLE. R9-17-303. Applying for a Dispensary Registration Certificate A. Each principal officer or board member of a dispensary is an Arizona resident and has been an Arizona resident for the two three years immediately (SHOULD BE ONE YEAR NOT THREE) DRAFT 01/31/11 member is an Arizona resident and has been an Arizona resident for at least two three consecutive years immediately preceding the date (TAKE THE THREE YEAR RULE OUT AND MAKE IT ONE YEAR...AGAIN.) R9-17-309. Administration A. A dispensary shall: d. Qualifying patient records, including purchases, denial of sale, any delivery options, confidentiality, and retention (WHY HAVE THESE RECORDS IN THE FIRST

PLACE? TAKE THEM OUT. SECTION D IS NONSENSE. A PATIENT SHOULD BE IDENTIFIED AND NO FURTHER.) e. Patient education and support, including: i. Availability of different strains of marijuana and the effects of the different strains; ii. Information about and effectiveness of various methods, forms, and routes of medical marijuana administration; iii. Methods of tracking the effects on a qualifying patient of different strains and forms of marijuana; and ( WHY ARE WE HAVING EFFECTS ON PATIENTS NOTED IN THEIR PROFILES AS WELL AS WHAT STRAINS THEY USE.SOME REASONABLE PRIVACY SHOULD BE GIVEN UNLESS THE PATIENT WILLINGLY GIVES SUCH INTRUSIVE INFORMATION) R9-17-310. Submitting an Application for a Dispensary Agent Registry Identification Card 5. A copy of the dispensary agent's: (SHOULD SAY, A COPY OF "ONE OF THE FOLLOWING") a Arizona driver's license issued on or after October 1, 1996; b. Arizona identification card issued on or after October 1, 1996; c. Arizona registry identification card; d. Photograph page in the dispensary agent's U.S. passport; or e. An Arizona driver's license or identification card issued before October 1, 1996 and one of the following: i. Birth certificate verifying U.S. citizenship, ii. U. S. Certificate of Naturalization, or iii. U. S. Certificate of Citizenship R9-17-315. Inventory Control System 4. For each batch of marijuana cultivation cultivated (TAKE OUT PARAGRAPHS 4B THROUGH E. UNNEEDED AND BASELESS. TOO MUCH NON-USABLE INFORMATION.) b. Whether the batch originated from marijuana seeds or marijuana cuttings; c. The origin and strain of marijuana seed or marijuana cutting planted, type of soil used, date seeds were planted, and the watering schedule; d. The number of marijuana seeds or marijuana cuttings planted; e. The date the marijuana seeds or cuttings were planted; D. A dispensary shall: 1. Maintain the documentation required in subsections (B) and (C) at the dispensary for five years (CHANGE THIS TO 1 YEAR. USELESS AND NEEDLESS RECORDS FOR FIVE YEAR PERIOD.)

Again, thank you Mr. Humble and the AZDHS for your efforts. I believe that the new set of rules is more fair to patients and dispensaries. The changes were necessary, and should remain. I think that holding doctors accountable is a reasonable thing, but to limit a doctor that believes medical marijuana can help someone from recommending that help is not fair to the patients, or the doctor. There may be a limited number of doctors willing to recommend MM if they feel they are being scrutinized for helping too many people. Unfortunately, that goes against the goal of a good Doctor. I also know that since I have moved to AZ, I have not had an interaction with a doctor that lasted longer than 10 or 15 minutes. It is going to be hard to separate the abusers from the qualified patients in that time, and if they err on the side of caution, patients who will benefit will not be afforded that opportunity. I understand wanting to avoid a recreational use program, but don't sacrifice a good medical program to do so. The quote I read today said something along the lines of... Not many 20 and 30 year olds will have chronic and debilitating pain. This is not a fair statement. They might. 20 and 30 year olds are often the ones doing hard physical labor that can cause chronic and debilitating pain. I think looking at the number of people that take acetaminophen or ibuprofen on a daily or almost daily basis will show that a lot of people are suffering from chronic pain, and may very well benefit from MM. I choose not to take either of those pain killers because of negative reactions I have had from them both. There are plenty of studies that show the damage regular use of some, even many OTC drugs can cause. It does not seem right to allow a doctor to say take those as needed, or prescribe something stronger and potentially more dangerous when a safer, more natural option is available. The voters approved prop 203 with the list of medical conditions. Please do not limit people that will benefit from the new law if personal feelings about the use of MM conflict with it. I thank you for your efforts on this. I think the law is very well written, and I am sure the final draft will

be as well. My biggest concern...Please do not limit access to those that will benefit from a good MM program. I know it will be hard to keep recreational use out of it, but I would much rather see a few people unfortunately abuse the program than qualified patients denied something that will make them feel better. Thank you.

Nurse practitioners should be allowed to prescribe since they treat the same conditions as medical and osteopathic doctors.

No taxation like the law states and add PTSD

A person who is approved for a MM card should be able to grow 12 plants even if they live within 25 miles.

The definition of 'enclosed', does not allow for greenhouses, however, greenhouses are included in the law. Additionally, you have RAISED the registration rate, and only allow a reduced fee for those receiving State Welfare. This is absolute discrimination against the working poor - those Citizens who continue working and live paycheck to paycheck, but do not qualify for Government programs. All this does, is give the working poor one more incentive to just stop working and go on Welfare. Furthermore, why is there even a registration fee for caregivers, at \$200, no less? Caregivers are usually family members/friends taking care of patients at great emotional, physical and economical cost to themselves. All this fee does, is bring more hardship.

To not allow medical marijuana patients to grow their own because they live within 25 mi.of the dispensary is not fair to the patients. Medical marijuana is supposed to cost\$300.00 or more per ounce.You can grow1 pound for around \$400.00 lights,soil,fertilizer, and pest control included. Patients should be able to grow their own marijuana as long as they stay within the rules set forth by the state.They should also be able to sell the overage to the dispensaries at a reasonable rate.There should also be a lower price for low income patients just the medical assistance they receive. This would also generate more tax revenue.

I think the draft rules are very good. Please don't change them back and make it impossible to get a cert for ordinary people who meet the requirements. I trust ordinary people to help people & give the money away to worthy causes more than I would ever trust a corp who will bonus the money away.

A stipulation that law enforcement officials can access anyone's medical records violates the health information privacy act. Physicians will be put in a negative spotlight if they write a scrip and somehow made libel and/or illegal.

First of all are you trying to prevent caregivers from coming to existence. This CHAA concept is a joke as it pertains to medical marijuana. Not many people can afford to pay over \$1000 a month for the acceptable amount of medication. Caregivers are individuals who are willing to give medicine to their patients at cost. Caregivers should also be able to sell their excess to the dispensaries. This would make the amount of different medical strains for different ailments available, helping patients get the best medicine possible. If the reasoning is that it is not known if it is clean, then require it to be tested. My wife is paralyzed from the waist down from a car accident that happened three years ago. Also along with this she has gastroparesis that basically puts her digestive system in reverse, resulting in uncontrollable vomiting and a three day hospital stay being stopped only by cancer nausea drugs by IV

that she cannot administer at home. It was not until finally after 12 trips to the hospital that her doctor illegally recommended that she smoke marijuana, and the hospital records are proof. She has only been a few times the past 2 years for something she and modern medicine could not control. Without caregivers medicine will be too expensive for her, forcing her towards the black market or the hospital.

Do not allow smoking marijuana on common areas of any HOA. These are for families and their children.

1) Let's make medical director include Pharmacists. At least Pharm D's. I am obviously biased but have some valid points. Many patients are on medications from specialists. A General Practitioner diagnosis and recommends treatments for general problems. When a problem or illness is severe a patient is sent to a specialist. The specialist then recommends treatment. Most GP's have a handful of drugs they recommend and are familiar with. Specialists are familiar with even less. They only prescribe drugs specific to their scope of practice. For instance, a Cardiologist who has been in the field for some time has little knowledge of advanced pain medications or medications for psychotic illnesses. A GP may dabble in epilepsy treatments but will forward a patient to a Neurologist for advanced treatment. A Pharmacist, on the other hand, dispenses medications prescribed from GP's, Neurologists, Psychiatrists, OBGYNs, etc. etc. The Pharmacist is a specialist in drugs. A specialist on their actions, interactions with other drugs and side effects. He/she can look at a list of drugs from multiple different specialists and identify possible interactions and side effects a patient should look out for. Most physicians hand patients prescriptions and tell the patient nothing about drug. They are informed to speak with the Pharmacist. In Arizona all new medications taken by a patient must be counseled on by the Pharmacist. Physicians are experts in diagnosis. Pharmacists are experts on drugs. We dispense medications that many physicians in a particular field have never heard of. Based on the current draft a Gynecologist could serve as a Medical Director. If handed a list of medications including: clonazepam, ranitidine, lamotrigine, lisinopril, atenolol, asacol and hydrocodone, he/she may recognize only a few of the drugs. How would he/she be able to explain how marijuana would increase or decrease the effects of these drugs if he/she has no idea what they are? Any Pharmacist worth his wait in salt knows all about everyone of these drugs and a thousand others. I am not saying in any way that a Pharmacist out ranks a physician. I have patients open their mouths everyday and ask me to look and see if anything is wrong. I always reply "I can not diagnosis, you would have to see your doctor." However, when that patient returns with a prescription I can tell him/her exactly what to expect with the drug he/she is about to take and how it will interact with his/her current medication list. A Medical Director needs to be a person who can educate patients about the benefits and risks of medical marijuana. He/she needs background in all drugs that a potential patient may be on. A patient will be best served by an individual with extensive knowledge in all fields of drugs. A Medical Director is to oversee the dispensing of medical marijuana. He/she must educate patients on possible side effects of marijuana and interactions with the patients current medications. This is the exact definition of a pharmacist. No one knows more about the broad spectrum of drugs available than a pharmacist. An MD does not have the qualifications to be a pharmacist. He/she would be doing things out of the scope of his/her practice. The Medical Director position by description best fits the description of a pharmacist. Let's at least include pharmacists in

the list of qualifying professions. Sorry for the length of this one! Best regards, [REDACTED]

This is medicine and it needs to be treated as such. \$160 for a card for your medicine??? This is being set up for legal drug deals with all the money it will take to buy your medicine!! There also is no mention on how much the marijuana will even cost. Obviously the people that actually need it won't be able to afford it because a lot of them like myself are on disability. In case you don't know a debilitating disease means you are dying. Why don't you worry about the danderous drug OXYCOTIN!!!! People rob and murder for that stuff because its the same as heroin!!!! To buy that people get a prescription, go to the drug store (i don't know what they pay)and its filled. This money making operation on marijuana in Az is no different from any other illegal drug deal. WE THE PEOPLE voted for this and WE THE PEOPLE expect to be treated right on this whole issue. You have to make it cheaper than people buy it on the street, thats a no brainer. Mew Mexico seems to have the best program I've seen so far.

The State can use high-tech identification cards to help track and regulate the entire medical marijuana system.

Between the landlords not wanting dispensaries and the too stringent city zoning requirements, It seems doubtful that there will be 124 locations available for lease to dispensaries? Also, Can a cultivation sites be divided for the purpose of growing for many dispensaries under the same roof? I saw a site where they are selling condos like cultivation timeshares. Is this going to be approved? For example, 5 dispensaries each have 1000 sq ft for a cultivation site that is 5000 sq ft?

Why is it necessary to hire a Medical Director to be available by phone when they already have a responsible party that is the recommending physician?

Under definitions: there is no defiintion of "Medical Marijuana" as opposed to "Marijuana" found illegally or on the street Medical Marijuanna needs to be defined in terms of its therapeutic patient value and the active ingredients showing levels of THC and Cannabisand others . THC is the the "pain killer- mind altering" component whereas Cannabis is the appetite increasing componenet used for cancer patients . Not all marijuana grown has the same levels. There is no quality control of the therapuetic agents.Look at the lowest levels of THC that are therapeutically valid for patients as well as for cannabis Reccomendation: Define medical marijuana and its active therapeutic agents using the the same rules for havesting herbs that are currently in place by FDA , Certified organic standards" as well as California herb standards because marijuana is a herb! Look at the tobacco growing laws also.... look the levels of tar and nicotine ...there is precedence! On the number of Farms : Since this is being approved by doctors, they should be filing treatment plans per patient identifying the number of doses per day are prescribed. By using the number of certificates and calculating the number of doses, the State could predict the usage of medicial marijuana on a monthly

basis and predict/control the shipments. Start with only one farm in the State and take it from there. There is no need to have anymore than one for the time being.

Prove Arizona Residency by 3 yrs previous Arizona State Tax Returns on each Applicant for Dispensaries.

The rules should also specify that a caregiver should not be allowed to grow marijuana if they reside within 25 miles of a dispensary. Additionally, caregivers must undergo a minimum of 8 hours of training on medical marijuana health and safety issues.

I Think That The Medical Marijuana Act Can Also Help Improve The Lives Of People With Mental Health & Substitute Some Medications,California Already Has This Under Effect

Quit treating this medicine more harshly than you do controlled substances. The type of growing facilities & rules for patients/caregivers should allow for easy indoor AND outdoor cultivation. Make the outdoor fencing/wall less costly for people to build.

Change the policy of choosing dispensaries, it should not be a random process. Change the requirements for outdoor growing fencing for card holders & caregivers. I think the current regulations on materials etc. are outrageous, & would cost way too much.

By including language that extends "common areas" to common areas of planned communities, such as Sun City Grand.

Include Common Areas of Planned Communitis in the definition of Public Place.

Use should be restricted to personal residential areas only. Usage should not be permitted in all public areas. Specifically, usage in "common areas of planned communities" should be prohibited by including common areas of planned communities within the definition of prohibited public areas.

See Below

do not charge patients \$160 in fees in order to aquire their legal pain medicine. people don't have to pay extra fees to get much more harmful pain medicines and narcotics from walgreens or cvs!

The AzDHS does not have the authority to define or re-define 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. Do not make more steps for a patient to get Medical MJ then a person who gets precribed much more dangerous opiates/narcotics meds.. 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.” Will HUMBLE Your Job is to impliment the law passed by the citizens of arizona on election day...not to rewrite a law you like.. the Voters have spoke more then once, WII now do your job!

My concern is with all the rules and guidelines that will be imposed upon doctors regarding prescribing marijuana for patients. If these rules are all implemented they will be the strictest of all medications. Narcotics can be dispensed to any patient at any time, even on a first visit by the patient. So can anti-depressants, etc. etc. The Medical Marijuana Act was voted in by the people of AZ. I do not think any of us expected it to be more heavily regulated than all other drugs.

I strongly disagree with R9-17-302 B2b: Random selection if there is more than one dispensary certificate application for a dispensary located in a CHAA. I understand the goal of ADHS is to provide qualified patient's and caregivers access to medical marijuana and to prevent "back door sales." I believe if more than one complete dispensary certificate application exist in the same CHAA, then a random draw would indeed increase the opportunity for "back door sales." The draft would greatly improve if ADHS would agree to review each application and award dispensary certificates based on merit of the application. Arizona needs medical marijuana dispensaries in which the mission of the dispensary is to improve quality of life not to just dispense medical marijuana. I believe a patient health survey would be an important tool to begin the process of measuring outcomes that is based on improving quality of life.

Why would there be a lottery system for multiple dispensary applications to one CHAA? It seems like it could be a big mistake and cause lots of legal litigation later down the road along with other parts of the draft. If you use a lottery system and lets say a person has \$5000 dollars for the application, but does not have any resources to actually acquire a building and pay for the initial startup, they can essentially start taking investors hostage because they are the ones with the GOLDEN TICKET if you will. Why not leave it up to the City to decide what dispensary they would like to have in their town... Maybe the one with a business plan and actually knows what they are doing. This will cause so much more issues for you in the long run. The second thing about the draft is the 100% taxation of medical marijuana... that is ludicrous. It will just cause people to buy off the black market, which is what we are trying to avoid by this bill and by these draft rules. It has to be affordable at a dispensary, so it can be controlled and taxed within reason. If you keep 100% taxation, no one will pay it and it will cause all these businesses to fold and more black market distribution of medication. The third thing I see wrong with the draft rules would be the 99 plant rule and being able to only open one onsite and one offsite grow facility for each dispensary. It does not take a mathematician to see the obvious flaw in this... If you are only going to allow 125 dispensaries and they can supply up to 198 plants total. lets say each plant produces 5 ounces of medication for patients and the dispensary is able to harvest 4 times a year... You are looking at about 4000 ounces or so of medication.. Now each patient is able to have up to ~65 ounces per year of medication.. you are looking that each dispensary can supply ~70 patients with medication.. that is less than 10,000 patients total... There are projections of 50,000 or 100,000 patients that might be able to benefit from the use of medical marijuana and you plan on telling all those people that they cannot have medication because of some simple math. This same

type of thing happened in Michigan and there are lawsuits because people are not able to get medication and i am sure you will not want 50,000 people trying to file lawsuits against city's or the state. In Conclusion, i see the following major changes that need to happen... Dispensaries should be awarded to committees/groups/people with the proper funding, a GOOD business plan and the city should be able to recommend which dispensary that should be located within their bounds. The taxation should be about 10% or less, NOTHING more than that or you are going to force black market sales. Lastly Dispensaries should be able to open as many offsite growing facilities as needed based on how many patients they have. this way patients can actually get their medication and no have to worry about if the dispensary is going to be out of medication for the last 1/4 of the year... All of these things will save ADHS a lot more time and energy not having to deal with litigation and people being held hostage for profit sharing or startup money because they were able to afford a \$5000 lottery ticket and won. it will cause an uproar.

Get rid of the on-site physician. That is absolutely ridiculous. Each time the patient goes to the dispensary, he or she has to risk being declared IMPAIRED OR ABUSING medical marijuana, by clinical observation of the physician. The patient has to keep a LOG BOOK and devise a system for rating his or her pain level. He or she has to adhere to guidelines to SELF-ASSESS and guidelines for reporting USAGE AND SYMPTOMS. The patient has to RUN THE GAUNTLET everytime he or she goes to the dispensary. Is my self-assessment up to date? I don't want to appear to be abusing or to be impaired, in the eyes of the on-site physician. Is my log book tracking my use and symptoms accurate and current? Will the on-site physician approve of my rating scale for pain? This is no different than the absurdity of the MINDER in Utah bars, whose duty is to watch someone and make sure the person under observation doesn't have too much to drink.

You must allow for a competitive grading system when selecting dispensary operators. Allowing bad operators to secure permits because the system was too lazy to do the hard work to ensure that good folks were chosen is absurd. Colorado accepted \$7.34 million dollars in application fees to process their providers. Arizona needs to do the same. Colorado has hired 40-50 staffers to manage their program based on ongoing fees. Arizona should do the same. It does not make sense to randomly select people to operate such critical businesses in the community that involve controlled substances. Communities would feel a lot better if there were a rigid application process, such as was put forth in Maine, Colorado and areas in CA.

Mr. Humbles blog, Marijuana Use & Earlier Onset of Psychosis? Posted: 08 Feb 2011 09:48 AM PST does point out that National mental health surveys have repeatedly found more substance use, especially cannabis use, among people with a diagnosis of a psychotic disorder. Something that doctors who recommend marijuana should consider before writing recommendations. However, this in no way changes how we and the patients we represent feel about having medical directors (as written in the draft rules) Would a resident medical director have to examine every patient who comes to the dispensary to see if they think a patient may have early signs of psychosis? Would they do this evaluation in person? or because they are on call, would they do it over the telephone? Screening and evaluating patients for marijuana treatment is something the doctor who writes a recommendation already does. Do you think pharmacists should evaluate patients before dispensing prescriptions? I can see no logical connection between the agreement for having medical directors and the early onset of Psychosis. We at [REDACTED] a hopeful future dispensary, and the

patients we represent again ask that the Medical Director draft rule be removed and replaced with the formation of a non-profit state board of dispensaries. A board that would be open to doctors and medical professionals. Just as pharmacists have the Arizona Board of Pharmacy to oversee and govern pharmacies and pharmacists, we need a board to continue to bring unity and conformity to this new medical marijuana industry. We respectfully ask you to remove the medical director draft rule and replace it with one forming a medical marijuana dispensary board.

The rule on the random drawing needs to be addressed for all the smaller towns benefit.

We can change the method for arbitrating the best choice to allowing the town council to take a vote for the best business plan that will work for their town and district. A random drawing could put the worst applicant in the drivers seat of a medical program. With all the work and cost of assembling a quality business plan with all of the essential elements to opening a quality Medical Marijuana dispensary and cultivation site, do we want to leave it to chance at that point? Thank you for the chance to give my input!

I was very confident in how AZ was going to implement Medical Marijuana rules until I read that dispensaries could be picked by a random process. This needs to change. I know you are under staffed but with such a critical issue it needs to be given to the right people & locations. I read that Globe reviewed all possible applicants & zoned the town to only allow the one they felt best fit the role. I think there should be some kind of process for towns to give a stamp of approval to the group they feel would be best for their community & that taken into consideration when awarding dispensaries.

I also have a question: If I were to become a medical marijuana patient and I wanted to fly on a commercial airliner, could I bring my legal marijuana with me if I were flying to a neighboring state that already has a medical marijuana law in effect, or would I have to go through that state's process, even if I were visiting my grandchildren for a week?

To Whom It May Concern: We ask that the Arizona Department of Health Services (ADHS) considers the 1,000,000+ indigent Arizonans living below poverty the level. Our organization, the [REDACTED] believes the spirit of Proposition 203 was to provide patients a choice when considering their health care treatment. Unfortunately, due to the high cost of unsubsidized medicine, state fees, physician visits, and sales tax a natural option can be put easily out of reach for those patients who could potentially benefit the most from medical marijuana. On behalf of the indigent community who often lives on less than just a few hundred dollars per month, we respectfully request that the ADHS consider waiving all related state fees and associated sales tax for qualified indigent patients. Sincerely, [REDACTED]

At R9-17-202 F.5.e., I have concern that physicians will not want to risk having the liability associated with "assum[ing] responsibility for providing management and routine care." What type of responsibility do you mean? I believe there should be standardized warnings and guidelines for

cannabis use that is established for all patients to receive that also contain a disclaimer for the physician in the form of a warning that states that the patient takes full responsibility for adhering to the standardized warnings and guidelines and under which circumstances they should consult their physician.

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300% tax rate for non-profit dispensaries should be reduced to 5%.

Add PTSD and limit tax to 60% to prevent skimming of our illnesses to fix the states budget woes

Add PTSD

add ptsd

add ptsd

add ptsd

R9-17-101. Definitions Add definition of 'Qualifying Patient', 'Designated Caregiver', 'Department', 'Physician' and 'Person' these terms are referenced throughout the document. Incorporate special protection of minors under 18 years old. Do not allow them to ever use medical marijuana even if they have parental consent. Incorporate protection of the other citizen rights that may be impacted by a qualifying patient's use of marijuana, including the designated caregiver, neighbors, family in the home and the workplace. Incorporate language that reinforces FDA, Federal law and Arizona state medical board license requirements.

In defining "public place", the draft rules are confusing when referring to condominiums and planned communities. "Other multifamily housing facilities" does not include planned community common areas like pools, playgrounds and green belt areas. Apartment complexes have common areas, and that language is fine. Condominiums do not have common areas - they have common element and limited common element. The common element are the areas that every unit owner has a right to access; the limited common element are areas that are not in the condo unit but which only the unit owner has access, e.g. patios and balconies. I don't much care whether DHS prohibits smoking medical marijuana on balconies and patios, but the draft rules don't make it clear whether such activity is allowed. If the DHS wants to prohibit smoking in planned community common areas and everywhere in condos except in the units, the rule should define it as follows:

Please allow patients to grow their own, otherwise patients that need it won't be able to afford it and will buy Mexican .

100 miles round trip on 'private grown plants' rather than 25 and create 'halos' of coverage to include

the entire state, decrease availability but still provides adequate care to patients. Physicians trained and licensed may prescribe to 50 patients per caseload, once trained and licensed (Similar to Suboxone licensures) Medical Directors/Physicians will be allowed to prescribe as well as hold directorships, following the rules indicated (not on site, a 12 month relationship established FROM the time of licensure, not previous) All illnesses including chronic pain, must be supported by standardized medical diagnostic tools; blood test, Xrays, MRI's All marijuana grown and dispensed for medical purposes will be assigned a tax stamp and business ID, to be taxed at a 11% sales tax; in addition to the licensure fees, at a dispensation of 25% to drug/alcohol education/prevention/treatment, and 25% to law enforcement, w/ 50% of indicated taxation provided to the standardized state budget. DUI Laws will remain with current statutes, driving under the influence where it is determined to be affecting hand eye coordination, will remain the same as any other DUI with prescribed medication If Marijuana is going to be approved as a medication it should be dispensed under the same statutes as other medications: Following pharmacy protocols, licensed medical prescribers, and tracked through DEA/FDA standards with only a few caveats for this type standard of medication. License Substance Abuse counselors will be trained and assigned as contractors or clinical directors to each dispensary; Providing Physician and law enforcement education for 10 hours monthly.

Please include common areas of planned communities” be included in the definition of “public place.” Our community is a planned community in Prescott Valley with many common areas and a community center included in the common area. We do not need to have "weed' smokers getting high in these areas. Sincerely, [REDACTED]

By not forgetting to remember those who are living at the poverty level or those that seem to slip through the cracks by being denied coverage on ability to pay... and to remember its for a population living near or towards the end of life regardless of age...don't tax it out of the hands its to be in...those people are living on food boxes, going hungry due to pride and discrimination of a particular group such as the HIV community.

The public areas in HOAs should be included in "Public Areas", where smoking of medical marijuana is not allowed. I don't want to smell/inhale ANY smoke when I'm in the dog park, playing tennis, on the golf course, at the swimming pool or anywhere else in the common areas of my HOA. I hope COMMON SENSE prevails.

Take medical related complexes out of the wording

this is too much of a distance and the rules need to be more in favor for the caregivers. caregivers pick up the slack for extra meds. If this is not changed dispensary's will have to break laws to turn out enough product, This is setting our program up for failure.

The draft rules (as stated) make the amount of MJ that may be grown by any, and all Dispensaries, Agents, Patients (if outside of 25 miles) and Caregivers no more than 12 plants. Where are these Dispensaries going to get enough medical MJ to service the entire community?? Increase the amount that can be grown and/or take the 25 mile radius away from patients How about allowing qualified businesses to grow what's needed?

Please have the rule include the definition of a public place to include all homeowner association planned community common areas.

Get rid of even the possibility of randomly choosing who will & will not get a dispensary.

Include the "common areas of planned communities" in the definition of public places".

If you could somehow state that smoking at HOA common areas and playgrounds is prohibited. That would be great! Thanks, [REDACTED]

It is still not clear regarding the City review processes required by municipalities versus the certificate application process conducted with the State. A certificate application is required to randomly select a dispensary. Then they are given time complete the dispensary site application, which then requires the documentation clearance by the City. This process step would potentially ignore the applications that took the early initiative to satisfy local jurisdictional requirements before applying to the state, and be potentially overlooked to a State application that has not yet received approvals from a City, or was rejected because their site conflicted with a previously approved medical marijuana dispensary that applied before hand. As a City staff representative that is currently involved in this process, the state needs to add information pertaining to acceptance of applicants completing their local jurisdictional requirements.

Anyway- there have been some public comments on our medical marijuana rules that have questioned the wisdom of requiring dispensaries to have access to a Medical Director. Hopefully this study and others that link marijuana use to bad outcomes will convince some folks that it makes sense to have some professional medical oversight at dispensaries to help protect the health status of the patients with debilitating medical conditions that will be using the dispensaries. You published this above section early today. It's not that people don't agree on a medical person oversight. What people disagree about is that it shouldn't be the dispensaries that provides that and should pay for a Medical Director to be or on call for a dispensary. This is why a patient and a physician are interacting with each other. They go to a doctor to get their medical recommendation not to the dispensaries. They have an ongoing relationship with a doctor and have to get a new medical recommendation every year. This should be up to the patient to address issues with their doctor and their doctor who wrote the medical recommendation to oversee this. One thing that could help is if you want the dispensaries to have a Medical Director than it should be that the dispensaries should be able to use that patients doctor as the contact doctor for questions or concerns. If there is a problem with the patient then the doctor that worte the recommendation should be the contact person to discuss this with, then they can make the decision if this is the best method for the patient. This would solve the issue on both ends. The Health Department wanting someone to oversee patients and Dispensaries having a Medical contact.

Add rules to prevent profiteering and backdoor defeat of the non-profit provisions of the law. Dispensaries will use "management companies" that they "hire" in order to obtain profits which violate the spirit of the law Arizona voters approved.

We are a 4,000 home master-planned community with over 100 acres of common area, a community center and a 42-acre lake. However, as currently written the definition of "public place" does not include planned community common areas. We would ask that you add "common areas of planned communities" to the definition.

the definition of "public places" should include common areas of planned communities, Hotels, etc.

Please include "common areas of planned communities" in the definition of "public places".

Add PTSD

The CHAAS is not feasible as it includes federal land and Indian reservations, many towns are not going to be represented because of the dense population. While I like dividing the city up into areas, the rest of the state is too unaccessable. (nobody is going to place a dispensary at the Grand Canyon) The biggest problem I see is that the cities have restricted so many areas that they have basically kept the dispensaries out of town and unreachable. It seems like they are expecting walkin traffic and not sick people. This will create a 25 mile gap of proportionate measures and will lead to many patients growing their own.

Making qualified patients purchase the "right" to a medical treatment should be dropped. What other substance that is considered a medical treatment requires people to pay before they are allowed the treatment? I understand that the government is now looking at this as their "cash cow", but a significant people will be denied treatment due to the excessive cost of the registrations card. ██████████  
██████████ Concerned Citizen

Allow patients & caregivers to grow in a more reasonable & natural location outdoors instead of driving them to buy & use power hungry lights & chemical fertilizers indoors. Allow them to grow in a more feasible fenced area using chain link with barbed wire, or a green house. This natural medicine is being treated like a nuclear bomb with the current block walls or similar. It should not have to have a top covering as well. Eliminate the random process to choosing dispensary owners. This will lead to thugs getting & running these & giving AZ a bad name just like in other states.

Find a better way to select potential dispensary owners. Choosing people to run such critical businesses should not be a random process. It should be based off the ties they have to the community, their past record, desires to give back to the community etc.

In a situation where there are multi-applicants for a particular CHAA, the losing applicants should be given an opportunity to be awarded a CHAA where there were no applicants. This would benefit the state as well as the applicant. The state would be able to provide service to an area that would go without service and the applicant wouldn't lose the non-refundable \$5,000 application fee.

3. The following statement "ARIZONA DEPARTMENT OF HEALTH SERVICES' WARNING: Smoking marijuana can cause addiction, cancer, heart attack, or lung infection and can impair one's ability to drive a motor vehicle or operate heavy machinery"; These are straight up lies. More likely that cannabis cures these and treats them. You guys need to bone up on the wealth of information and research that's been done.

about the medical director- 2. Assist in the development and implementation of review and improvement processes for patient education and support provided by the dispensary. Huh?? Like the pharmacy does when people come in month after month and pick up their opiates? Oh. that's right, they don't do that they just push, I mean deal, I mean sell them the drugs.

I think there is no need for a medical director. The stores and bars/clubs do not need a medical director to sell beer .And the effect of booze makes you very drunk to where you cant even stand,walk,drive ect. And there is still no regulations on it.

v. Disposing of unusable marijuana, which may include submitting any unusable marijuana to a local law enforcement agency; Why? What are the police going to do with what may become mountains of stalks and stems and fan leaves? I'll compost them. I'll be a certifiend mmj compost facility. green is good

R9-17-303. Applying for a Dispensary Registration Certificate A. Each principal officer or board member of a dispensary is an Arizona resident and has been an Arizona resident for the two three years immediately preceding the date the dispensary submits a Dispensary certificate application. This regulation is grossly ineffective in many ways, from the perspective of contributing to the whole of Arizona. Economically, this is a deterrant to out of state residents to contribute to the immediate taxable income created not only by the dispensaries themselves, but the income generated by the general population as result of increases in residency. The security risks of Arizona and its people is further increased immensely with the rules regulating dispensary owners, board members , and patients alike to obtain three years of residency prior to receiving medicinal marijuana benefits. With the border crossings and trafficking so rampant in Arizona, by only allowing three year plus residents, in my opinion creates a highly potential partnership with Mexico and its cartels to infest the industry otherwise open to Americans exclusively. Many Arizona residents have ties with Mexican family members. There is potential for disaster relating to extortion, and or other harm to not only to the people of Arizona, but their Mexican family members as well.

Dump this crazy CHAA garbage. Why shouldn't patients be able to grow their own? What's wrong with that?

Add post traumatic stress disorder

Clarification of evidence based science on plants strains properties insuring uniformity. Selection

process of dispensary and their responsibility to give back to the community.

Dr.s should not be afraid of recommending MMJ due to overly strict rules to patients when its so easy to prescribe much more toxic controlled substances. Eliminate any kind of random processes for choosing between potential dispensary owners. Change the current fencing materials to include chain link with privacy screen, with barbed wire on the top with no covering. This is much more reasonable. Allow greenhouses to be used in growing

Make growing outdoors easier for card holders & caregivers. This uses much less energy & can be done organically easier. The current fencing materials listed treat the medicine as a radioactive waste product! Make the fencing more reasonable like chain link, without any type of covering on it.

-I'd like to see the residency requirement reverted back to two years. Three years only slows an individual's right to open and operate a business, non-profit or otherwise. But, at least there are no residency requirements for caregivers. -Is the signed or initialed statement provided by the doctor facilitated by a common Prescription? This medication must be as easily attainable without creating any bias or sense of criminality whatsoever as all other prescription medications to facilitate the financial earnings of these establishments. -People, companies, taking up the burden of this service in the community need to be protected with immunity should the law ever be overturned. -Do agents of the dispensary need a food handler's license from the Board of Health? -The cataloging of a patients identity seems to violate their HIPAA privacy rights. There is also no privacy area specified at the dispensary for administering the medication. -Question: Who will be providing the patient reporting software required?

Rules should allow for medical marijuana for patients who are given permission by the original attending physician, NOT just any physician. Cancer and macular degeneration are the two that come to mind. PLEASE do not do what STUPID California did. NO smoking in any public area

Please include "common areas of planned communities" in the definition of "public places". It equivalent to the common areas of condominiums and apartment buildings.

1) As a previous employee of a mental health facility, I find it difficult to understand why certain mental health conditions are not included as debilitating medical conditions? I have heard from clients that disorders (including anxiety and insomnia) can also be treated medically with marijuana. Many people do not handle traditional prescription medication side effects well, and these people will continue to treat themselves using marijuana with or without approval, through criminal distribution sources. 2) Please don't make it any more complicated (or nearly impossible) to find suitable locations for dispensers. Perhaps even more importantly, carefully consider how the reality of

supply/cultivation will work. What will happen if/when supply runs short? The numbers don't seem to add up at this point for dispensers having enough cultivation area to maintain inventory for patients. There also doesn't seem to be any plausible way for a patient to meet the 25 mile radius criteria for growing their own. The whole industry will be in jeopardy if that is the case, which means serious issues and consequences. 3) The majority is okay with the basic concept of allowing sick people to use medical marijuana. Respect that vote in your intentions behind crafting the finite details in this legislation, or those same people will vote to replace representatives! 4) If the industry fails, Arizona loses the opportunity to gain MUCH needed revenues. Last time I checked, we were in a deficit. That's the primary reason I want this to work. So, if patients can't access or afford it... the criminal element will continue to profit, rather than the state. It's your choice when crafting the rules and criteria to determine how cumbersome you want them to be. The more cumbersome, the more that people resort to sidestepping Prop 203 altogether. Either way, people who need it medically can and will (continue) to use it, with or without the profits going to state deficit reduction.

Stipulate that ALL common elements and/or areas within ALL condominium homeowner associations AND ALL planned communities, such as but not limited to single family home communities, townhouse and patio home communities, etc. within Arizona, that are governed by a homeowner or community association, are designated as "public places." This is a must as medical marijuana users should not be allowed to smoke or ingest by any other method marijuana within the common elements or areas (ie. community pool area, green belts, clubhouse, etc.), of any community governed by a homeowner's association whether a condominium or a planned community.

As a board member of an large HOA, I request that "common areas of planned communities" be included in the definition of "public place."

As people who live in a planned community, we do not wish to inhale second-hand marijuana in and around our public areas, coffee shops, etc. Please include "comon areas of planned communities" in your definition of "public places" in this ordinance. [REDACTED]

Please include "commons areas of planned communitites" in the definition of "public places".

It is still unclear as to whether or not a dispensary must be fully operational before applying for a certificate. Since there is no guarantee of receiving a certificate it would place an extreme financial risk on the applicant if they had to be fully operational prior to submitting an application. This needs to be clarified quickly. Also, when will we know how many certificates are available within a give CHAA? It would be difficult to plan a location without some idea of the availability of a certificate within a given area. Lastly, since all individuals must have a physician in order to obtain an identification card, it seems excessive to require that a dispensary hire a physician also. Perhaps a review of a registries rules and regs by a licensed health entity would suffice instead.

After reading the 2nd round of improved rules for dispensary owners, i was very disappointed that in the rules it states that potential dispensary owners can not qualify for a dispensary licenses if they have filed for bankruptcy, this rule is absolutely absurd, i am a 60 years old man and never in my life did i ever think that i would someday file for bankruptcy, you see my wife had stage 3 breast cancer and as a retired contractor i could not cover all of our medical expenses reaching well over 78,000, sir you are adding insult to injure for people like myself and others, my wife could never qualify for health insurance because of her preexisting conditions i have been working all my life taking care of my wifes needs putting food on the table i raised two adopted children and i paid my taxes i never expected this type of trials in my life, why should the Arizona Department of Heath restrict myself and others the opportunity to get a dispensary license because of a bankruptcy, i am requesting for the bankruptcy rule restriction to be removed for dispensary owner applicants. Thank you. [REDACTED]

The Department cannot propagate changes as it does in R9-17-318 Edible Food Products section C. by stating "Adding medical marijuana to an edible food product does not adulterate the edible food product." Both the current State Rule and the Federal Food Code would classify any medical additive as an unapproved additive, and simply stating that it is not an adulteration is grossly overstepping the necessary oversight granted to protect the public's health and safety. All food contents must come from an approved source that is licensed and inspected, if ADHS is ensuring that this product (medical marijuana used in food) is of an approved source then they should regulated the operation used to infuse the product. As for the issue of having the dispensary contracting with a food facility which meets the code requirements for a food processor, this is lacking oversight in the quantification of "seed to final product" verification. In addition, at least in Maricopa County we would look at medical marijuana as an adulteration of a food and would not allow for its presence in the establishment let alone allowing it to be added to a food product. Elsewhere in the State, if other counties are allowing for this product to be produced in licensed facilities where they serve the general public, what precautions are being enacted to ensure that cross contamination of a medical additive is not being carried over into other products unannounced to the buying public?

The placement of dispensaries; these people are suffering from medical conditions they are not criminals or drug addicts. Living with chronic medical conditions; having to go through medication after medication to find out it is not working; is a lot. To be faced with the possibility of going down that road again just to satisfy a rule will discourage and possibly deter some long time suffers.

R9-17-305 A. states that a dispensary can not change it's location for 3 years after being issued a dispensary registration certificate. This is an unfair burden to dispensaries. Due to the strict zoning regulations that many cities, towns and counties have written it is very hard to find locations that also meet the needs of our patients within the deadline time frame we have to submit our applications. Many dispensaries are planning on opening in less than ideal locations just to be able to open and then move to better locations when more properties that meet zoning regulations come on the market.

R9-17-102 Fees A." For registraton of dispensary: \$5000.00" ( TOO HIGH -- \$2500.00). " To renew

registartion: \$1000.00" (TOO HIGH --\$500.00). "To change location.....:\$2500.00" (TOO HIGH-- \$500.00). "To change cultivation site: \$2500.00 (TOO HIGH-- \$500.00). "For registration I.D. of qualifying patient: \$160.00" (TOO HIGH-- \$80.00)."For renewing reg. I.D. for qualifying patient: \$160.00" (TOO HIGH-- \$60.00).

R9-

17-106 Adding a Debilitating Medical Condition, C. time specified in subsection 'C' (there is NO category in Table 1.1 for "Adding a debilitating medical condition" (A REASONABLE time period should be given ((e.g. 60 days)) to accomodate compilation of info. to support addition of new condition, for example: Anxiety & Related Nervous Disorders.). A. subset #5. ENTIRE LINE #5 NEEDS TO BE REMOVED (This line implies the useage of OTHER medications before marijuana.). subset(s) #6 & #7: both #6 & #7 need to be revised or omitted entirely.

R9-17-202 Item G,

#11, subset 'e', # vi, subset i: "Medical records from other physicians from previous 12 months..." (IF APPLICABLE). subset ii: "Response to conventional med." (IF APPLICABLE-- BOTH i & ii SHOULD BE REMOVED). R9-17-204 Renewing Qualifying Patient's or Des. Caregiver's I.D. Card. A subset 1. subset 'f' :ADD "Recommending", DELETE "providing written cert. for". subset 'g': "Because the qualifying patient believes that the qualifying patient resides at least 25 miles..." (CHANGE: 5 miles). Number 4, subset 'c': "Physician has made or confirmed a diagnosis of..." (REMOVE THIS LINE- ADD: "Qualifying Patient").

R9-17-204 Applying For Dispensary

Registration Certificate. Subset 'A'. ADD: '2 years', DELETE: '3 years'. Subset 'B' ,number 3. ADD: '2 years', DELETE: '3 years'.

R9-17-316 Product Labeling & Analysis. A, subset 3:

DELETE: "...can cause addiction, cancer, heart attack, or lung infection..." (there is NO medical evidence supporting these claims.).

WELL FIRST OFF THE COST FOR THE CARDHOLDER IS STILL UNREACHABLE FOR MOST PEOPLE THAT ARE ON SSDI AND LOW INCOME PEOPLE. THOSE PEOPLE SHOULD BE ABLE TO GET THE CARD FREE! AND THIS HAVING TO BE ON FOOD STAMPS OR GETTING FINACIAL AID FROM THE STATE IS THE ONLY WAY TO GET A DISCOUNT ON THE CARE IS DISCRIMINATION. THE DESPENSERY LOCATIONS ARE GOING TO BE OUT OF REACH FOR A LOT OF PEOPLE WHO DON'T DRIVE OR THE PEOPLE THAT HAVE A HANDICAP. YOU ARE MAKING PEOPLE WHO RIDE THE BUS MORE ACCEPTABLE OF BEING ROBBED. PEOPLE WHO CAN NOT GET OUT OF THEIR HOMES OR WITH HANDICAPS SHOULD BE ABLE TO GROW THEIR OWN. HAVING TO HAVE A DIFFERENT PICTURE THAN WHAT IS ON YOUR DRIVERS LIESCENS IS GOOD ENOUGH FOR THE POLICE AND OTHERS SO IT SHOULD BE GOOD ENOUGH FOR . MAKING THE DESPENSARIES BE ALL SET UP AND READY TO GO IT SO WRONG. IF THEY DO NOT GET THE LIECENSE THEN THEY HAVE WASTED ALL THAT MONEY AND IF THAT HAPPENS THEY YOU SHOULD HAVE TO REIMBRUS THEM FOR THE MONEY THAT THEY HAD TO SPEND GETTING IT ALL READY. THE 25 MILE SHOULD BE DROPPED OUT OR THE MILE LOWERED FOR PEOPLE WHO CAN NOT MAKE IT THERE. IT IS NOT JUSTIFIED THAT YOU JUST WANT TO KEEP PAITENTS MONEY IF YOU DENI PEOPLES APPLICATION FOR A CARD. THAT IS THEIR MONEY NOT YOURS TO KEEP. THE STATE OF ARIZONA IS NOTHING BUT A MONEY HUNGRY COMPANY JUST LIKE ALL THE OTHER LARGE CORPORATIONS. HAVING TO HAVE A DRIVERS LICENSE DATED ON OR BEFORE 1996 IS REDICULOUS. CUT OUT SOME OF THE STATEMENTS THAT THE PHYSICIAN HAVE TO PROVIDE..

If you have qualified an application and the locality they are applying for is not available, why no use these qualified applicants for other locations or at least offer them a different area? Do we have to have city zoning approval before we receive our license? Will there be a centralized computer system for tracking sales to individuals? How are you going to distinguish "shills" from legal Arizona

residents?

There needs to be an educational aspect of this law to make perfectly clear that this is NOT a recreational drug bill. This is a serious bill not to be flippant over and not to make fun of the people taking part of this opportunity. The narrow minded people thing we are clammering and will stampede the dispensaries when their doors open. This is the last thing we want. We want an end to our pain and suffering.

by simply following the ARIZONA MEDICAL MARIJUANA ACT, PROP 203. also the ADHS has little choice but to follow the hole law in this case. 1998 voters act. and prop 203 the ADHS has no authority in adding to or changing the law to suit his agenda. which has been clearly documented. stop the unfair abusive and entrusive sanctions, on doctors behavior in recommending medical marijuana. which is their right under federal law as well.(conant vs walters) 2002 the 9th circuit court, rule in favor of the doctors patient privedidged is protected from prosecution in recommending medical marijuana. STOP Persecuting medical doctor for doing what their trained to do. practice medicine.

Okay, What is going on here I have looked over many different locations and have found some disturbing things. Why do you need all of these restrictions. Do you know there is a mathematical equation that proves the Arizona Department of Health Services is setting the system up to fail. FOUL play guys this is peoples lives we are talking about not a game of Simon Says. The most commented things for patients were not even adjusted at all. The only things adjusted were for Dispensary benefit. What about the patients I met a gal who has cancer shes in bad shape she needs medical marijuana just to eat. at 89 pounds soaking wet she told me "They are trying to kill me with these restrictions." If a dispensary is limited to the amount of plants they can grow then they are limited to the amount of patients they can take care of, and from what I personally have read there is no way this is going to work. Remove the restrictions for a dispensary to grow, make the restriction that if you can prove you need more medication to dispense you can add another location or let the department know that more plants will be added to their inventory. It doesn't matter how you keep track of how much they can grow. It just matters that there will be enough medication when right now to keep up with expected supply and demand the restrictions would force a dispensary to break even Arizona's medical law. Let patients grow their own responsibly look around at other places the dispensaries are still getting a lot of business even though people are allowed to grow their own. Everyone doesn't have the desire to grow just look at the proof from other states. Remove the unfair restrictions and make this a real Medical Marijuana State future states can proudly model their Medical Marijuana Programs after. The time for change has passed the time for fair change is now. [REDACTED]

Please consider including homeowner association owned common areas as "public places."

[REDACTED]

In reviewing the latest draft of the Pinal County medical marijuana draft zoning ordinance amendment, I have the following comments: Pinal County, well done! The draft truly reflects the thought, effort and consideration of public comments. This document and process surrounding it rises to the level of excellence I expect from my County Government. Clone that quality and ethic across all that the County does, and our County will be the marvel across the nation. 1) In the ordinance draft, the County is creating a link to the concept from DHS medical marijuana rules, of relationship to when a dispensary or cultivation site registration certificate is revoked by DHS. The DHS language in its current rules draft, and the associated language in the Pinal County draft ordinance amendment is problematic. Consider the concepts in play here: "revocation for noncompliance", "lapse in currency of a registration certificate", "temporary suspension of a registration certificate for noncompliance", "volunteer surrender of a registration certificate". As you can see, of the concepts presented, only the first one rises to the level of concern for the intent in the Pinal County draft ordinance amendment. These are concept problems that needs reconciliation by both DHS and Pinal County. 2) The Pinal County ordinance needs to stipulate that each new 'use permit' for dispensary or cultivation site will not be authorized without public hearings (zoning commission and BOS). Just because the County establishes standards for these use permits, does not mean that the County should remove the opportunity for the public to voice concerns in a public hearing on what will surely be very contentious dialog. The Pinal County ordinance needs to also stipulate what conditions would trigger public hearing for renewal of the 'use permit'. 3) The Pinal County ordinance needs to stipulate a requirement that the use permit will be suspended if the property owner allows the dispensary or cultivation site property taxes to become past due (define how far past due), or any other required licenses lapse. The Pinal County ordinance needs to stipulate time-lines for correcting inspection deficiencies, and that if those time-lines are exceed, suspension of revocation of the use permit will occur. Pinal County needs to provide a process and associated fees for restoring a use permit from suspension. 4) The Pinal County ordinance needs to stipulate that the 'use permit' is non-transferable. If ownership of the property or operations change, the use permit will be revoked, and the new owners must re-apply. However, Pinal County should provide a orderly process by which a change of ownership can occur without disruption to the operation of a dispensary or cultivation site. You all covered everything else so well, this is all I could come up with. I hope the issues I raise here will be resolved in the final version of the ordinance amendment. Respectfully, [REDACTED]

common areas of planned communities should be included in the definition of public place.

“common areas of planned communities” be included in the definition of “public places.” Homeowners should not have their children subjected to legalized drugs use around their homes and where their children play in parks ect. of HOA's

Part 21 b. Public places. I feel that defining what is considered a public place is important. One question. Why are schools not listed specifically. I know it is a given that the schools are a public place, but as a school nurse, I feel it is important to be specific on that point. We administer medications in the school Health Office all the time. We have students who self administer inhalers for asthma, diabetics who self administer insulin and Students with severe allergies who self carry and administer epi pens. I would like to see SCHOOLS included in 21 b.

theres no patient protection in pricing since we have to buy from a dispensary within 25miles of our home even if its a apartment,condo,hotel,hospital or even a private single family home. smoking areas need to be opened up for patients like myself who happens to live in a apartment due to my disabilities that i cant maintain a yard etc. and i also have kids where do i smoke at? please answer that since we the voters voted this in and now you the state want to make it so hard for us to get. also parks lakes campgrounds all need to be included in the allowable smoking areas! its not like every arizonan resident will be on the card and just blazing up everywhere. have some common sense for us patients. the pricing on the cards are also way to high. \$80 for low income should be like \$15.

The dispensaries may open in July, but they won't have anything to sell to pay the bills for just under a year or more as so many people think growing marijuana is as easy as spreading pixie dust on the floor with a drop or two of water. I farm thousands of acres. It will take months to sex your plants from seed. Another 2 or 3 months to grow enough mother plants to produce enough clones to actually have something substantial to harvest will be another 3 to 4 months. Of course, this is only 1 strain. How about growing 25 strains at once? Naturally, nothing in agriculture is 100%. Last year, I had a record wheat harvest with record prices. This year we had a drought. Farming is still farming. Time, hard work, lots of money, and even then, it may not be enough. Mother Nature rules. That is farming outside, not inside. We grow lots of tomatoes and lettuce inside. It is a tricky business, and it costs a lot of money: space, lights, other equipment, fertilizers, pesticides, herbicides, soil, containers, etc... Lots of people will fail, because the wrong people are applying. Maybe they think they will bring in a bunch of California boys to do it. People think if they have grown a couple of tomatoes, then they will be great farmers. Try growing 25,000 tomato plants and see what happens. You are forcing people to rent retail space a year before they will have anything to sell. Most of the people involved know nothing about agriculture. You have to be able to absorb losses in agriculture. If you have 2500 plants ready to harvest, but in the last week they get struck by white flies, what will you do? Will you spray a pesticide that might harm a cancer patient? Or will you have the resources to pull them up and throw them away? Most people who are applying won't throw them away, because they would go bankrupt. You have turned a agriculture operation into a retail operation.

Common areas of Planned Communities need to be included in the definition of public place. As an example of the legitimacy of the concept: A pool in a Planned Community is considered to be public for all intents and purposes when defined by Maricopa Health Services.

Planned Community (Homeowner Association) common areas should be considered "public places" for purposes of the law.

Please make that the areas in a planned community be included as "public places".

request that "common areas of planned communities" be included in the definition of "public place."

My best friend has cancer and it is his dream to be a dispencery owner, I am doing everything i can to help, actually i am doing all the work. We have little money, our money will come from investors once the rules are not so backwards. our dream is to help the sick, not get rich off of them. The rules can be improved by makin it easier in the pre application process. dont make folks gamble with there hard earned money. how can i spend 20,000 to 100,000\$ on a gamble. approve people first and then make them get their location and cultivation site. it is the only fair way to not exclude the folks who are not

wealthy.

you can always keep the little guy in mind when you write a rule. Please MR will humble, dont let the whole thing go to the wealthy.I am a person of little means , but i have been involved with prop 203 before it was even law. It is heart breaking when i read the rules that stump the little guy, like having to gamble with the little money i have on leaseing a spot, only to find out it is no good because you gave a licence to a person less than a mile from me.on the cultivation site. i would think you would want the cultivation sites close, so the police can monitor them easier.

How about just have the first part of the application process only be, backround checks and making sure the applicants meet all requirements, make sure the applicant financialy to open a dispencery or cultivation site. approve them to then go out and get their site and all the other requirements, so people dont waste a asorbenent amount of money. the way you hae it set up is back assward, but it has gotten better than the first round of rules, but still not quite there.keep up the good work, but please think of the little guy and the patients.

stop writing ridiculos rules that only benefit the wealthy.what happend to oppertunity for all. this is my first business venture ever and i have learned much about the world , really being one sided to benefit the wealthy. How can you have a pre enrollment with out making that info public. i hope that is just a rumor because if it is not , you better be prepared to get sued.

why are these ridiculous rules being put into place, ya you want to ensure you dont get clustering of dispencerys and cultivation sites, I can see the dispencery, but who cares if cultivation sites are clusterd in one area or a few industrial areas, it will make it easier for the police patrol one area then , several .ontop it is not fair to people like me who are not wealthy. if some one else gets approved for there cultivation site before i do with in a mle of mine then i just wasted my investors 40,000\$. I know it is not easy when you have so much to do, but it seems like common sence is not being used, why. it really does seem like there is a hidden agenda.

why are these ridiculous rules being put into place, ya you want to ensure you dont get clustering of dispencerys and cultivation sites, I can see the dispencery, but who cares if cultivation sites are clusterd in one area or a few industrial areas, it will make it easier for the police patrol one area then , several .ontop it is not fair to people like me who are not wealthy. if some one else gets approved for there cultivation site before i do with in a mle of mine then i just wasted my investors 40,000\$. I know it is not easy when you have so much to do, but it seems like common sence is not being used, why. it really does seem like there is a hidden agenda. just because a person i wealthy does not mean they can do a better job than a middle clas person who is not in it for the money.

Add PTSD

I would like to see the draft rules be improved by removing the bankruptcy rule. Bankruptcy is a credit issue that is in the past. To discriminate against one because of unfortunate circumstances is unfair and not the right thing to do. Personal credit should not be in the equation as a decision factor in the approval process. Please reconsider this rule and delete from draft rules.

Please provide language in the rules that recognizes that common areas of the community should be regarded in the same sense as "public areas" have been defined elsewhere in order to restrict smoking use of the drug to the discomfort of others in the common areas. It is for medical use only and should be handled in privacy by the patient, not socially.
The rules should not allow smoking of MM in common areas in planned unit housing developments or planned communities. While these may be defined as "private areas" they are shared by all members of the PUD which can include children and others affected by the smoke and smells.
Concentrate on the patient, and less on the dispensaries. Where are the laws for protection for patients that have legal Arizona medical marijuana cards? Example- Joe has a card, goes to the local dispensary, buys his medication, is driving back to his home, gets pulled over by local law enforcement, they smell the marijuana, search his car, his person, take away his medication, and overall hassle this sick person.
No restrictions please. If a Dr. says a patient needs medical marijuana, it's on the dr., not the patient. Since many clinics restrict their doctors from making medical marijuana recommendations, the secondary dr. doesn't need to give a physical exam, especially for those confined to their homes due to lack of mobility, let them make their decision based on a phone interview and with the patient's medical records. Keep med marijuana costs down. Don't put unnecessary restrictions on dispensaries. Some lawmakers want to charge a 300% tax so KEEP COSTS DOWN!
We request that "common areas of planned communities" be included in the definition of "public place". see below
I request that "common areas of planned communities" be included in the definition of "public place."
See my specific language comments
please include all public areas of planned communities
We would appreciate it if Planned Unit Developments or "planned communities" are included as public places to prohibit the setting up of a marijuana store and smoking it. These communities have a lot of children, and families in them that this may create an unwanted attraction. Thank you
NUMBER OF DISPENSARIES APPLIED FOR should they lose one in the lottery.
Don't treat this substance like heroin or cocaine----eventhough it's (erroneously) a schedule 1 drug.Look at the intent of the initiative and follow it.

B. The Department shall accept dispensary registration certificate applications, [pls. see below for insert] for 30 calendar days beginning May 1, 2011. 1. A city or town that contains more than one CHAA may request the reassignment of a dispensary registration certificate allocation from one CHAA to another CHAA under the jurisdiction of the city or town. 2. If the Department receives: a. Only one dispensary registration certificate application for a dispensary located in a CHAA that the Department determines is complete and is in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter by 60 days after May 1, 2011, the Department shall allocate the dispensary registration certificate for the CHAA to that applicant; or b. More than one dispensary registration certificate application for a dispensary located in a CHAA that the Department determines are complete and are in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter by 60 days after May 1, 2011, the Department [shall randomly select:] i. One dispensary registration certificate applicant and allocate the dispensary registration certificate for the CHAA to that applicant; or ii. As many dispensary certificate applicants as there as dispensary registration certificate assigned to the CHAA, if the CHAA has more than one dispensary registration certificate assigned as a result of a city or town's request in subsection (B)(1), 3. Except as provided in subsection (B)(2)(b)(ii), from the dispensary registration applications received within the time-frame in subsection (B), the Department shall allocate only one dispensary registration certificate for each CHAA.

I think the \$5000.00 application fee ( non refundable) is insane. I understand paying if you are chosen, but that much just to apply? Maybe it's the thought that that will weed out ( no pun intended) the not so serious applicants, and it may end up being the case, but at least make the fee refundable if you are not chosen to receive a dispensary license! At this high of an application fee, you are going to receive applicants who are strictly in it for the money, not a small business owner who wishes to help people in need.

Please consider adding that smoking is prohibited in the common areas of planned communities.

PLEASE INCLUDE "COMMON AREAS OF PLANNED COMMUNITIES" IN THE DEFINATION OF "PUBLIC PLACES"

1. Do non-smoking laws apply to medical use of marijuana? 2. What precludes a patient from smoking marijuana for medical purposes in a public venue if it is for "immediate emergency medical purposes"? 3. Under section 21. B. of definitions, please include "common areas of planned communities" in the definition of "public place." We live in a planned community and would not want marijuana smoked in the common areas where children and others may be exposed to its use publicly. Although for medical purposes, we would not want medical injections or other personal medical procedures performed in common community areas either. We consider medical marijuana smoking in the same category as these medical procedures but far more intrusive because of the effect on others within the same immediate area. Thank you.

They should include common areas of Homeowners Associations as non-smoking not just public areas. I really do not want to be having a cup of coffee or lunch on the patio or park area of our community

and have smokers next to me.
Public place to include " Common Areas" of all Planned Communities" in the State of Arizona.
dont be so harsh on the patients that need it.
Dis allow the smoking of marijuana in public areas within planned communities
If an HOA already has a no smoking rule in place that means, NO smoking, period.
Common areas of planned communities should be included in the definition of "public places"
By expanding the areas where it will be illegal to smoke medical marijuana.
When finalizing the rules please keep in mind that while the smoke may have a benefit to the patient...it, like cigarette and cigar smoke inhaled by bystanders has proven deadly. I have known many people who get sick from breathing it...I for one have asthma and get very ill...in fact, I am very allergic to marijuana.
Incorporate the use of common areas for medical marijana. In my case, a debilitating chronic back pain attack can occur at any time or place,this treatment will be a godsend for those of us who struggle everyday of our lives....to be free of the pain and able to use all the facilities that Sun City Grand offers will be maraculous,to be able to sit by the water/fountians with friends and family should be a option that all Sun City grand residences should be entitled to.
The section R9-17-202 - F-1-f Whether the qualifying patient is requesting authorization for cultivating marijuana plants for the qualifying patient's medical use because the qualifying patient believes that the qualifying patient resides at least 25 miles from the nearest operating dispensary; The distance should be reduced to 15 or more miles. Even the lower distance can be an issue for those who don't drive especially in areas without public transportation.
As I read the rules, does it mean that if you have children than you can not be a grower?
Please consider changing the rules to make it possible for companies in California, or Colorado (by lottery), to at least set up new dispensaries for a short period of time. This is so that they can provide initial product to the new dispensaries in Arizona before the first crop is grown. Patients should not have to wait for the first crop to grow just because some at the AZDHS assume it is ok for the patients to wait the extra few months. Some of those patients only have a few months to live. It is especially important that this issue be addressed, as it appears the AZDHS has not even made one statement

about how initial seeds are to be legally obtained. This cannot be ignored, and the question must be answered. The question must be answered because a patient growing their own plants can get in trouble if they do not have a legitimate source of seeds or clones for their initial crop. This appears to be an issue for the future dispensaries as well. This idea that the business should stay in Arizona, and they should be residents for two years probably means nothing now to those who initially requested this be part of the initial draft rules. It has been reported that it will cost in the hundreds of thousands of dollars to set up a dispensary. Since only those with means can participate now in the dispensary business, please let any and all who have real experience at least participate in setting up dispensaries in Arizona. The "By the end of the summer" phrase is really not acceptable regarding when patients will be able to receive this new medicine. The law will go into effect much earlier than that. I do not see where it is ok for patients to wait much later than April to obtain their medicine. If out of state dispensaries are allowed to set up new dispensaries in Arizona, then patients would be able to receive much higher quality medicine by those who have experience. This helps the patients. Some of these companies already have very good quality controls for the products they produce.

Common areas of planned communities certainly must be defined as public places in this act.

The common areas of our Sun City Grand Homeowner's Association should be considered within the definition of a public area for the purposes of prohibiting smoking of Medical Marijuana. Thank you,

Please include common areas of planned communities like Sun City Grand in your restricted areas for smoking medical marijuana.

I'm sorry that that Bill was ever passed---just one more way of "coping out"....is that the only pain killer?

Please include common areas in planned communities as areas where the use of medical marijuana will be prohibited.

Add to the places where pot CANNOT be smoked is "Common Areas in a Planned Community". Add to the places where pot CANNOT be smoked is "In Designated Cigarette Smoking Areas".

Medicating yourself in PRIVATE !

Please include that the common areas of planned communities be included in the definition of "public place". Meaning can not be smoked anywhere but home.

By adding the following: "Public place" will include common areas in planned communities.

Banned in all public places.
"common areas of planned communities" be included in the definition of "public place."
Pleas include "the common areas of planned communities be" included the the definition of "public place"
Non permission to use MJ on property of HOA communities.
Do whatever you can to make it easy for qualified patients to obtain marijuana at the LOWEST possible cost. Do whatever you can to make it as easy as possible for dispensaries to operate at the lowest possible cost, so marijuana prices will be low as possible for the patient.
Smoking marijuana in public areas - i.e. Planned Community common areas: I have no problem with medical marijuana at all, but I do have a huge problem with smoking in public areas. I totally agree with the AZ ban on public smoking, and that to me includes tobacco, marijuana or corn cobs - I don't want to breathe any kind of smoke! Thank you. [REDACTED] [REDACTED]
I feel that the 25 mile rule is a little outrageous. Why should patients have to go through the trouble of always having to go to a dispensary across town everytime they need medication? Why does living within 25 miles disqualify you to grow your own medicine, growing your own saves time and money. The rules for growing should be applied to all patients that qualify. If I have to drive across town to pay outrageous prices for a plant that needs only dirt water and light to grow, I might as well consult a neighborhood drug dealer to get the same product for half the price without having to drive anywhere. I feel like this 25 mile rule would cause patients to support and fund organized crime a lot more due to the fact that they simply cant grow their own medicine. By patients supporting these drug dealers they can grow larger and bring bigger problems into nice residential neighborhoods. The rules for growing should be equal all across the board, growers should be required to be secured and locked at all times and follow all the other restrictions on number of plants, etc. And if you do not follow the rules you should have to face the legal consequences.

it is unfair to discriminate against medical marijuana with these expensive fees for patients and caregivers. why patients need these registry cards, why not just a doctors prescription. that's all you need for other, more harmful prescription drugs

I am a resident of Sun City Grand. The proposed rules prohibit smoking marijuana in "public places." The definition of public places includes the common areas of condominiums and apartment buildings; it does not mention the common areas of Planned Communities. Under Arizona State Law, Sun City Grand is considered to be a Planned Community in Surprise. I am requesting that "common areas of planned communities" be included in the definition of "public place."

The draft rules can be improved by clarifying or providing a few examples of commercial devices that will require certification as mentioned in R9-17-320 - D, 1/2/3 at the dispensary or cultivation site.

The rules can be improved by clarifying the following in the conditions: Given: 1. A medical marijuana dispensary can distribute and cultivate marijuana at the same location. 2. A medical marijuana dispensary can have one location for dispensing medical marijuana and have a second location as a cultivation site. Clarification #1: If a dispensary has a certificate for a medical marijuana dispensary that is distributing and cultivating marijuana at only one location, there needs to be a process in place to allow the dispensary to add a second site for cultivation. Clarification#2: If a dispensary has a certificate for a medical marijuana dispensary that has one location for dispensing medical marijuana and have a second location as a cultivation site., then it should be allowable to cultivate medical marijuana at both locations.

The rules can be improved by changing the title of RS-17-320...Physical Plant. The title of 'Physical Plant' implies that it refers to the marijuana plant, not the actual dispensary or cultivation site

That HOA Common areas fall into public places that the drug should not be smoked in

The Marijuana draft rules should also exclude smoking Marijuana in Planned Communities.

I am TOTALLY against smoking in ANY public place. Why should the rest of us have to inhale marijuana? If someone is so sick they have to smoke this stuff in a public place, maybe they should stay home in bed!!!!

Include "common areas of planned communities" in the areas where smoking medical marijuana is prohibited.

Common areas within a planned community should be considered as public spaces. I do not wish to be subjected to second hand marijuana smoke. It is a substance that is illegal except for medical purposes and as such, should be used privately and away from the public.

Please do not let medical marijuana be smoked in public areas. I live in a planned retirement community. I have been so thankful that there are no smoking ordinances here in Arizona. Medical marijuana usage needs to be included in those ordinances. I believe people who really need to use medical marijuana should not subject others to any possible smoke from the marijuana. Please. We do not need this pollutant added to what we already are subjected to. Thank You [REDACTED]

Public places should clearly include anywhere that athletic games are held. Paid and unpaid spectators come to these places to watch their children participate in sports activities or watch professional sports events and not to inhale 2nd hand marijuana smoke.

Please include "common areas of planned communities" in the definition of "public place." Thank you. [REDACTED]

I request that common areas of planned communities be included in the definition of public place

common areas of planned communities" be included in the definition of "public place. [REDACTED]

I did not notice the formation of oversight--i e policing of rules.

to include no smoking marijuana in "common areas of planned communities"

"common areas of planned communities" be included in the definition of "public place."

Hello, We do not believe the use (public or private) of marijuana is a good idea. The Surgeon General of the US and most states have had campaigns against smoking for decades because we know ingesting ANYTHING into lung tissue is not healthy. We are constantly fighting air pollution and it's effects. All one has to do is walk into a public place now here in Az and witness people carrying oxygen tanks to ameliorate the effects of smoking years ago. Secondly, there are NO adequate double blind studies proving the efficacy of marijuana for relief of pain or nausea. Supporters may feel or say there is a positive benefit but this is NOT based in science. There are approved medications, that are not habit-forming, for symptom relief. This effort to "medical-ize" marijuana should be abandoned totally because it is only going to send a double message to young people and it undermines good medical science. We hate the idea of someone smoking anything in our common areas and we oppose this trend. [REDACTED]

Common areas of planned communities should be included as public places!
I request that "common areas of planned communities" be included in the definition of "public place." The same rules of no smoking in public places, restaurants, stores, etc should apply
The drug cannot be used in public areas of planned areas.
Common Areas: common areas of planned communities should be included in th definition of "public places".
Please do not change the definition of Public Place to include "common areas of planned communities"
I am a resident of Sun City Grand, Surprise, AZ. It is my understanding that Sun City Grand is considered a "planned" community for purposes of the medical marijuana draft rules. I do not believe that it is appropriate that marijuana smoking be permitted in the common areas of planned communities such as Sun City Grand and would request that the draft rules be amended to provide that the common areas of planned communities are included in the definition of public places where such smoking is banned. There are many reasons for this, including, but not limited to, the fact that children are customarily present during certain hours in various of the common areas of our community. [REDACTED]
Add PTSD for a myriad of conditions that are life long for those with a considerable degree of trauma like our nations wounded warriors who are overly exciteable.
Please be sure that "common areas of planned communities" be included in the definition of "public place." There are many Planned Communities in Arizona. And we don't want people who qualify for this Medical Marijuana Act to be a nuisance and smoke this awful stuff in public places. I sure hope this also includes public restaurants, parks and any other places that the general public might go and expect not to be subjected to this. I think that anyone smoking this substance should do it inside of their home and nowhere else.
no taxes no permites
The use of Marijuana in any public place shall be considered a breech of the purpose of the substance and should be treated as a crime. By smoking this substance in public you will expose the general public to the residual effects of the substance an endanger the public. Many jobs require that a

person be drug free and by allowing this substance to be used in any public place you could very easily jeopardize these people.

Common areas of planned communities should be included in the definition of "public place."

The draft rules can be improved by eliminating or changing the requirement of defining the strain of the medical marijuana. Only the verification the what is being distributed to qualified patients is indeed marijuana. R9-17-315. Inventory Control System B – 2 – a : A description of the medical marijuana acquired including the amount and strain; This seems difficult. How would the Caregiver or patient know the strain? How do you describe a marijuana plant that makes it different from other marijuana plants? B – 3- a : A description of the medical marijuana acquired including the amount, strain, and batch number; How would the dispensary really know the true strain?

The draft rules can be improved by eliminating or drastically reducing the responsibilities of the Medical Director described in R9-17-312. R9-17-312. Medical Director The requirements and need of the Medical director are near nonsense. I do understand why the ADHC would want a licensed physician to be associated with a dispensary that distributes medical marijuana to qualified patients, but their role should be no more than of a consultant. A patient's physician can provide all the required information about marijuana and other information can be found In-line or be in the form of information pamphlets at the Dispensary.

The draft rules can be improved by only allowing the medical marijuana a dispensary distributes to qualified patients be grown only by that specific dispensary. Do not allow Dispensaries to get medical marijuana from other sources,

The draft rules can be improved by eliminating the requirement that Dispensary or Cultivation Site not change its location until after three years. R9-17-306. Applying for a Change in Location for a Dispensary or a Dispensary's Cultivation Site. A. A dispensary shall not change the dispensary's location during the first three years after the dispensary is issued a dispensary registration certificate. This is unreasonable. No business should be prevented from moving to a different location for any reason. As long as a transfer fee is paid, and all other requirements are fulfilled, there should be no reason to not allow moving a business to a different location.

The draft rules can be improved by streamling the conditions for adding a new Medical condition. R9-17-106. Adding a Debilitating Medical Condition The requirements for adding a debilitating medical condition seem ridiculous. The patients doctor should be the one to decide if their patient should be able to receive medical marijuana to help relieve the paints pain and suffering of whatever the type of debilitating medical condition the doctor has determined. I view the conditions in R9-17-106 impossible to fulfill and as just a way to say no to all medical conditions other then those already defined in the proposition. I understand the need to review and approve, but this section is totally unacceptable in its methods of determination.

The draft rules can be improved by eliminating the rule that all fees are NON-refundable. R9-17-102. Fees A. An applicant submitting an application to the Department shall submit the following Non-refundable fees: The fees for a Dispensary registration, renewal, and especially for registration ID cards are to high and making them non-refundable is unfair and wrong. I do understand that there is a

cost involved in maintaining the computer database of registered users, caregivers, and dispensaries but I'd like to see the estimated costs as compared to the fees that are being charged. I do hope that the \$5000.00 fee for a Dispensary certificate is refunded if the application is denied.

The rules can be improved by eliminating R9-17-302 (F) or changing the rule to return a full refund of the application fee. R9-17-302. Dispensary Registration Certificate Allocation Process F. If the Department does not allocate a dispensary registration certificate to an applicant that had submitted a dispensary registration certificate application that the Department determined was complete and in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter, the Department shall return \$1,000 of the application fee to the applicant. This is wrong...if a dispensary registration certificate is denied, the full application fee of \$5000 should be returned. Don't financially punish everyone who is denied a certificate just because Proposition 203 limited the number of possible dispensaries

Please include "common areas of planned communities" in the definition of "public places" where medical marijuana cannot be used.

Prohibit smoking in common areas of planned communities.

Eliminate even the possibility of RANDOM drawings for anything. This whole process needs to be checked through & through in ALL elements.

The draft rules can be improved by eliminating the use and reference to CHAA's. I do not recall the use or mention of CHAA's at all in the first draft or in Proposition 203 and if required, should have been brought to everyone's attention in the first draft instead of suddenly on the second draft so everyone could complain about the unfairness of them in the first place. With the stance of ADHC being against the use of medical marijuana, the concept of using a CHAA as a tool to block the creation of dispensaries is understandable but should not be implemented. Let the market decide where dispensaries are located. It is a shame that Prop 203 restricted the number of dispensaries. The market should decide how many can exist and where they should exist. Competition and free enterprise will weed out the excess.

Common areas of a planned community such as Sun City Grand should be classified as public places.

Vacate the law.

include common areas in Areas of planned communities in the definition of "public place." Under Arizona State Law, Sun City Grand is considered to be a Planned Community and I definitely do not want marijuana smoking in our public/community areas.

The draft rules need to include the following in the definition of public areas. "Prohibit the of smoking of marijuana in the common areas of planned communities".

Please include "common areas of planned communities" in the law's definition of public spaces - otherwise my HOA will have to permit smoking marijuana at our tennis courts, clubhouse, and open areas.

Common areas of planned communities should be included in 'public places'. Thank you for following the concerns of your constituents. [REDACTED]

I am very concerned about the possibility of those qualified to use medical marijuana smoking it in the common areas of planned communities. Please include "common areas of planned communities" in the definition of "public place."

requesting common areas of "planned communities" be included in defination of public places.

See last question

There is no verbage regarding planned communities.

Ban smoking medical marijuana in public areas of Home Owner Associations.

While providing many useful details,the draft fails to address the most essential elements of concers: Safe and effective use of Marijuana as a medication requires that it has to be treated as a "prescription drug". All medical and legal requirements for prescribing and dispensing of a scheduled prescription should therefore apply to Marijuana as well. DEA and state board of Pharmacies have established detailed regulations that this draft could have utilized. In fact, lack of any mention of pharmacy functions in this document is both suprising and a public hazard. Many of inventory control, security requirements, etc. are already addressed in any U.S. pharmcy with regards to diversion-prone drugs such as Oxycontin, Percocet, Ritalin and others. Why exempt Marijuana from such oversight by professional pharmacists? More importantly, patients need education (on dosing, use and side-effects of this drug). The importance of screening for possible drug-interactions and/or interfering concomitant medical conditions can also not be over-emphasized. I am aware that the draft proposes that a "medical director" should address these issues; unfortunately this looks only good on the paper. Experience shows that a bunch of "educational paper" is a very poor substitute



If Marijuana is to be used for medicinal use it should only be sold in medical complexes. Storefronts should be prohibited

NEED TO ALSO EXCLUDE COMMON AREAS IN PLANNED COMMUNITIES. THESE AREAS SHOULD BE CONSIDERED AS PART OF PUBLIC AREAS EXCLUSIONS.

Big Mistake

Change the random drawing for dispensaries. That is a bad idea overall. Groups that have good intentions should be able to show that somehow through the application process. Allow towns to have a vote or say on who gets dispensary licenses. Allow dispensaries to preapply with a city or towns recommendation coming from the city or town council.

What needs to be included is No Smoking in public places of Planned Communities also, as I live in a planned community, and I feel that we should not have to put up with smoking in the common areas of our community either.

Can only be smoked privately in their home.

Need to add verbage regarding the common areas of planned communities. You state that the rules prohibit smoking marijuan in "public places" and then your list the common areas of Condominiums, but the common areas of Planned Communities was not mentioned. Please include this.

See below

Please, no permitted smoking of marijuana in planned community public areas. We request that "common areas of planned communities" be included in the definition of "public place."

Include "planned communties in "Public Places". Within Planned Communities we have gathering places, restuarants, and recreation centers. Please do not allow marijuana in these areas! [REDACTED]

Common areas of planned communities MUST be included in the definition of "public places". Otherwise, planned communities will have to endure such activity in their picnic areas, clubhouses, pool areas etc. - areas that are heavily used by families and childern.

ensure that planned community common areas are included in the areas banned from smoking the stuff
"Common areas of planned communities" should be included in the definition of "public place."
I don't understand why a patient would need to pay a \$200 fee to have access to this medication. I can't think of another medication where payment for access is needed. I believe this policy may be violative of the Equal Protection Clause of the United States Constitution.
It needs to include common areas of Home Owner Associations as well as condominiums.
As it currently reads, the law does not include common areas of planned communities in the definition of Public Places. This is a serious oversight, as children and other owners, residents and guests will be subjected to the "medical benefits" of the qualified user. I will be the first to admit that the common grounds are not "Public" public places, but they are open to the use of the membership of the Association in the same manner that school grounds are open to the use of all the students. It is my opinion that the use of medical marijuana, just like the use of any controlled substance, should be done in the privacy of the home and not in areas where others are affected by the side effects of the drug.
The draft rules can be improved by including "Planned Community common areas" to the definition of "Public Place" (R9-17-101 [21]). We are concerned that we could have smokers in our common areas.
I believe Director Humble should bring in outside sources for help. Director Humble is charged with crafting the implementation rules on a topic that he knows very little about and does not comprehend the real world implications of those rules. There are many people who will be happy to assist Director Humble that have expertise in their respective fields. They have all indicated that they would assist on a pro bono basis. Some of them include [REDACTED] and the law enforcement community. I would also suggest spending some time with DHS's internal legal counsel to determine what rules are lawfully permitted under Proposition 203 and what rules are beyond the DHS rule making authority. This may well prevent future legal challenges.
Include HOA, Condominium and Planned Community common areas in the definition of a public place
The requirement to list a dispensary address and then not change it for three years is not workable in

practice. Just as the certificate of occupancy created problems, this does as well. All ADHS needs for the application is the CHAA where the dispensary is planned, not the exact address. Otherwise, dispensaries would need final local approval of their location just to apply. We still believe the medical director role is not needed at the dispensary level and is something that may subject the process to unnecessary legal challenge. A medical director for the industry is a great idea and the industry could take advantage of the one person's expertise to create an industry-wide, consistently high level of service to its patients. Forcing the system to have more than one medical director still looks like a retired doctors employment program. The move to a license lottery was a great improvement. You should further refine the process so that the public is aware of the number of applications in real time for each specific license during the period you will be accepting licenses. The total number of applications for a specific license is data that informs the applicant as to his chances of winning. Not having this information generally available will increase the risk that some parties will obtain superior information and make competitive use of it.

Patient costs for certification and for caregiver, are way too high.

It is believed by popular vote that restrictions on amounts of Medical Marijuana is not fair. 2.5 ounces may seem like a lot of medication for someone who does not need medical Marijuana. Unfortunately those that do need it will tell you that on some days they only need to smoke a little bit to get by. Other days the pain or the nausea, tics, spasms, are worse than others meaning that more medication is needed restricting the ability to gain access when needed is not a smart idea I sincerely believe you will have a lot of patients counting hours down to minutes with the 14 calendar day rule desperately needing their medication try imagining not being able to eat for two, three, or even four days. How about not being able to enjoy life due to the persistent spasms or tics caused by MS, Dystonia, Tourettes, Epilepsy. Those that have to suffer the intense pain due to the fact they needed their medicine. I believe this will fuel the black market on Marijuana when a patient runs out where will they turn can not turn to a dispensary can they? I also believe that public use should be permitted in smoking areas. Imagine having to be out doing errands for the majority of the day or shopping how about an all day concert? the effects of most strains of marijuana last for 1.5 hours the average concert 3.5 - 4 hours, leaving a time of the concert where patients are unable to medicate. Where is the fairness in that just because the medication is Marijuana? It should not be treated Taboo anymore the people have spoken and it is now a legal medication. With the price of gas today people should not have to travel more than 15 miles to get their medication (Most people now wouldn't Drive 15 miles to a pharmacy) that would be a fair distance for patient to cultivate marijuana 12 plants is fair as long as if they are growing from seed they may start with a few more due to the fact some come out a male version of the plant and you need to remove those from your cultivation center they are not good for medication, but 12 female plants is fair. if 2 patients live in the same house they should be able to grow for themselves that meaning 24 plants as not everyone shares medication think of a room mate scenario that would cause an unnecessary conflict if they must be kept in the same place that would be fair as long as they are labeled who's plants are who's.

An explanation or rules should be drafted dealing with folks like me who move to Arizona from other

locales. I suffer from Primary Progressive Multiple Sclerosis and winter here in Arizona because of it. I live in Canada in the summer and access MMJ through a compassionate club at home. How can I access same here when I am here for the winter months? My diagnosis is available from my doctor at home, do I have to go through the same process all over again here? (i.e. tests and procedures) I have photo ID from my compassionate club in Canada, is that acceptable at a dispensary?

300% tax? How is this showing compassion to the sick, disabled or dying? Although as long as those who qualify can grow their own at home a reasonable tax; matching that of all other medications in Arizona could be beneficial to the state and local communities.

The CHAAs is a terrible idea...The distribution of dispensaries need to focus on the density of population. You can't worry about spreading out dispensaries into rural areas....they will not be utilized, not create any sort of tax revenue thus be unbeneficial to Arizona's economy....

As an employer I believe that it places a burden on an organization to determine impairment. To have the proof determined by metabolites is ludicrous since metabolites can stay in the human system for 30 - 45 days. The most accurate way to determine impairment from recent use is through a relatively expensive blood test that can range in cost from \$750 to \$800 which could become quite costly. Broaden the employment categories in which medical marijuana use can be cause for termination to include healthcare workers.

1. Reduce the cost of the card to \$10.00. There is ABSOLUTELY NO REASON why you need to charge \$160.00 for the card. 2. Reduce the state tax from \$10 an ounce to \$1 an ounce. If only 20,000 people in Arizona register and purchase an ounce per week, the state will be pulling in over \$10 million per year in fees. And you want the dispensaries to be non-profit? This is ridiculous!

A lottery could be very bad for patents in need like me that can no longer take pills. A grower has to know what he is doing and who he is growing for. I need a sativa I have Hip C and type 2 diabetes which works very well in my blood sugar controls. I have tried Indiac and I get sleepy with no energy. I have neck and low disk damage and nerve pain " It also works very well for that". Controlling cost is a factor for medical patents we don't have the money! I noticed the cost went up \$10 on this new draft. So For the month of May I will submit \$160 and I will have to take it out of my food money or my medication money that makes sense! I am on Medicare and have not receive a pay raise in 3 years and prices are not coming down. I really need this to work so I can live a health and some what normal life with out pills.

Making the rules that keep the recreational users from being apart of this program

Yes the medical doctor requirements. What you require to obtain a card is not required for any other medication. When I'm hurt or sick I can go to any doctor any time and be seen and get treatment and or get medicine. Also the cost of the card is ridiculous. California is \$66 for non or new residents and \$33 for long term residents. Colorado is \$90 flat. I could go on and tell you the rest of the states fees as

well but I think the point is made on your parts" ADHS" that you guys are in this for the money. \$160 for the card or if you participate in the Supplemental Nutrition Assistance Program it is \$80, How about just make it \$80 flat.

I believe the method the AZDHS has chosen to distribute the licenses throughout the State is flawed. Here are some of the reasons. Prop. 203, as it was passed by the voters, expressly based the number of dispensary licenses to be awarded on the number of retail pharmacies in the State. Recently, the total for the State was 1,249, which, if rounded up would result in 125 dispensaries. Prop. 203 does not expressly state how the dispensaries are to be distributed throughout the State of Arizona. There are two obvious methods that could be used. One would be to distribute them among Arizona's 15 Counties according to the number of pharmacies in each county. After all, Prop. 203 based the total for the state on the number of pharmacies statewide. The other method would be to distribute the dispensaries throughout the 15 counties according to the per-capita population of each county compared to the total for the state. Using either the pharmacy method or the population per county method would have similar results. Although urban areas have more pharmacies per capita than rural areas, the differences are not so great as to make the distribution result significantly different based on the method chosen. In general, using numbers of pharmacies per county slightly increases the number of dispensaries in large urban areas and using population per county slightly decreases the share of the large urban areas and transfers a few of the dispensaries to smaller population counties. In the 2d set of Agency rules distributed by AZDHS on January 31, 2011, they have come up with a different method of distributing the dispensaries. They have used AZDHS's Community Health Analysis Areas (CHAA) and have decided to locate one dispensary in each one of them. There are 126 of these CHAA zones. 19 of them are located throughout the State on Indian Reservations Although I have not seen it in print, I have heard that possibly all of the 19 tribes may allow the State to refrain from locating a dispensary in their lands. I believe that AZDHS is counting on this. The reason I believe this is that in his January 28 posting to his blog, Director Humble stated that individual CHAA districts in Arizona include as few as 5,000 residents and as many as 190,000 residents. If you take into account Indian Reservation CHAA districts, there are 6 districts with fewer than 1,000 residents and 11 with fewer than 5,000 residents. On this basis, I am assuming that AZDHS does not plan to distribute dispensaries to the 19 Indian Reservation CHAA districts. AZDHS has not said whether it intends to distribute 19 additional dispensaries among the non-Indian Reservation CHAA zones in order to bring the total back up to 126. They will likely be required to do something to make up the difference between 107 and at least 125, since Prop 203. specifies that at least 1 dispensary license will be distributed for each 10 pharmacies. Since there are 1,249 pharmacies, AZDHS should be required to distribute at least 125 licenses. Using the CHAA districts as the basis for distribution of the dispensaries throughout the State will result in a radical redistribution of dispensaries from urban areas to rural areas. I have learned, from the AZDHS website, the 2010 population totals for each of the 107 non Indian Reservation CHAA zones. The smallest is Ajo, in far West Pima County which had 4,290 residents. The largest is Maryvale in Phoenix which had 224,678 residents. I divided the CHAAs into two groups. The first is the 54 CHAAs with the smallest 2010 population totals. The second group is the 53 CHAAs with the largest 2010 population totals. Here is some information comparing those two groups. \* The 54 smallest CHAAs have a total of 1,165,676 residents. They average 21,587 residents per CHAA. Their total population represents 18% of Arizona's total non-Indian Reservation population of 6,535,445. \* The 53 largest CHAAs have a total of 5,335,808 residents. They average 100,808 residents per CHAA. Their total population represents 82% of Arizona's total non-Indian Reservation population. \* Under the AZDHS proposal group 1, representing 18% of Arizona's population will receive 54 dispensaries. Group 2, representing 82% of Arizona's population will receive

53 dispensaries. I have also looked at how dispensaries would be distributed among Arizona's 15 counties based on number of pharmacies per county, per capita population per county and distribution by CHAA. As mentioned above, by pharmacy total Maricopa County would receive 80 dispensaries. By per capita population it would receive 75. Since there are 41 CHAAs in Maricopa County, per the AZDHS proposal, Maricopa County would receive 41 dispensaries. Although Maricopa County has 64 % of the State's pharmacies and 60 percent of the population, it would only receive 38% of the 107 non-Indian Reservation dispensaries. Pima County receives a similar percentage of the number of dispensaries whether they are distributed by number of pharmacies, per capita population or by CHAA. The difference between the 80 dispensaries out of 125 that Maricopa County would receive by pharmacy total and the 41 of 107 it would receive according to CHAAs would be distributed to the smaller and more rural Counties. Here are some facts concerning the population totals that would be served by Maricopa County's 41 dispensaries and those of smaller rural Counties.

- \* Maricopa County's 41 dispensaries would each serve, on average, 98,130 residents.
- \* La Paz County is the 2d smallest population County in Arizona. Its population is 21,616. It was one of the Counties that, per Prop... 203 was guaranteed at least one dispensary even though it would not receive one if it were determined by number of pharmacies or by population. Since La Paz County has 2 CHAAs, it would now receive 2 dispensaries which would each serve 10,808 residents.
- \* Cochise County has a population of 140,623. If dispensaries were distributed by number of pharmacies (23), it would receive 2. If they were distributed by population, they would receive 3. Cochise County has 6 CHAAs and will receive 6 dispensaries per the AZDHS proposal. These dispensaries, would, on the average, serve 23,377 residents, compared to the Maricopa County average of 98,130 residents.
- \* By virtue of distribution by CHAA, Santa Cruz County, Gila County, Navajo County and Coconino Counties would each gain dispensaries compared to the distribution by number of pharmacies or population. In each of these Counties, less than 30,000 residents, on average, would be served by the dispensaries the County would receive according to CHAAs. AZDHS could make up the difference between the 107 non-Indian Reservation CHAAs and the 125 dispensaries required by Prop. 203 by distributing 18 or so additional dispensary licenses. The most logical way to do this would be to assign an additional license to each of the 18 highest population CHAAs, so that each of the 18 largest CHAAs would have 2 dispensaries instead of 1. 16 of these additional dispensaries would go to Maricopa County and 2 would go to Pima County. This would reduce to some extent the radical disparity between the treatment of urban and rural areas. The disparity would still be large. If Maricopa County received 57 dispensaries out of 125 as opposed to 41 out of 107, its share of dispensaries would increase to 46% from 38%. This compares to Maricopa County's 60% share of Arizona's population. This would not alleviate the problems AZDHS will be creating by insisting that every tiny population CHAA receive a dispensary license. These problems are discussed in detail below. According to AZDHS figures, Arizona has 6,535,445 non-Indian Reservation residents. Dividing this total by the 125 dispensaries mandated by Prop. 203 would result in an average of approximately 52,000 residents per dispensary. Close to this average would result whether the dispensaries were distributed by numbers of pharmacies or by per-capita population per County. Distributing the dispensaries by the AZDHS CHAA proposal radically revises the distribution so that dispensaries in rural areas will serve far fewer residents than those in urban areas. In my opinion the AZDHS proposal is a clear and blatant violation of the Arizona Voter Protection Act and the provisions of Prop... 203. The fact that Prop. 203 provided that the total dispensaries in the State would be determined by a 1 to 10 ratio clearly implies that distribution of dispensaries throughout the State should be done by the same method. As mentioned above, distribution by per-capita population would yield similar results, with just a few dispensaries being transferred from Maricopa and Pima Counties to several smaller rural Counties. Prop. 203 implied that distribution should be based on number of pharmacies. Moreover, it dealt

specifically with the situation where a small population County might not be entitled to a dispensary because it has few pharmacies. It provided that each County, no matter how small, would be entitled to no less than one dispensary if there were a qualified applicant. Prop. 203 provided that the State total of dispensaries could be increased above the number specified in the law, if necessary to provide at least one to each County. Distributing dispensaries by CHAA flies in the face of the clear language of Prop. 203. If litigation were filed, the CHAA distribution would probably be struck down by a Court, since it flies in the face of the language of Prop. 203 and its effects are so clearly unjust. It is obvious that the reason AZDHS decided to distribute dispensaries per CHAA is that it will spread the dispensaries out throughout the entire State and increase the percentage of Arizona's land that will be covered by "grow your own exclusion zones" of 25 mile radius which will exist around each dispensary. I can understand how many could consider this to be a worthy goal. Even if the goal is worthy, it does not justify such a radical perversion of the intent of Prop. 203. I can see several specific negative consequences of distribution of dispensaries by CHAA. \* Since the urban areas will have dispensaries serving very large populations, those dispensaries will become very large operations. This could be difficult in light of the fact that many if not most Cities and Counties are putting square footage limitations on dispensaries. \* Of the 20 smallest CHAAs, 13 have 2010 populations of less than 10,000. All of the smallest 20 CHAAs have 2010 populations less than 15,000. Some have only the smallest of towns or settlements and may not have commercial suitable space available for a dispensary. Many of these CHAAs are very large geographically with their population densities being extremely low. \* In many cases, because of the very small populations and very low population densities, these low population CHAAs may not be able to support the operation of a dispensary. Many of these dispensaries could fail and go out of business. As they were in the process of going out of business, numerous problems involving patient services, defaulting on financial obligations and others could arise. Having dispensaries go out of business would decrease the stability of the industry and create additional problems for AZDHS to have to deal with. \* Presumably if a small population CHAA went out of business, the "grow your own exclusion zone" would go away and the original motive of those proposing distribution by CHAA would be frustrated. The CHAA proposal is not necessary. There are better ways to distribute dispensaries in a way that would not create such radical distortions. Gila County is a good example. It would receive only one dispensary whether they are distributed by number of pharmacies or by population. Gila County's population is divided, more or less evenly, between Payson in the North and Globe in the South. The road between the 2 towns is over 80 miles. They have a legitimate desire to have a "grow your own exclusion zone" surrounding both towns. Here is a way to solve the problem without creating all of the problems involved with the CHAA rule. AZDHS could write a rule that would allow a County, such as Gila County, to request, based on its particular circumstances, that it have its one dispensary operate out of 2 locations, one in Payson and the other in Globe. It could qualify as one dispensary rather than 2 by operating out of the 2 locations on alternate days and never being both open at the same time. AZDHS would impose a "25 mile radius grow your own exclusion zone" around each location of the one dispensary. Although the dispensary would have increased costs maintaining 2 operating locations, it would be able to share other costs like wages between the 2 locations. A single dispensary operating out of 2 separate limited hours locations would be more likely to survive financially than 2 separately owned dispensaries with larger operating costs. Other rural Counties with large distances separating their population centers could benefit by such a rule. This would satisfy the goal of reducing the area where self cultivation is allowed while avoiding the instability involved with trying to force people to operate dispensaries in locations that are not viable. There will inevitably remain some locations that will not have dispensary locations even with the suggested rule. Even the CHAA rule does not completely eliminate areas where card holders could grow their own. These areas have very low population

density and the number of card holders living in them would likely be quite small. It seems unlikely that many cardholders would move to one of these unprotected locations just so they could grow their own medical marijuana.

I believe the restrictions for the homebound and seniors on a fixed income who have to drive the 25mi. to a pharmacy should be relaxed. In the AZ mountainous terrain being 25mi. from a pharmacy can mean a 50mi just to get to a pharmacy and or 100mi. road trip. Just the expense of gas and the heat of the summer would be an extreme health issue and a financial burden. Seniors and homebound should be excluded from the dispensary rules if they if they have walking problems and are capable of being their own care giver. The people of AZ voted in prop 203 in as humanitarian relief for the infirm. not to make the state of AZ rich. Each case should be judged on its own circumstances.

I think the two part application process is much more realistic. To require use permit at time of original application is just not fair to the average entrepreneur.

The vote on proposition 203 by the people of Arizona is actually a vote of no confidence to the federal designation of cannabis as a schedule 1 narcotic and a vote that it should be treated as any other prescription medication. Hence, the rules governing a cannabis license should be similar to that already established for prescription medications including those that are medically more dangerous than cannabis. Specifically: Section R9-17-202 section G, 11, e iii: it should read "...for providing management and routine care regarding use of cannabis to treat the qualifying patient's...". This is appropriate opening option for marijuana specialists to provide for those whose doctors are not intellectually comfortable discussing marijuana with the patient. This would be similar to a radiation oncologist discussing only the radiation treatment for their cancer while leaving the overall treatment and how it affects a body to the treating general oncologist. Section R9-17-202 section G, 11, e v. There should be no requirement for an "in-person physical examination". Hepatitis C has no specific physical findings other than a positive blood test...as does HIV. Chronic nausea has no specific physical findings. Chronic and severe pain has no specific physical findings. Chron's disease has no specific physical findings. Agitation of Alzheimer's disease. Seizures and muscle spasms have no specific physical findings. Glaucoma should be diagnosed by an eye doctor but any doctor should be able to prescribe cannabis as part of their glaucoma treatment but would not need to primarily diagnose it with a physical exam finding. Not removing this also keeps technology from being used to treat patients. Already, critical care doctors in Israel take care of your family members overnight in ICUs all over the valley using cameras to assess patients allowing local doctors to get a good night sleep. If they can be allowed to order any medication including narcotics in that way, shouldn't an online camera evaluation be allowed. Arizona doctors are allowed to prescribe opioids, amphetamines or any other prescription medication without a physical exam finding requirement nor a physical exam requirement. In all, the requirement for an "in-person physical exam" is not appropriate on many levels.

R9-17-302. Dispensary Registration Certificate Allocation Process. It is still very unclear who will be

awarded a Dispensary Registration Certificate if there is more than one approved applicant in a given CHAA. Wouldn't it better serve the people and the applicants if there was a point process of some sort for selection? Such as; how long has the applicant(s) lived in the area they propose to operate a dispensary from, Who supports their operation i.e. local doctors, health care providers, city officials, local law endorsement, other business persons in the community, Is their business model viable enough to be successful, ext. This way we can all be assured the best operators, with the most community support will be the ones that serve the community they live in.

Just pass something that works, look at Colorado, it hs the best system.

The use of the CHAAs map for dispensary locations is a poor idea. It will force many low income patients located in depressed rural areas to go without their medication, as they will not be able to afford to purchase it from a dispensary. Growing their own medication will be the only way many patients will be able to get the medication they need. Many of these patients are already struggling just to make ends meet.

NOT ONE CASE OF CANCER HEART ATTACK OR LUNG INFECTION REPORTED. THE ADDICTION PART COMES FROM BASICALLY PERSONS STARTING OUT DRINKING ALCOHOLIC BEVERAGES,LIQUOR IS LEGAL. DELETE- DELETE-DELETE ARIZONA DEPARTMENT OF HEALTH SERVICES' WARNING: Smoking marijuana can cause addiction, cancer, heart attack, or lung infection and can impair one's ability to drive a motor vehicle or operate heavy machinery POSSIBLY; SMOKING OR INJECTION OF PRODUCT MAY IMPAR YOUR ABILITY TO DRIVE A CAR OR OPPERATE MACHINERY.

Keeping it away from recreational use

Randomly choosing who can own or operate dispensaries is not a good idea. You will get flooded by groups with the wrong intentions that have a lot of money, submitting multiple applications. This is not good for our communities & not the intention of prop 203.

AZDHS's Community Health Analysis Areas (CHAA) Zones would be devastating business/financially wise to a low population area dispensary!!! Please don't do this!

Patient that meet the criteria required, can not touch all the bases your requesting, thus limiting it's use. If they could run around and get different evaluations etc. they probably wouldn't need it.The rules almost appear to have been drafted to punish a persons use, or discourage this avenue of treatment. I understand the necessity for some or most of these rules, this is not a South American country. As an ex-law enforcement officer, I'm the last person who wants to see civilians hurt unnecessarily due to neglect. Perhaps the law was passed and those opposed to it, now seek to over regulate this substance. I'm sure time will iron out many of the social or legal concerns. Thank you

Allowing a dispensary to be chosen based off a random drawing seems like the wrong choice to me considering the possible outcomes. I think that there has to be a rating method used based on some kind of merits. I think having the town or cities recomendation should be a huge factor in who does get the license. I know there are many organazations that have won town approval already by demonstrating the characteristics they are looking for. There are some organizations that have blatantly gone against the cities & towns they plan to operate in since they feel they have no power in

the process. I know I want upstanding people running the MMJ dispensaries in my area, people known in the community to be good citizens that will lead the nation in responsible MMJ business. Also, there should be more reasonable ways for patients to grow medicine outdoors instead of the current extremely costly walls & coverings listed in the drafts. Chain link should be able to be used with barbed wire on the top without a covering, & with the privacy slats installed. That should be beyond adequate. Greenhouses as mentioned in 203 should be listed as a means of growing besides in homes or expensive fort knox type of walls & enclosures.

REMOVE THE WARNING ON LABELS ABOUT RISK OF HEART ATTACKS THAT'S NEVER BEEN PROVEN Recently in the media there has been a story about the study that shows marijuana raises the risk of heart attacks. ██████████ annual conference in San Diego, showed that smoking marijuana significantly raises the risk of heart attack in people already at risk through heart disease. In response to this ██████████ also of ██████████. said that the study of 37 marijuana smokers was incomplete, and raises questions but does supply answers. ██████████ stated that in 1997, Kaiser Permanente did a large-scale study which included more than 65,000 admitted marijuana users, and they could not demonstrate any impact of marijuana use on mortality. If marijuana use really was a significant risk factor for heart attack, it is hard to believe that it didn't turn up there. ██████████ is one of the world's foremost marijuana researchers and is author of several books including the "Marijuana Reconsidered."

More simplicity , less complicated.

Being randomly selected for an application is unfair, I think the application should be approved to the best person/persons/business plan fit for the application of a dispensary.

The proposal to decide between competing complete applications by lottery is a big mistake. 1. Your rules require applicants to submit some very specific information in support of their request for the right to receive a license. Included are a business plan, security plan, inventory control plan and other items. Your proposed lottery system says that in order to qualify for the lottery an applicant must only submit a complete application. You have no standards to determine the completeness of an application. For example, you could receive 2 competing applications, each of which includes a business plan. 1 business plan could be comprehensive and convincing in terms of its author's ability to succeed. The other could be cursory and unconvincing. Yet each application, under your proposed rules, would be considered to be complete (if it contained the other required items) and would be eligible for the lottery. 2. If you are charging \$5,000 for to apply, you should have the resources to be able to read and evaluate and score the applications received. If you were to receive 2,000 applications, the fees would be \$10,000,000. The refund for an application that makes it to the lottery, but doesn't win is only \$1,000. You should have the resources to do the job properly. 3. If you decide between competing applications based on nothing but a lottery, you will be encouraging people to file multiple applications. I have heard of people who say they may file up to 20 applications. A group of people could split and file multiple petitions as individuals with an agreement in advance to re-join each other if any of the petitions would be successful. You could receive petitions from straw people. You are encouraging fraud. 4. If you are not willing and/or able to thoroughly evaluate and rate the applications, you should require some sort of proof of financial responsibility such as a surety bond or a cash deposit in the case of non-performance. If you are willing to neither evaluate the applications nor sanction non-performance by unqualified applicants who get the right to obtain a license by winning a lottery, you encourage multiple petitions by

unqualified applicants. By granting applications on the basis of a lottery you create a situation where there will be less stability in the industry. AZDHS purports to want a stable and well-run industry. Awarding licenses by lottery does not promote this goal.

I am part of a group that plans to apply for one of the medical marijuana dispensary licenses to be awarded by the Arizona Department of Health Services. I believe the method the AZDHS has chosen to distribute the licenses throughout the State is flawed. Here are some of the reasons. Prop. 203, as it was passed by the voters, expressly based the number of dispensary licenses to be awarded on the number of retail pharmacies in the State. Recently, the total for the State was 1,249, which, if rounded up would result in 125 dispensaries. Prop. 203 does not expressly state how the dispensaries are to be distributed throughout the State of Arizona. There are 2 obvious methods that could be used. One would be to distribute them among Arizona's 15 Counties according to the number of pharmacies in each County. After all, Prop. 203 based the total for the State on the number of pharmacies Statewide. The other method would be to distribute the dispensaries throughout the 15 Counties according to the per-capita population of each County compared to the total for the State. Using either the pharmacy method or the population per County method would have similar results. Although urban areas have more pharmacies per capita than rural areas, the differences are not so great as to make the distribution result significantly different based on the method chosen. In general, using numbers of pharmacies per County slightly increases the number of dispensaries in large urban areas and using population per County slightly decreases the share of the large urban areas and transfers a few of the dispensaries to smaller population Counties. In the 2d set of Agency rules distributed by AZDHS on January 31, 2011, they have come up with a different method of distributing the dispensaries. They have used AZDHS's Community Health Analysis Areas (CHAA) and have decided to locate one dispensary in each one of them. There are 126 of these CHAA zones. 19 of them are located throughout the State on Indian Reservations. Although I have not seen it in print, I have heard that possibly all of the 19 tribes may allow the State to refrain from locating a dispensary in their lands. I believe that AZDHS is counting on this. The reason I believe this is that in his January 28 posting to his blog, Director Humble stated that individual CHAA districts in Arizona include as few as 5,000 residents and as many as 190,000 residents. If you take into account Indian Reservation CHAA districts, there are 6 districts with fewer than 1,000 residents and 11 with fewer than 5,000 residents. On this basis, I am assuming that AZDHS does not plan to distribute dispensaries to the 19 Indian Reservation CHAA districts. AZDHS has not said whether it intends to distribute 19 additional dispensaries among the non-Indian Reservation CHAA zones in order to bring the total back up to 126. They will likely be required to do something to make up the difference between 107 and at least 125, since Prop 203. specifies that at least 1 dispensary license will be distributed for each 10 pharmacies. Since there are 1,249 pharmacies, AZDHS should be required to distribute at least 125 licenses. Using the CHAA districts as the basis for distribution of the dispensaries throughout the State will result in a radical redistribution of dispensaries from urban areas to rural areas. I have learned, from the AZDHS website, the 2010 population totals for each of the 107 non Indian Reservation CHAA zones. The smallest is Ajo, in far West Pima County which had 4,290 residents. The largest is Maryvale in Phoenix which had 224,678 residents. I divided the CHAAs into two groups. The first is the 54 CHAAs with the smallest 2010 population totals. The second group is the 53 CHAAs with the largest 2010 population totals. Here is some information comparing those 2 groups. • The 54 smallest CHAAs have a total of 1,165,676 residents. They average 21,587 residents per CHAA. Their total population represents 18% of Arizona's total non-Indian Reservation population of

6,535,445. • The 53 largest CHAAs have a total of 5,335,808 residents. They average 100,808 residents per CHAA. Their total population represents 82% of Arizona's total non-Indian Reservation population. • Under the AZDHS proposal group 1, representing 18% of Arizona's population will receive 54 dispensaries. Group 2, representing 82% of Arizona's population will receive 53 dispensaries. I have also looked at how dispensaries would be distributed among Arizona's 15 Counties based on number of pharmacies per County, per capita population per County and distribution by CHAA. As mentioned above, by pharmacy total Maricopa County would receive 80 dispensaries. By per capita population it would receive 75. Since there are 41 CHAAs in Maricopa County, per the AZDHS proposal, Maricopa County would receive 41 dispensaries. Although Maricopa County has 64 % of the State's pharmacies and 60 percent of the population, it would only receive 38% of the 107 non-Indian Reservation dispensaries. Pima County receives a similar percentage of the number of dispensaries whether they are distributed by number of pharmacies, per capita population or by CHAA. The difference between the 80 dispensaries out of 125 that Maricopa County would receive by pharmacy total and the 41 of 107 it would receive according to CHAAs would be distributed to the smaller and more rural Counties. Here are some facts concerning the population totals that would be served by Maricopa County's 41 dispensaries and those of smaller rural Counties.

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- Cochise County has a population of 140,623. If dispensaries were distributed by number of pharmacies (23), it would receive 2. If they were distributed by population, they would receive 3. Cochise County has 6 CHAAs and will receive 6 dispensaries per the AZDHS proposal. These dispensaries, would, on the average, serve 23,377 residents, compared to the Maricopa County average of 98,130 residents.
- By virtue of distribution by CHAA, Santa Cruz County, Gila County, Navajo County and Coconino Counties would each gain dispensaries compared to the distribution by number of pharmacies or population. In each of these Counties, less than 30,000 residents, on average, would be served by the dispensaries the County would receive according to CHAAs. AZDHS could make up the difference between the 107 non-Indian Reservation CHAAs and the 125 dispensaries required by Prop. 203 by distributing 18 or so additional dispensary licenses. The most logical way to do this would be to assign an additional license to each of the 18 highest population CHAAs, so that each of the 18 largest CHAAs would have 2 dispensaries instead of 1. 16 of these additional dispensaries would go to Maricopa County and 2 would go to Pima County. This would reduce to some extent the radical disparity between the treatment of urban and rural areas. The disparity would still be large. If Maricopa County received 57 dispensaries out of 125 as opposed to 41 out of 107, its share of dispensaries would increase to 46% from 38%. This compares to Maricopa County's 60% share of Arizona's population. This would not alleviate the problems AZDHS will be creating by insisting that every tiny population CHAA receive a dispensary license. These problems are discussed in detail below. According to AZDHS figures, Arizona has 6,535,445 non-Indian Reservation residents. Dividing this total by the 125 dispensaries mandated by Prop. 203 would result in an average of approximately 52,000 residents per dispensary. Close to this average would result whether the dispensaries were distributed by numbers of pharmacies or by per-capita population per County. Distributing the dispensaries by the AZDHS CHAA proposal radically revises the distribution so that dispensaries in rural areas will serve far fewer residents than those in urban areas. In my opinion the AZDHS proposal is a clear and blatant violation of the Arizona Voter Protection Act and the provisions of Prop... 203. The fact that Prop. 203 provided that the total dispensaries in the State would be determined by a 1 to 10 ratio clearly implies

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- Since the urban areas will have dispensaries serving very large populations, those dispensaries will become very large operations. This could be difficult in light of the fact that many if not most Cities and Counties are putting square footage limitations on dispensaries.
- Of the 20 smallest CHAAs, 13 have 2010 populations of less than 10,000. All of the smallest 20 CHAAs have 2010 populations less than 15,000. Some have only the smallest of towns or settlements and may not have commercial suitable space available for a dispensary. Many of these CHAAs are very large geographically with their population densities being extremely low.
- In many cases, because of the very small populations and very low population densities, these low population CHAAs may not be able to support the operation of a dispensary. Many of these dispensaries could fail and go out of business. As they were in the process of going out of business, numerous problems involving patient services, defaulting on financial obligations and others could arise. Having dispensaries go out of business would decrease the stability of the industry and create additional problems for AZDHS to have to deal with.
- Presumably if a small population CHAA went out of business, the "grow your own exclusion zone" would go away and the original motive of those proposing distribution by CHAA would be frustrated.

The CHAA proposal is not necessary. There are better ways to distribute dispensaries in a way that would not create such radical distortions. Gila County is a good example. It would receive only one dispensary whether they are distributed by number of pharmacies or by population. Gila County's population is divided, more or less evenly, between Payson in the North and Globe in the South. The road between the 2 towns is over 80 miles. They have a legitimate desire to have a "grow your own exclusion zone" surrounding both towns. Here is a way to solve the problem without creating all of the problems involved with the CHAA rule. AZDHS could write a rule that would allow a County, such as Gila County, to request, based on its particular circumstances, that it have its one dispensary operate out of 2 locations, one in Payson and the other in Globe. It could qualify as one dispensary rather than 2 by operating out of the 2 locations on alternate days and never being both open at the same time. AZDHS would impose a "25 mile radius grow your own exclusion zone" around each location of the one dispensary. Although the dispensary would have increased costs maintaining 2 operating locations, it would be able to share other costs like wages between the 2 locations. A single dispensary operating out of 2 separate limited hours locations would be more likely to survive financially than 2 separately owned dispensaries with larger operating costs. Other rural Counties with large distances separating their population centers could benefit by such a rule. This would

satisfy the goal of reducing the area where self cultivation is allowed while avoiding the instability involved with trying to force people to operate dispensaries in locations that are not viable. There will inevitably remain some locations that will not have dispensary locations even with the suggested rule. Even the CHAA rule does not completely eliminate areas where card holders could grow their own. These areas have very low population density and the number of card holders living in them would likely be quite small. It seems unlikely that many cardholders would move to one of these unprotected locations just so they could grow their own medical marijuana.

In today's world of electronic media, it's incredibly important to secure personal data. The draft rules aren't nearly specific enough about how patient, physician, and state records. With the current draft, I would feel unsafe to give out any personal information because of a lack of electronic security measures.

1.Explain what is meant by reviewing a patients profile with the Arizona Board of Pharmacy Controlled substances prescription monitoring program database. Aren't those records confidential and protected by HIPPA regulations. How can a certifying physician access those records? 2. If the certifying physician agrees to assume responsibility for management and routine care of the debilitating condition, why are homeopathic and naturopathic doctors without MD or DO degrees allowed to certify? 3. Current pain clinics do not assume responsibility for management and routine care of a patients underlying condition. They certainly prescribe controlled substance medications. Why is this any different?

As a dispensary applicant and voice for medical marijuana patients we support warning labels on marijuana. But lets make sure we are quoting facts not assumptions. We had opposed to a warning label stating marijuana can cause cancer. When in fact the evidence shows the opposite. CANCER Many people just assume that marijuana is similar to tobacco when it comes to causing cancer. Some will quote ██████████ one of the few American doctors who have been allowed to study marijuana. In 1990 he did a study that stated marijuana has more carcinogens than cigarettes. However, years after that report he was given a grant to further document a connection between lung cancer and marijuana smoking, ██████████ received a very large grant from the ██████████ ██████████ With over 2,200 subjects, the research was one of the largest case control studies of its kind ever! However, to his surprise, ██████████ found the opposite of what he expected. Users of marijuana had lower chances of developing cancer than those who did not smoke marijuana. His studies showed that perhaps the cannabinoids found in cannabis are such powerful anti-cancer agents that they can prevent the development of cancers even in the presence of cancer causing agents. Then in 2003 ██████████ from the ██████████ did a study with cannabinoids injected into the brains of rats with brain tumors. He found Cannabinoids are selective antitumour compounds, as they can kill tumour cells without affecting their non-transformed counterparts. The cannabinoids found in cannabis can not only slow the growth of tumors, they can actually selectively kill cancer cells. In November 2007, researchers at the ██████████ ██████████ published a report showing that the non-psychoactive cannabinoid cannabidiol found in cannabis can inhibit the spread of breast cancer. In January 2008 investigators at the ██████████ ██████████ reported that the administration of cannabinoids halts the spread of a wide range of cancers, including brain cancer, prostate cancer, breast cancer, lung cancer, skin cancer, pancreatic cancer, and lymphoma. Like ██████████ research, the report noted that cannabis offers significant advantages over standard chemotherapy treatments because the cannabinoids in cannabis are both non-toxic and can uniquely target malignant cells while ignoring

healthy ones. Resources of research on marijuana and cancer: [REDACTED]

It would be better to NOT have the initial address in the application but allow the dispensary some period of time after the application and board member's and medical director are approved to come up with a location. Without that, a potential business would be out 80% of the application fee several months rent, renovation fees and employee wages without even being given the opportunity to help people.

what if i live in a condo and have kids? do i smoke in front of them or hows that gonna work since we cant smoke at parks or apartment or condo common areas? so this is going to be only limited to homeowners or patients in nursing homes? price caps need to be put in the rules for dis to charge patients. \$50-60 a ounce should be more than fair for both patient and dis.

nothing in the draft about protecting patients from high prices. if the state wants to tax and make money off MEDICAL marijuana then legalize it and shut up. but the dhs keeps claiming its gonna have the best rules well protect the patients and not try to fill the budget with medicine. smoking areas need changing. what if i live in a condo or apartment. i have kids and cant smoke inside now where do i go? what about if i stay in a hotel up north or in tucson? so your saying if i smoke marijuana for pain management i cant go nowhere? we need a cap on what dispensaries can sell pot for. it needs to be no higher than \$50.00(fifty dollars) a ounce!!! if they dont want to do it then they dont get approved for a license that simple. we need protection from whats happening in other states. theres noway that a non profit dis should sell pot over fifty dollars!!!!

Someone needs to stand up for the physicians. I have seen my neurologist for more than 15 years, the requirements that you are asking from him are offensive! Put yourself in his shoes a moment, medical marijuana is still a federal offense; one which the AMA can still suspend DR. licenses. You are asking him to prepare a statement that says .... 'I've been her doctor for awhile - I monitor her meds - she knows the risks of marijuana - I keep her medical records - she will keep me as a specialist - it is 'therapeutic' for her use medical marijuana - I swear on my medical license that medical marijuana is good for her.' Is your objective to demonize the doctors? You are just shy of asking him to notarize the letter! \*\*REGISTRATION ANNUALLY?!?!\*\* So repeatedly, over and over again you want him to attest to this statement?!?! NOT TO MENTION... I get to do this for the REST OF MY LIFE & him too; if I can keep him! A doctors reputation is on the line; my neurologist is quite admired in the neuro community and I cannot ask him to jeopardize his practice. Are you creating a list of MD's that don't mind the scrutiny? You are making this quite criminal!

ARS 36-2801 et seq.does not authorize any food establishment, aside and apart from a registered dispensary, to be in the possession of marijuana for any purpose, including to infuse medical

marijuana into edible products. ARS 36-2801 et seq. does not authorize a registered dispensary to enter into a contract with a separate food establishment for the purposes of infusing medical marijuana into edible products. Any food establishment, aside and apart from a registered dispensary, that would be in possession of medical marijuana (whether or not subject to a contract with a dispensary) would be in violation of the Arizona and Federal controlled substance Acts. Please carefully consult with your legal advisors before including this provision in the regulations.

The numbers don't seem to play out here. If indeed the allocation of dispensaries are going to geographically distributed based on CHAA's, there will be very large discrepancy between number of dispensaries made available to the populace. For example, Arizona has as of 2009, 6,595,778, which would lead one to think that a pragmatic approach would be to allocate one dispensary for every 53,191 citizens. However, in the Kaibab Paiute CHAA with a populace of 380 there will be a dispensary? And, in N Scottsdale CHAA with a populace of 145,744 there will be one dispensary. Maybe I just need to read the latest draft better, because this can't be a rational direction and makes no sense.

Adhs should not be allowed to have private health information that violates Doctor / Patient rights. Adhs cannot call wallgreens to see what meds someone takes now. Also needing a doctor to act as medical director can cost a dispensary too much thus driving up cost. I feel patient will suffer and regulations out weigh the real need to provide lower cost medication. I feel there should be a class required to qualify the medical director. Nurse practitioners can prescribe most medications, Nurses verify and correct life saving measures daily. Many doctors may be clueless and be directors in order to be certified. Having a name on the marque may help a paranoid public feel better at the expense of the patient. I hope Adhs wont pander to the extremists and regulate costs through the roof. If someone is suffering lets not pour salt in the wound.

The granting of dispensary licenses needs to incorporate some sort of judging on merit. I'd like to know which applicants have the best patient education program, the best quality control, the best medical oversight, the most transparent not-for profit structure, the best cost-control program etc. The citizens of Arizona, whether they voted in favor of this proposition or not, deserve higher standards than simply drawing multiple applications from a hat!

SUBMITTED 02/02/11 10:40PM (HOW CAN THE DRAFT RULES BE IMPROVED) R9-17-202. Applying for a Registry Identification Card for a Qualifying Patient or a Designated Caregiver ... F. Except as provided in subsection (G), to apply for a registry identification card, a qualifying patient shall submit to the Department the following: ... 5. A physician's written certification in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient's application that includes: SECTION 5. SHOULD BE CHANGED TO READ "A written certification dated and signed by a physician within the last 12 months that includes:" (AZDHS HAS NOT PROVIDED ANY FORMAT FOR THE CERTIFICATION AND THE AZDHS HAS NOT CLARIFIED IF A PHYSICIAN'S WRITTEN CERTIFICATION THAT WAS SIGNED AND DATED GREATER THAN 90 DAYS PRIOR TO SUBMISSION OF THE QUALIFYING PATIENT'S APPLICATION, WILL STILL BE ACCEPTABLE, AS SOME PHYSICIAN'S WRITTEN CERTIFICATIONS ARE DEEMED VALID FOR A PERIOD UPTO 12 MONTHS.

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R9-17-108. Notifications and Void Registry Identification Cards I believe a 30 day notice before the card is void is needed. Say somebody is out buying there medication. They think there legal and have a card. They get pulled over and then find out there card is void. Then they get a felony for possession. I think when you guys notify in writing that the patients card is no longer valid. They should have 30 days from receipt of notice, before the card is void. That way nobody is wrongly arrested. Also another thing I wanted to say. There will be abuse of this program. Just like with prescription medications now. No matter how hard you try this will be the case. I fully believe we will have the best medical cannabis law in the country, and other states will copy our model. So the only thing I ask is please try not to make it to difficult for patients to get there medicine. People will get cannabis just to get high just like they do now. Let worry about the health of the sick. Not some average Joe getting high. Thank You.

R9-17-202. Applying for a Registry Identification Card for a Qualifying Patient or a Designated Caregiver ... F. Except as provided in subsection (G), to apply for a registry identification card, a qualifying patient shall submit to the Department the following: ... 5. A physician's written certification in a Department-provided format dated within 90 calendar days before the submission of the qualifying patient's application that includes: REGARDING THE ABOVE SECTION 5. PLEASE ADDRESS WHAT TYPE OF PHYSICIAN CERTIFICATION FORMAT WILL THE AZDHS DEEM APPROPRIATE? REGARDING THE ABOVE SECTION 5. PLEASE CLARIFY IF A PHYSICIAN'S WRITTEN CERTIFICATION THAT WAS SIGNED AND DATED GREATER THAN 90 DAYS PRIOR TO SUBMISSION OF THE QUALIFYING PATIENT'S APPLICATION, WILL STILL BE ACCEPTABLE, AS SOME PHYSICIAN'S WRITTEN CERTICATIONS ARE DEEMED VALID FOR A PERIOD UPTO 12 MONTHS.

However I believe that the use of this medicine should be for mentally ill patients with bi polar disorder or schitzophrinia

Medical Marijuana is a medication and shouldn't be burdened by extra, unnecessary rules that would hinder a doctors ability to use it as a treatment. A primary care physician should not be burdened with the extra paperwork and investigation that the current draft would require, as this extra burden would discourage physicians from utilizing the medication. This current draft will make a person wait for a year to get the medication that they need just because they don't have a years worth of paperwork? seriously? It sounds to me like the panel has an agenda to legislate.

R9-17-306. "Applying for a Change in Location for a Dispensary or a Dispensary's Cultivation Site A. A dispensary shall not change the dispensary's location during the first three years after the dispensary is issued a dispensary registration certificate." What are you smoking to think you'll be able to dictate commerce like this?! R9-17-312. Medical Director Please delete this section! Why would a patient who has seen their own Doctor need to pay to see another Doctor. No Doctor is going to act as a Medical Director for Free, and dispensaries will need to pay them and pas along the expense to patients. This is a ridiculous nonsense and an undue burden on the dispensaries as well as a totally unnecessary expense for the patients! Section B. is the worst part of this, if you want a licensed Doctor to oversee the educational materials and such require dispensaries to have one as a consultant for that purpose. No patient requires two Doctors to take prescription drugs which are many times more addictive, many times more dangerous, and in most cases many thousands of time more deadly than cannabis(see the LD-50 ratings). What are you thinking here, keep it real! You are not acting as agents of KADF (or any other bunch of idiotic hate mongering buffoons), your task is simply making this now legal via state law and very safe by any medical definition (much safer than aspirin and/or tyleno!!) MEDICINE available to the patients with legitimate medical need to have it! Good luck defending these direct violations of the law in court! Dispensary license applications that are not accepted should be refunded \$4,000! How can you call yourself ethical and charge people more than \$1,000 to review an application. \$1,000 is Very steep by any logical and responsible standards! Are you on a dedicated mission to create distrust and hatred towards your agency by the citizens of our state?

There MUST be more stringent requirements to get a license other than you have \$5 grand, you're 21 years old, a 3 year resident, don't owe the governement any money and haven't been convicted of a felony. You'll get every former pothead in the state. NO business is expected to run or could run without a solid business plan and some financial wherewithal. You have specific criteria that you want to see - operations plan, disposal, management, hours, security, etc. - so why can't you just create objective scoring for each of those areas? The highest scoring plans in a designated area is awarded the license. Creating a good business plan doesn't take a lot of money; it simply takes the time of the business owner to think through how they're going to run their business. SCORE offers free consulting on writing a business plan. Does the state really want shuttered dispensaries 3 years from now because they gave licenses to unprepared applicants who didn't have a plan? What a NIGHTMARE!

I think that the draft should be rewritten to not HAVE to hire a medical director, unless the dispensary would like to act as a site where patients can get medical advise on becoming a medical marijuana patient. I think that in lieu of the medical director literature should be given out with every medical marijuana dispensed. The need to hire a medical director doesn't allow for small business to excel (owned and operated by patients or caregivers). Maybe bring down the requirement of a physician being the medical director and allow RNs or even pharmacist to be the medical director. I believe that a medical director being a physician would drive up the pricing of the medicine and the state will not come out of debt.

Your CHAA map is completely outdated, non-applicable and inefficient for this purpose. These

licenses should be distributed based on population, with a minimum of one license per County. Your map is not in accordance with Proposition 203 and will not provide access to medication fairly throughout the state. The fact is, some people will be allowed to legally grow marijuana in their homes. This map will do NOTHING to change the number of individuals that will be growing legal medical marijuana. It is just a way for you to not have to remap your outdated preexisting (or should I say prehistoric) map. This is an unacceptable SHORTCUT and should be changed.

I think that the draft should have a provision for dispensaries that want to cater to patients that don't have great mobility and would like their medicine delivered to their homes, or even just delivered for discretion reasons. (No one wants the whole world to know that they are taking Viagra.) I believe that the food establishment license should be reviewed, a patient or caregiver that has experience in making edible food items would not be able to do so unless they had that license. Not only that but not all dispensaries are going to be able to provide the edible type because they have no way of obtaining that licensing and what do the patients of that dispensary do if they do not choose to smoke the substance?

KEEP THE PRICE'S FOR MEDICAL MARIJUANA DOWN TO NO MORE THAN \$150.00 AN OZ. STOP IMPEDING ON US PATIENTS, WE ARE BIG BOY'S & GIRL'S, WE DO NOT NEED TO SEE A STRANGE DR. FOR ONE YEAR, THAT IS NUT'S, WHO MADE THAT UP ANYWAY'S ? IF PATIENTS HAVE THEIR MEDICAL RECORDS WITH THEM, THAT SHOULD BE ALL THEY NEED, LET DR'S DESIDE, THEY ARE THE DR'S ANT THEY ? NOT THE STATE !!! STOP TRYING TO FIG- OUT HOW TO TAKE US FOR EVERY DIME WE HAVE, YOU SAID NON PROFIT, NOW EVERYONE HAS THEIR HANDS IN IT, TAX, TAX, TAX, WHAT HAPPENED TO NON PROFIT ? MEDICAL MARIJUANA'S TOP PRICE SHOULD NOT GO OVER \$150.00 OZ. PEOPLE BUY GROWING EQUIPMENT IN LARGE QUANTITIES, THAT BRINGS THE PRICE'S WAY DOWN, THEY GET CUT IN HALF, SO DON'T TELL US IT COST \$200.00 TO \$400.00 AN OZ. YOU LIE !!!

It is unfortunate that a patient will not be able to provide their own medicines free of charge if a dispensary is located near them. Health care costs are all ready to high and we do not need to monopolize what has the opportunity to be low cost medications. The restriction against providing your own medication if a dispensary is located near you increases the cost to the patient, provides no benefit to the community, and continues to stigmatize the medication itself.

As I understand it, the initiative provides that a dispensary will have a non-profit structure. By definition, that means that the entity will not have shareholder/owners and the members, officers or directors will not receive income from the entity. The dispensary need not be an exempt organization for federal income tax purposes, but that doesn't diminish the non-profit requirements. Arizona law recognizes only one non-profit entity, the non-profit corporation. There is no such thing as a non-profit LLC or a non-profit partnership. However, under the draft regulations, any "person" can be a dispensary, including a sole proprietor or a partnership. How can an individual be non-profit? Where would the income go? Additionally, he or she would be taxed on the profits, but would be unable to receive the income to pay the taxes. The regulations should be modified to provide that the dispensary must be a non-profit corporation.

I think that BEFORE any rules are established more research needs to be done to find out what has happened in other states. What the benefits have been , to what age group. and what the consequences have been' Who has benefitted, who became addicted,who "abused" etc. I also do not think that rules for growers and rules for users should be in the same bill.

"Requires a statement from a doctor saying the doctor agrees to assume responsibility for the care of the patient's condition and will maintain records of the patient's treatment." This is yet another roadblock that will scare away doctors from recommending and interfere with patient care. They are already responsible for the patients care. Furthermore, I don't need a doctors note to smoke cigarettes or drink alcohol. This is getting ridiculous. Stop it! The people have voted, don't ruin it for the sick, elderly and disabled. \$160 for a card? Those on disability cannot afford it. It should be free for those on low incomes.

This is being set up so that only the wealthy can afford it. Any patient should be able to grow their own. Such discriminatory practices will lead to litigation and false imprisonment.

What about testing? Please read the following article by Curtis Graves. Without testing or limits, we are no better than CA and those who use for pleasure. Arizona voters passed the Arizona Medical Marijuana Act in last November's general election. Perhaps the most interesting aspect of the law is its prohibition against disciplining employees who test positive for medical marijuana without evidence that the employee was actually impaired by marijuana. The evidence linking a positive urinalysis test result to employee impairment is not very convincing. Marijuana metabolites—the chemicals urinalysis detects to confirm marijuana use—remain in the body for weeks. Therefore, it is entirely possible that an employee will test positive even when completely "sober." This disconnect seems to render portions of the Arizona law nonsensical. If you can only discipline an employee for medical marijuana use when you have evidence of impairment, and drug testing can't provide that evidence, then you can never discipline an employee for medical marijuana use. But recent activity by Colorado lawmakers provides a clue as to how Arizona and other states might address this issue. A Colorado legislator plans to sponsor a proposal this year to establish 5 nanograms per milliliter of marijuana in a driver's bloodstream as the legal intoxication threshold for the drug. A motorist suspected of driving under the influence of marijuana would have to submit to a blood test—rather than the more commonly used urinalysis—or face license suspension. Critics argue that the measure is too heavyhanded, citing a lack of evidence that driving while under the influence of marijuana is really a problem. They also point out that the proposed intoxication threshold is more or less arbitrary. But proponents counter that some limit must be set to ensure the safety of other motorists, and that 5 nanograms per milliliter is reasonably indicative of intoxication. It's possible Arizona lawmakers are contemplating a similar measure for drug testing employees. However, if legal thresholds gain traction, there may be another consequence: a legal basis for Colorado employees to argue they were inappropriately terminated after testing positive for medical marijuana. As Colorado's medical marijuana law is written, employers need not accommodate the use of medical marijuana "in any workplace." Because urinalysis can't really tell when marijuana was last used, language such as "in any workplace" is usually interpreted in favor of employers. In other words, if an employee had marijuana metabolites in his or her bloodstream at work, then they were using in the workplace, regardless of intoxication. If Colorado adopts such a measure for drivers, it's only a matter of time before a terminated employee argues that they last used marijuana well before they were subjected to urinalysis, and a blood test would have proved as much. Once technology exists that can determine whether an employee used marijuana within hours instead of days or weeks, terminated employees will use it to their advantage

Hello there.... Be extremely specific when it comes to everything....not just patient status. Everything has been dotted and crossed when it comes to patients and Dr's recommendations. We have yet to see any submittal forms, but everyone needs to know in what capacity they can be

involved. I have hundreds of questions and so do many of my friends who are looking into this industry. But 99% of them have to do with business and working within the industry. I would like to start a delivery service for patients who can't make it into the store. Is this going to be allowed? How far can I make deliveries? Can I deliver for more than one dispensary at a time? How much is this fee for opening delivery service? Is it the same fee as a designated caregiver = \$200?? What if I want to start a recycling business for plant & growing debris? Do I still have to get a registered caregiver status, since the sticks and root mass are harmless after cultivation....or do I get a biohazard certificate since the plants were grown with chemicals? There are literally hundreds of questions. Please start telling everyone about these questions. To tell you the truth, everyone understands the patient and Dr info. We need to understand the industry standards from AZDHS.....what are you going to allow and in what capacity?

1) R9-17-302. Dispensary registration certificate allocation process. Section bi. The plan to select a potential candidate by random method is a VERY BAD idea. There should be some kind of merit system or committee selection to consider a candidate's attributes, such as previous clinical experience with medical marijuana (if any) and the intent of a potential distributorship as to how any of the after-overhead net income will be spent, as the dispensary must operate as a non-profit entity. Merits of the business plan should also be considered. 2) Using CHAA criteria for the allotted number of dispensaries a given community may be permitted to have is not a good solution. This would restrict a medium size community like Casa Grande to have only one distributorship: To balance out this discrepancy, a community should have at least one distributorship per 20,000 inhabitants. In a large patient population CHAA, there is no way a single dispensary could meet the needs of up to 190,000 patients as suggested.

I fail to understand why the residency status was changed from 2 to 3 years. In the end this only hurts the patient. As a BSN RN in the Pain Community for over 20 years I have an excellent business plan that helps our residents living with all forms of debilitating pain. Yet, I will be forced out of the bid for a license because I fall short of the three (3) years now required for residency status. Who are you trying to keep out? Or, rather who are you trying to make win the few slots available? The big out of state company's have the money and resources to get around most anything, and maybe you only want "people brought in from the outside"? I am not someone who just randomly thought of doing this on a whim, I have been working on this for a long time, and while we are all residents, I am the only one that falls short, yet I have a lot to offer this community. I am looking at a long term clinic. If I opened a pharmacy, what would the residency rules be, or what about a Medical supply company? Do you require everyone that opens a business to be a resident for 3 years?

While I understand the need to control and track patients, in my honest opinion the rules requiring finger printing of patients or caregivers violates our basic rights. I think the draft rules would be improved by completely removing the fingerprinting requirement out of all areas of the draft. The draft rules would be benefit from completely removing the 25 mile restriction on home cultivation, as in my opinion the abuse of system that is present in California is the result of the amount of dispensaries and the lack of control over them. Allowing patients to grow their own would not require

them to purchase any medication, which would be helpful for patients burdened with medical bills. I do not want to see the medical marijuana system turn into a business where profit is made off of cancer patients. I think that the restriction placed on obtaining a doctors recommendation will make it very challenging for patients to get referrals from their doctors. The draft rules could benefit from putting more trust in the hands of our doctors lifting some of the restrictions they would face to place a recommendation for a patient.

In these tough economic times people are stretching their dollar as far as it can go. Why put extra stress onto an already stressed budget. People should be able to grow there own Medical Marijuana. It has worked in California and Colorado why cant it work for Arizona.

Section R9-17-302 says applicants will receive a \$1000.00 refund if not selected. Is it really your intention to make a \$4000.00 profit on all applicants not selected? That sounds more like a lottery! Is there a registry some ware for medical directors?

CHAA there needs to be more permits allowed in very high density areas- mainly the phx metro area. or rather than random selection process, a full critique then selection for approval. those of us that apply for a dispensary permit will be spending a large amounts of capital. it is unconstitutional to ask us to gamble such a large amount

If a person goes to the expence to grow his own marijuana which is considerable and several months into the growing period a new clinic opens up he would have to destroy his plants. That would create a hardship for that person. Wouldn't it be fair to allow the growers to complete their grow. There could be standards like the plants have to be picked in 30/45 days.Of course no more then 12 plants and no "baby" plants. This would prevent a lot money spent needlessly.

First starting with Dispensary having Medical Directors. Why should the dispensaries be responsible to have a doctor work there or have on on call. The patient should and is under care from a doctor. The patient should have an on going relationship with the doctor that writes their rec. It would be like if a patient was seeing a pain management doctor. They see their doctor at least once a month to go over any problems that arise. If there are questions or concerns and a facility needs to contact a doctor they should be able to contact the patients doctor with any concerns. This program is a Non-Profit. Lets not forget that to pay a doctor is a very high salary to pay for one thing and on the other this is the doctors responsibility to over see there patients not a dispensary to over see them. What the dispensary should do is have educational material in the facility so that if anyone would like to review informations then they could review. Another thing that I'm seeing is people coming from other states to get a dispensary or to grow. Why are we not having people show were they file their federal and state taxes from for the last 3 years. People are soming here and either they own a house here or they are renting one and using that to say they are residence. This is so unfair to the people that have lived here their whole lives and trying to get one operating. Also, to a lot of people it should be first come gets one stand in line and wait your turn to get one. This is what we have to do at the city planning department. There should be a limit to 1 per person or business . These people coming in with money and corp businesses should not be allowed to just come in and get one. What happens to the everyday famlies that are working very hard applying their pay checks that they earn every

week to make this happen for them. I have worked very hard to make this work for me and my family and at the end of the day whats going to happen to us about getting one. Why is it that you will have to draw if there is more than 1 in an area. It should be first in line waiting and gets there application in should have the chance to get it first, All I'm trying to do is get a place to make sure it is ran in the correct way. There is a Kind Clinics Dispensary that are trying to open up all over Arizona not only here but have them in other states this is not fair to be able to have so many. As for taxes why are we going to be taxed on this now this is medical and we are having to operate as non profit so this can't happen. If this is not accepted Federal how can this be put into play. The FBI is still going to see this as against the law. Something needs to happen. I think that what has happen is that you have taken this law that has passed and are trying to cross a line over the law. I think that things are very hard on the dispensaries but maybe this is what the Health Department and others want to happen. It's no secret that the Health Department was against this law. I think you need to sit down again and go through this draft and put some more lines through it and be more resonable. It seems as what people address you guys went and reworded things more difficult then added this new thing with the CHAA. Why this now is this something that one of your groups are getting together and putting their input into it now. Let's be real and be more understanding. Will a sliding scale be put together for low income people trying to open up a dispensary? That would help it is a Non-Profit

I am a [REDACTED] dissabled person,I live on 674.00 a month. I don't understand only allowing someone that lives 25 miles from a despensery to grow a few plant. I don't have a car to drive....I had a car wreck in 2002 wich was not my fault. My neck was broke and I have pain in my neck and spine. Every month I have to decide werther I buy grocery's or Prescription (Narcotic) pain medication...which is KILLING Me. Finally something comes along that I could grow a few Plant and not have to buy the expensive prescription medicine, I could get off the narcotic's which is a plage in Arizona..With all the abuse that goes on. Because of the luck of the draw some Rich person that opens up a 500,000 dollar despensery in my 25 mile area..denies me the right to grow free Medicine...And I have to pay his HIGH PRICES. So I'm stuck on the adictive Narcotic's because of were I live...If people don't deserver this card it should be,stopped at the Doctor level. Make the people that will profit from this new Multy Million dollar business, be responsible for there new found wealth..Don't penalize the POOR! I am going to call on all DISABLED ARIZONANS to stand up and CONTACT a CIVIL LIBERTY'S LAWYER and NOT BE DISCRIMINATED AGAINST....

25 MILE LAW IS WRONG it DISCRIMINATES AGAINST THE POOR AND DISABLED I am a [REDACTED] DISABLED person..I had a car wreck in 2002 than brock my neck and hurt my spine..I live on 674.00 a month every month I have to choose between food or Costly Prescription Medicine.. These narcotic Medicines are KILLING me ! Not to mention the Plage it's causing our great state of ARIZONA...Because of the luck of the draw some RICH person that gets a 500,000 DISPENSERY in my 25 mile area DENIES ME THE RIGHT TO GROW FREE MEDICINE... Plus who knows what they will charge or the avalibility..If I can't afford my co-pay for insurance. How can I pay the DISPENSERY'S..I do not own a car.. I can not make it to the bus stop because I hurt so bad..I do not have family to be my caregiver I have panic attacks and am afraid to let people in my house..If your afraid of abuse of the recarational drug abusers,the law breakers, let it be CONTROLLED by the RICH DOCTORS that will profit from this New LAW. I contacted a lot of my fellow DISABLED citizans and we Contacted a Civil Liberty's Lawyer and will not be DISCRIMINATED AGAINST.thank you

See response to final question

The allocation of dispensaries is not well thought out or fair in many respects. We are interested in operating a dispensary in the Prescott which is a 57,000 population area. It is showing only "one" dispensary in Prescott but has dispensary licenses available Cordes Junction and the Bagdad/ Wilhoit area and the Paulden area. These areas are now served by Prescott. The people living in these areas travel to Prescott for their medical and pharmaceutical needs. It would be a much more realistic allocation to allow 3 to 4 dispensaries in Prescott than in these outlying areas. There is a reason these areas do not have "pharmacies". The Pharmaceutical companies have determined that it is not economically feasible. Further there is a lack of available industrial/commercial space in these outlying areas. It places an undue burden on a company to attempt to lease or purchase a space in these outlying areas. In addition selecting from multiple applicants through a "random" drawing is also not a "fair" and unbiased method to determine the best applicant. The State is happy to collect multiple application fees and retain \$4,000 of the \$5,000 in fees and turn this into a lottery akin to gambling to obtain a license. A fair evaluation of the "quality" of the applicant should be applied in the case of multiple applicants. In our case we have owned our building( for the dispensary) for over 7 years. Many applicants are leasing with "escape" clauses from the lease. This will not serve the "medical" needs of the public as well as a qualified tenant with larger financial commitment to the dispensary. In the "interest" of serving the public, it would better to place multiple dispensaries in higher population areas where the medical services ( Physicians) are located. This would better ensure the success and monitoring of said dispensaries. Monitoring is another reason to add multiple locations to an existing larger population rather than issue licenses in remote outlying areas.

The intent of the law was for no patient to drive more than 25 miles to obtain his or her Medical Marijuana .There is a great difference, in the rural areas of our state between a 25 mile radius and the actual driving distance. 25 miles radius is as the " crow flies". In many areas of our state, one could drive considerable more miles by road! We live in just such an area, to get to town it is about 35 mile drive by road-- and less than 15 as the crow flies. The 25 mile radius rule should be changed to read driving distance. thank you [REDACTED]

R9-17-202-F5e: How can you expect a recommending physician to assume management of a patients care once they have recommended medicinal marijuana. The medical conditions associated with medicinal marijuana use are complex in nature and require physicians who specialize in these conditions. Not all physicians can manage the care of all patients illnesses. This added paragraph essentially prohibits doctors from recommending medicinal marijuana unless they are prepared to assume primary responsibility for a patients specialized medical care, thus eliminating the medical specialties who were previously utilized. please do not force a recommending doctor to assume the primary management of a patients care just because they are willing to recommend medicinal marijuana. pain management doctors currently do not have to assume primary management for the care of every patient which they prescribe pain medication. Is this an attempt to eliminate the use of medicinal marijuana after the people have approved the law and voiced their opinion? expect law suits to be filed if this added paragraph remains in the established rules.

The rules need to specify a source where individual patients, caregivers, and dispensaries can obtain seeds and/or clones of various strains legally. Also, perhaps an agreement can be made with a few



right to require someone to change to Dr's that might not be up to date on certain types of medical problems. This does not mean that the recommending Dr. does not know that medical marijuana wouldn't be of great help to the patient.

Set a max. amount a dispensary can charge per oz. lower the cost for patient card.

I am concerned about patients not having the ability to produce their own medicine. While dispensaries will be very effective, dispensary prices will be too expensive for many patients. The rules regarding cultivation should be changed to reflect that patients and caregivers will be able to produce their own regardless of where they live. (not sure if this can be changed due to it being in the "language" of the prop.) People should have the option to keep their condition and treatment behind closed doors if they wish. Other states have used "co-op"s that allow patients to gather on common ground and exchange information, techniques, genetics (cannabis strains via clones, seeds), people are required to reimburse one another for materials and time invested but nothing more. If Arizona could revise this rule regarding cultivation, the law would truly be a success in every sense. The state would be able to regulate dispensaries accurately. The state would have the ability to regulate cultivation accurately. Patients, regardless of stature, could have access to medicine.

A three year residency is unconstitutional. I have filed taxes for two years voted in elections worked to make this state a better place I have no criminal record and you are telling me that since I didn't live here 3 years I can't own a non-profit that is against the AZ regulation of residency law. This must be changed to give every AZ resident a equal opportunity.

"only qualified organizations would be allowed into the random drawing" The licensing rules are biased toward preexisting establishments and businesses who can leverage their wealth. A local entrepreneur who would like to start-up an AZ dispensary cannot raise funds to build a qualified dispensary based on only the hope of winning a licensing lottery. An entrepreneur would first need to win a license BEFORE being able to raise the necessary funds to construct the operation. Any resident who wishes to apply for a license should be able to enter the random drawing. Upon winning a license, there would be a set time to leverage the license in order to raise capitol and build the new organization to qualifications. The AMMA should be an AZ small business initiative. The licensing lottery must not be for the few privileged elite and large corporate access alone. Additionally, there should also be a resident bias (Only AZ residents with 3 years residency may apply) in order to keep the wealth distribution in our local economy. The rules for licensing must not be inequitable toward the small Arizona entrepreneur.

I am a Marine Corps veteran and ASU graduate with MS, and I am treated by a VA neurologist. He's been my doctor for 5 years and agrees that marijuana is useful for my symptoms, but says since he's a federal employee he will not write me the recommendation because he could get in trouble. He said I should be able to take my medical record to a civilian dr. to get the recommendation, but who do I go to? I go to the VA for everything, will there be a network of doctors available that work with people like me? How much would it cost for this type of exam?

Adding conditions such as depression, anxiety, ADD, ADHD would all benefit a great number of

patients who are left suffering in the illegal market trying to get their medicine.

Explain how a greenhouse can be used as an "enclosed" area for outdoor cultivation as stated in the law. Change how dispensaries are chosen if there are more than one applying in the same area. It should be based off some type of criteria like who the town or city backs rather than just a random process. Large organizations would have the money to submit multiple applications to try and secure a license where smaller groups would not have the money to do so & compete. I think if a town or city council recommends an organization that should make a difference. Allow patients & caregivers to grow anywhere initially since the dispensaries will not be up & running yet, Then just not renew cardholders that are within the 25 miles of a dispensary

There is a potential conflict between two rules. R9-17-316.D states that a dispensary shall provide a sample to the Department upon request to enable the Department to conduct an analysis. R9-17-321.C.1.b allows the Department to revoke a dispensary's registration certificate if it "...delivers, or otherwise transfers marijuana to a person other than another dispensary in Arizona, a qualifying patient, or a designated caregiver." Since the Department is not a dispensary, a qualifying patient or a designated caregiver, providing a sample to the Department could be interpreted as cause for revocation. Not likely, but possible. You might want to add another exception for compliance with 316.D.

The removal of requirement R9-17-303 Section B Subsection G v. The default status on government issued loans. This should be removed from the draft. Loan status should not forbid participation in a non-profit organization.

i read about the rule change to randomly chose the organisations through a lottery sounds like a JOKE. how do you expect people to put up hundreds of thousands of dollars and months of time to get a REAL business plant and team put together for this industry, then just to leave getting the license all to chance?

REMOVE THE LOTTERY!

Caregivers who are also medical marijuana patients are in unique position to offer their own experience and solutions to new patients. The fee of \$160.00 is prohibitive to many people with chronic illness. A large proportion of those with qualifying conditions are unemployed or underemployed, and some receive disability compensation which is rarely a large sum. Patient fees

should be calculated on a sliding fee scale so that those who can afford to will bear more of the burden than those who cannot. The \$200.00 fee to become a caregiver should also be calculated on a sliding fee scale. Many caregivers live in the same household as their patient. This represents a significant cost to families in which there is more than one patient and or caregiver. In many cases, couples may consist of two patients who wish to have the option of each acting as their partner's caregiver. This would mean fees totaling \$720.00 per household, an amount entirely out of reach for many households.

Several permanently disabled people, some of which could benefit from medical marijuana, receive Supplemental Security Income benefits from the Social Security Administration. This is a fixed monthly income and leaves little room for extra money after rent. If a reduction in application fee is made for patients on the SNAP "food stamps" program, a similar provision could be made for SSI recipients. Having SSI is an automatic qualifier for the SNAP program, but many recipients do not participate in the SNAP program. My fiancée, a possible medical marijuana patient, is one of these people.

treat the medical professionals and pharmacies dispensing marijuana the same as doctors and traditional pharmacies, who prescribe and fill prescriptions drugs much more harmful than marijuana.

If the California Medical Marijuana cards are recognized by Arizona, guess what. Every recreational user in Arizona will be making a trip to California to get their card. It defeats all the processes/safeguards that you have done to date. Please do not let this loop hole go un-noticed in your new law.....

Please consider being more specific regarding the physical distance that a medical marijuana dispensary must be located from any entity serving children including private child care day care facility preschool or "nursery As of now the rules only state that a dispensary must be 500 feet from a school district but this does not include the many private entities that serve children on a daily basis

I really like how you have divided up the city to place a dispensary in each area, however because of all the zoning restrictions implemented by some cities (Surprise for an example) they will not be allowing a dispensary. Between the Landlords and the planning commission's there are only a few spots allowed in any given city.

The initiative is long so if I missed pieces that resolve my two issues - I apologize. The first issue is requiring an MD or DO to be on staff or available via pager. Our physicians are so incredibly over-worked right now - to add this burden to their plate is too much - especially for the rural areas. Instead, I would suggest that a Physicians Assistant or Nurse Practitioner be allowed to also fill that role. If we allow these individuals to operate "mini-clinics" within pharmacies - then they can surely handle this type of responsibility! Second is regarding the seeds or clones for the INITIAL marijuana crop only. People cannot obtain seeds from California, Oregon, Colorado, etc because the seeds cannot be legally transported across state lines (federal offense). Lets face reality...the seeds are either going to have to be obtained from someone who has been growing marijuana illegally within Arizona or obtained from a state that has a legal marijuana law. I see no other way of legally

obtaining seeds or initial clones to start the first crop (immaculate conception doesn't count). Therefore, my suggestion would be that for the INITIAL crop only - no documentation is required. Any seeds or clones purchased within the first 30 days of the license being issued to the dispensary is allowed to be undocumented. Nobody is going to admit to taking seeds across state lines and nobody with half a brain is going to step forward and admit that they have been growing marijuana illegally. So to get documentation under either scenario would be impossible. This initial undocumented will allow a "first crop" to be grown. After that, clones from that crop (or other dispensary crops) will be used and must be documented. Keep up the good work!

It does not seem fair to only allow a dispensary to grow marijuana. There should be an allowance for approved cultivators who are not dispensaries.

Why do I have to buy dispensary weed if I live within 25 miles of a dispensary? First off, I don't want to smoke hydro. I want to smoke weed grown outdoors with organic soil. In other words, I don't want to smoke poison grown by some freak that is a profit monger. What if I live 26 miles from a dispensary and I'm growing my own organic weed and then some other profit monger opens up a dispensary 23 miles from my place? I guess I'm out of luck and I have to stop growing my weed and now donate to this rich idiots cause. I go from spending maybe \$1000 a year to grow my own to spending \$1000 a week to get the same amount I was growing. And I get to smoke poison now, instead of real weed. Plus, if I did have extra organic weed to sale to the dispensary, then I wouldn't even be spending a \$1000 dollars a year to grow my own. Also, if I sale my weed to the dispensary, now the sidpensary has some good weed to sale instead of the poison they are producing. So, the 25 mile rule only benefits the rich, greedy, and power hungry freaks that I refuse to tolerate, let alone do business with. The common person is again being ripped off by the rich because of the 25 mile rule. One more time, smoking poison produced by a dispensary is only going to make me sicker and cost me a ton of money to get sicker. Oh boy! For those who can't do the math. A dispensary will probably sale an 1/8 ounce of weed for approximately \$50. This is \$400 an ounce. This is \$6400 a pound. 12 plants grown outdoors will yield well over 6 pounds (12 plants grown indoors with real soil and lighting will yield 6 pounds also). This is at least \$38000 dispensary dollars. What a trip, the math works. Again, I don't want to smoke hydro, just like I don't want to smoke tobacco (man made poison) unless I grow it myself.

Rules on up-front , non refundable fees are unreasonable. Documenting seed origin, watering , chemical usage , etc. seems to be unnecessary and burdensome. Paperwork for those who do operate a growing or dispensary operatio will be overwhelming.You seem to be more fixated on the fact that somebody might get stoned who does not have a qualifying condition. ANYBODY who wants to get stoned can and already does aquire marijuana . You are NOT adding the easiest or cheapest access. You are only making it accessable to the small minority of potential patients who would not smoke because it has been illegal. Quit acting like you are reinventing the wheel! The voters voted and they did not intend for this to be a giant government operation. I think thew fees to aquire a card are very costly. If I were to be perscribed morphine I would not need anything else to pick up my narcotics.If we are going to treat it like a drug , which the voters mandated , why are we treating it like the WORST drug? Why do the regulations smell of fear? Why are you trying to refight this battle daily? ( I know , it's your job) Keep trying, it is getting better!

people that have a medical condtion like diabetes should be able to grow there own marijuana it would save them money on gas and other essitentials. Plus it would going green itstead of wasting

plastic on the bags they would put the marijuana in. anybody with a medical condition and a doctor's approval should be able to buy or grow.

You'll probably need to come up with another dispensary license allocation scheme. Given how restrictive the requirements for both patients and dispensaries are as proposed, there is no way dispensaries will be economically viable in rural areas or small towns. Maybe if the restrictions on qualifying conditions are significantly relaxed they could be. As things stand though, there won't be enough customers to keep such an operation in the black. I doubt you can force anyone to open a business that will just bleed red ink.

Please don't talk about a 300% tax. Yes, there should be a benefit for the state, but let's not forget that many of us who voted for this law are very ill and many will not be able to afford the medicine - much less a huge tax. We have waited for this law for a long time, and you seem to be dragging it out even longer. This is the second time AZ voters have approved this. Why are we having to wait so long? It was approved in November!!!! As it is, many will not be able to afford to buy an ounce. Believe me, this is NOT for recreational use. WE NEED IT FOR PAIN. And it does work.

1-The draft rules state a dispensary will be chosen randomly if more than one application is received for that CHAA, how can you assure the applicants as well as the public it is a random selection? This is going to cause unnecessary problems. Unless there is a way to make the selections public and very transparent the process will be questioned. Our suggestion would be to leave the decision up to the cities in the CHAA. If three cities are located in the CHAA then let the three cities choose which dispensary model best suits the needs of their CHAA. This will undoubtedly be easier in some cities than others however, it truly appears to be the most beneficial to the communities in which the dispensaries and associated facilities will reside. No offense but a random selection between two applications when one of the applicants could be a native and resident of a city in the CHAA, and the other could be clear across the state applying for the same area or multiple areas just isn't the best option for the community. More than likely one of the applicants would serve the community far better than the other would. 2-Clarify whether or not a patient can assign caregiver rights to a dispensary agent.

Provide a very good channel for the patient with options. Due to so many laws in the state plus the laws of insurance companies it is very difficult to get treatment for chronic pain in this state doctors brush most of us off. If you make it too difficult then no one will participate. And patients won't get the help we need. The next step for a lot of us is to move out.

In regard to my comment above about applying for specific a CHAA, I believe it would be more reasonable and fair to allow dispensary applications to be considered for more than one location.

These rules (understanding that it is still in the earlier stages of draft) are still very lax. I believe, that these lax rules will result in a higher usage rate and a fairly easy way to obtain the ability to use medical marijuana.

R9-17-302.B.2.b States if "More than one dispensary registration certificate application for a

dispensary located in a CHAA that the Department determines are complete and are in compliance with A.R.S. Title 36, Chapter 28.1 and this chapter by 60 days after May 1, 2011 the department shall RANDOMLY SELECT I disagree with the Randomly Select. The selection should include; 1) Applicants ties to the community (CHAA) that they are applying for. As an example we have been long time residents of our community and have been active with the community as business owners supporting our town for over 30 years and are well respected. Our local Chamber of Commerce is in support of our application along with town officials. With this RANDOM SELECTION process you are disregarding all of this. Applications should include letters of recommendations from outside interests and this should be part of the selection process. 2) Also the corporation that we are in the process of setting up includes a medical doctor, a dentist, an attorney and a retired police officer who was certified as the DEA as an advanced narcotics investigator. We feel that our combined experience in the medical field and law field should carry more weight in this process then someone who has NO EXPERIENCE. Therefore the selection process should be based upon the background and experience of the applicant(s). Therefore I would suggest some sort of "scoring system" in the selection process and that some of the scoring factors should include; 1- Letters of recommendations from stake holders within the CHAA (Chamber of Commerce, City/Town officials, other business owners) 2 - The ties that the applicant(s) have to the CHAA that they are applying for 3- The proximity of the current residence of the applicant(s) for the CHAA they are applying for 4 - The Education/Experience of the applicants applying

One of the biggest problems I see is the fact that we are allowing the medical marijuana to be grown and sold or covered in part or in whole by the patients insurance company. It seems to me you are making the rules so difficult that the people who need it will just continue to buy it from the street vendors there by no accomplishing anything that will truly provide for the patient and if anything allowing the illegal use, growing, and distribution to those who really have need for this medication. I personally have chronic back pain and am a regular patient on one of the pain centers here in Arizona. They have me on high doses of narcotics which help the pain for a short period of time but it requires me to take this medication 4 to 5 time a day just for partial relief. I have great concern as to how difficult it will be to discontinue the medications I am on even if I am granted a recommendation for a marijuana card. The pain center will not allow me at this point to try marijuana to see if it will actually provide me with some relief or no. I understand this because the dispensaries are not up and running, one of my fears is someone who has no idea as to my level of pain is allowed to make a decision as to whether or not I qualify under the rules you are setting up now. I also believe that if you have a patient who has been suffering for several years due to multiple wrecks including a hit and run when I was a pedestrian walking across a parking lot that I should have to come in once a year or more just to satisfy someone who again I state is in no position to judge my my level of pain and make a determination as to whether I qualify for something that could be quite effective in managing my pain. I have tried to keep this from being personal but I think that is an impossibility. On the other hand I commend the state, counties, and city governments for there attempt to bring this into law in order to help those who need it.

RE: TIME IN BETWEEN RECEIVING A DISPENSARY TICKET AND APPLYING FOR APPROVAL TO OPERATE: "R9-17-304. Applying for Approval to Operate a Dispensary To apply for approval to operate a dispensary, a person holding a dispensary registration certificate shall submit to the Department at least 60 days before the expiration of the dispensary registration certificate the following [...]" - Allowing dispensary operations 305 days to be ready for inspection is way too long! Now that you have lowered the initial cost of applying for a dispensary drastically by no longer requiring a notice of

inspection before certificate approval, there will be a large increase in the number of applicants! This means that many applicants who didn't get chosen will be eagerly waiting for dispensaries who did get chosen to slip up, so they have a chance of getting grandfathered in. 305 days gives a newly certified dispensary organization too much time to raise money. They should already be ready to start building, construction, and training RIGHT when they get selected for the certificate! It should be something like: "To apply for approval to operate a dispensary, a person holding a dispensary registration certificate shall submit the application for approval to operate to the Department within 75 DAYS after the registration certificate was given." You are allowing entities who do not have enough funds to create an operating dispensary, to get accepted for a registration certificate! Then you are giving them 305 days to try to come up with enough money (if they don't already). This is cruel to the persons who have put in more work trying to open a dispensary and didn't get a certificate.

RE: MEDICAL DIRECTOR: I do see the importance of providing patients with educational information on the risks of using cannabis, but I do not think a licensed physician is necessary to distribute that information. A pharmacist, plant biologist/scientist, or registered nurse may still be overqualified to share this information, but these types of people would make patients feel safer, knowing that they are getting information from a somewhat certified expert. The fact that the medical director doesn't even need to be on-site, and only needs to provide training and information one time a year, AND there is no limit to how many dispensaries he/she can be contracted with, shows me that you also agree that the medical director is somewhat "for show". There are certainly many other people qualified (some, even MORE), than a licensed "physician". Please clarify what a physician is. If a medical director can work with all the dispensaries in the state, why not just appoint a person whom the Department deems qualified to be the Medical Director for all dispensaries? I believe the way you should implement the idea of patient safety and education is to have each dispensary designate a qualified Medical Director who works solely for that dispensary and is on-site or on call during all hours of operation. A qualified medical director could be a pharmacist, scientist (with Ph. D and work relevant to cannabis or other drugs). With cannabis being a federally illegal substance, it is near impossible to prove who is qualified to distribute information and guidance for the patient. Just because you are a licensed physician, doesn't mean you know a thing about cannabis. This is important!

RE: MULTIPLE APPLICATIONS Now that you guys have lowered the initial cost of applying for a dispensary drastically by no longer requiring a notice of inspection before certificate approval, I imagine some persons will want to make multiple applications in multiple CHAAs, so they have a better chance of being selected for a certificate. Are you going to allow this? If not, you should state that each person (or entity, whatever) is only allowed to apply once!

There should be a requirement that if a site is proposed in a CHAA when the application is submitted, the actual location must be in that CHAA, even if the particular location is changed. You have no restriction that the proposed location and the actual location must be in the same CHAA.

Insomnia and depression should be added to that list of ailments that can qualify a patient for a marijuana medical card because they are both serious mental illnesses. A lot of people with those ailments turn to alcohol or pills which are far worse for their health than smoking or eating marijuana. I suffer from insomnia myself and I hate pills and their horrible side effects so that's why I prefer marijuana over anything else because it is a lot safer and natural.

I am a ex-professional athlete and has been living in Arizona for over 14 years now. I use marijuana for my chronic pain from an old injury I had in sports. I do not like to smoke marijuana, I more like to bake with it myself into edibles (butter, cake,...etc). I live in mesa which is a fairly large city so I know a dispensary agent will be within 25 miles from me. I know marijuana from a dispensary is not cheap and to cook with it I waste alot of the herb cooking with it and need to grow my own plants. I dont have the money to keep going to the dispensary every couple of weeks spending hundreds of dollars when I can save so much of my money growing my own plants and using it to make edibles. So can you please change the law on homegrown cultivation? I know many others out there are the same way and cant afford going to a dispensary each week for medicine we need. Using a guideline like having 6 mature plants and 12 immature plants and 1 mother plant, as a starter and be able to have more prescribed from physicians if needed like myself to make edibles. Also the rule for a medical marijuana patients ability to use more than one dispensary. From what it sounds like marijuana dispensaries could possibly run out of strains, especially the more popular ones for medicinal purposes. If a patient goes to his or her dispensary and they have ran out of the strain they desperately need for their symptoms they should be able to go to any dispensary in the state and show their ID card and pick up that strain where ever in AZ is very simple. The process of obtaining a card sounds very difficult so making it even more difficult by just restricting that patient to only one dispensary is uncalled for. The price for acquiring a card should be alot less than \$160, should be under \$100 atleast to make it more affordable to middle class and lower class as well. With all the doctor fees and the money to purchase the marijuana at the dispensary, this will be expensive enough.

I am slightly concerned with the implementation on the CHAA map, as it seems many of the regions will go unused due the inability to comply with the zoning of the local municipalities. A comparison of these areas to local allowable zoning maps for instance, indicates that there is no place for a cultivation facility in CHAA 58, as there is no I-1 zoning there; and there can be no dispensaries as there is no C-O zoning that is not outside of 500 ft from a residential zoned area. I think that this concept need to be reexamined to comply with local zoning ordinances, or local zoning ordinances need to be reexamined to comply with the CHAA's.

what about the people like me who don't take pain medications are you refusing me the right to ask my doctor for a natural pain medication. I'm sure im not the only person out there who doesn't like chemicals. yes I take Anti-biotics but I dont want pain meds. my favorite saying in life is if god put here then there must be a good reason. Marijuana isn't morphine ,its not cocaine, its not meth, its not alchol ,its not heroin. these are all thing that doctors have created not nature!! you can't deny the rights of person to make the choice do I want a chemical drug or a natural drug.

If marijuana is being used for medical reasons, then shouldn't it be distributed by a pharmacist in a pharmacy? The infrastructure is already there.

These sections within R9-17-202. dealing with the Patient Doctor Relationship should be REMOVED: "A statement, initialed by the physician, that the physician agrees to assume responsibility for providing management and routine care of the qualifying patient's debilitating medical condition after conducting a full assessment of the qualifying patient's medical history;" "A statement, initialed by the physician, that the physician: i. Has established a medical record for the qualifying patient, and ii. Is maintaining the qualifying patient's medical record as required in A.R.S. § 12-2297;

To define the twenty five mile distance as a radius from the dispensary is not appropriate. It needs to be measured obviously in driving distance to that location. although [REDACTED] does not want sick folks to grow.. the law passed It is important to be fair to the people of this state and not just listen to [REDACTED]. many of the members of which have a vested financial interest in keeping marijuana criminal. Your use of CHAA areas coupled with the new definition of the 25 mile radius reeks of collusion with [REDACTED], who last I heard was not the voters of this state.

Anything to reduce dispensary costs is important....as the state is already proposing taxing MJ at 300%. A poor person will have trouble buying medical MJ at those high rates. I know that is not your fault or area, but it should help motivate you and staff to not have to high a burden for dispensary owners. They don't need a medical doctor to head their operations or any unnecessary bureaucratic regulations

Dear Mr. Humble, I believe that the period of residency requirement for the applying agent for a registered dispensary certificate should remain at two (2) years AZ residency prior to the date of application. Thank you.

Please reconsider the selection process for dispensary permits. The process should be competitive, rather than random selection. This will ensure the patients are taken care of by the best team available.

I am not sure if you are going to allow the sale of bongs ,pipes or other smoking devices. I also have a problem with the transportation part. If a cultivator has several stops, he will have to carry a lot of maps.

1. I don't see any language for Mental Disabilities, this should be included. 2. The tool you are using for determining distances is outdated, the tool of "as the crow flies" was used by British Sailors to find land. We travel using roads not the airways and there is a huge difference in travel. Example: [REDACTED] Prescott Az to Cordes Junction AZ is 24.38 bird miles but 36.2 miles in people miles (roads) per Google Earth. This really holds true for the dispensary locations. Example: I own a building in Prescott [REDACTED], directly behind my building is a dirt alley and then another industrial building housing a private high school, the distance from building to building is no more than 100', back to back, but from door to door it maps out at over 900'. If a high school student wanted to visit the dispensary he would have to travel the roads not the airways. 3. I read that if my application is denied then all I get back is \$1,000.00 what happened to the other \$4,000.00?, got to think this is a typo?? 4. Your saying that we can't move a dispensary for the first 3 years, way too many variables for

this, like getting evicted or buying a building that just came available, would suggest a move can be made with approval. 5. R9-17-307 #3/#4 I cant see any reason for you to become the IRS, you dont check on the financial security of restaurants. 6. Inspections, they should be random with no pre set time, just like the food industry, run it right or get in trouble. 7. What happened to growing 70 of the cannabis, I liked that rule, without is the balck market becomes stronger. 8 8.

Why don't you put dispensary's" 25 MILES OUT OF CITY LIMITS."

In the new draft rules there was no mention of Visitor cards which was in the original Proposal that was approved by voters, 01/31/11 36-280117. "VISITING QUALIFYING PATIENT" MEANS A PERSON: (a) WHO IS NOT A RESIDENT OF ARIZONA OR WHO HAS BEEN A RESIDENT OF ARIZONA LESS THAN THIRTY DAYS. (b) WHO HAS BEEN DIAGNOSED WITH A DEBILITATING MEDICAL CONDITION BY A PERSON WHO IS LICENSED WITH AUTHORITY TO PRESCRIBE DRUGS TO HUMANS IN THE STATE OF THE PERSON'S RESIDENCE OR, IN THE CASE OF A PERSON WHO HAS BEEN A RESIDENT OF ARIZONA LESS THAN THIRTY DAYS, THE STATE OF THE PERSON'S FORMER RESIDENCE. 36-2804.03 C. A REGISTRY IDENTIFICATION CARD, OR ITS EQUIVALENT, THAT IS ISSUED UNDER THE LAWS OF ANOTHER STATE, DISTRICT, TERRITORY, COMMONWEALTH OR INSULAR POSSESSION OF THE UNITED STATES THAT ALLOWS A VISITING QUALIFYING PATIENT TO POSSESS OR USE MARIJUANA FOR MEDICAL PURPOSES IN THE JURISDICTION OF ISSUANCE HAS THE SAME FORCE AND EFFECT WHEN HELD BY A VISITING QUALIFYING PATIENT AS A REGISTRY IDENTIFICATION CARD ISSUED BY THE DEPARTMENT, EXCEPT THAT A VISITING QUALIFYING PATIENT IS NOT AUTHORIZED TO OBTAIN MARIJUANA FROM A NONPROFIT MEDICAL MARIJUANA DISPENSARY. I am a 71 year old man that would like some way to get my medication when in Arizona. I do not wish to transport through other states or deal with the blackmarket (loard knows what is in it or even if it is of medical quality) Please make some means for receiving a VALID REGISTRY IDENTIFICATION CARD.. Even if their is a fee for the card. Plus acquring medical marijuana from a dispensary means more income for the state of Arizona.(not the bad guys}

Allow license to cultivate without havig to have license for dispensary.

We should make it easier for people to cultivate plants for their own personal use. Making herbal tea out of the cannabis plant is a safe, cost effective way of relieving joint pain, and bypasses the need to inhale harmful by-products of smoke in the process of relieving pain. Thank you.

You need to have Arizona Medical Marijuana doctors to visit home bound people like me. I must be worst then most people. I have a home doctor for awhile now. For blood work, ex-rays,, ect.. All done in my home. These people that can make it to yer clinic aren't bad off as I am. I was approved January 18th 2011. Just need a Arizona Medical Marijuana doctor to visit me. I have home delivery for everything.

Add PTSD

Add PTSD to the medical conditions

your pdf document is color coded to areas.there is no detail as to where the sites may be in your area.also,the 25 mile rule must contain exceptions regarding the ability to travel to said sites. in my case,im on social security disability and own no vehicle.if i live in a rural area there most likely will be no public transportation to an aproved site.thus i feel a waiver should apply to me to grow my own product.taxi fees are unacceptble on a fixed income.i need more detailed info on the terms and conditions of the plan including the option i mentioned above.feel free to contact me and direct me to a place to get the correct [REDACTED]

I know many Nurse Practitioners who work in Pain Management or Palliative care that might need to order and manage patients on this substance. Has anyone discussed the wording changing from physician to licensed health care provider?

ELIMINATE the monopoly or money grab of the 25 mile rule. you are denying patients of there medicine.

The 25 mile rule is restrictive for patients. This either needs to be lowered to (5 or 10 miles), or removed all together.

With respect to section R9-17-202 F (f), and R9-17-203 B (6) and all similarly worded subsections: A qualifying patient issued a patient's card should not have to request permission to cultivate cannabis. This should be automatic upon issuance of the card. Furthermore, in the event that a dispensary goes out of business, any area affected by the 25 mile rule should be automatically expanded if appropriate. No qualifying patient should have to request further permission for cultivation of cannabis: the burden of proof that such a qualifying patient does not meet the 25 mile rule should fall upon the state for purposes of prosecutions. Proof of citizenship should be irrelevant for the purposes of the Act. No statement "pledging not to divert marijuana" should be required. There are already laws forbidding the sale or delivery of marijuana in effect that apply. Therefore this requirement would be superfluous. Fees for denied applications should be refundable.

Come up with a whole new set of rules and regulations. First, everyone who is filing to open up a dispensary, how many dispensaries are going to be allowed to open in the entire state of Arizona? Second straight out how much for the application fee, then the license fee, the locations of these "Dispensaries" if a doctor needs to be on call on on location in the dispensary? How big does the dispensary have to be, where can one actually grow the product, either in their own dispensary or as Scottsdale has said, not within 25 miles of the dispensary. Again the application fee, if an individual or group of individuals want to open one up does that secure a license for the dispensary? The whole draft of rules is really confusing, considering most of these people who want to open up a dispensary say they know all about growing and distributing and also using Marijuana for recreation. How does the AZDHS determine who is and who is not going to receive a license to open one up? Plus all the other towns and cities in each county in Arizona, needs to know how many dispensaries are going to be place? I have a lot of people asking me this because reading all the 56 or 58 pages of this draft, it is like a giant circle where it always goes back to location, location, location, plus where can the growing take place, in or out of the city or town. Does the FDA and Federal DOT have to be in on this as well. We need to have this straighten out and finally addressed to all.

in the draft it says that dispensaries will not start operating until summer 2011 does this mean that

until late fall early winter 2011 no one will be able to get medical marijuana or will patients be allowed to grow for the 1st year?

the draft rules do not give a sliding scale for those individuals on a limited income like disabled veterans. This is an issue I believe should be addressed.

everything

By not over stepping what you were asked to do by the proposition. The proposition clearly assigns the separation requirement guidelines and allows for the individual cities to in act their own additional zoning requirements. Your CHAA zones cross city lines and mix very different zoning requirements. Yes it is quite nice for the department that there are already 126 CHAA zones making it easy to separate 127 possible certificates but this is not about what is easy it is about making rules to implement the proposition not add to it. I.E. The cities can add additional zoning affecting where the sites can be as per the Prop but there is nothing that says the state can... . The state does not have the authority to say where these go outside the guidelines passed by the voters of the state. It is also disturbing that some form of the cultivation linked to dispensaries did not make it into the draft. The 70/30 element allows for only professional business operators, not all wealthy, to enter the market. These are the types of people and the level of intelligence it seems the Department and the cities are looking for to minimize any negative impact assumed with the industry. Opening the door... this door is contradicting all the efforts of policy makers and allowing for another Colorado. The operators involved should have an element of control over every aspect of the operation to ensure the objectives of the governing bodies. Per reviewing the first draft rules comments and documenting what several members of the AMMA were looking to change it is as though some of the rumors are true as the items they wanted removed were removed. Knowing also other items were added outside of their knowledge will hold up as impartial as long their reaction doesn't materialize again in the next draft.

It seems that a number of patients stop going to their pain doctors after they are told that outside of pain medication, there is nothing else the doctor can do except to continue pain medication. I don't want to spend \$75 for each visit (times 4) to my doctor to just have him tell me he can't do any more for me. I have prescriptions for strong pain medications for my constant back pain including narcotics. I also have a spinal stimulator implanted that doesn't do much. I will have to go to this doctor 4 times a year to have him be able to write me a letter of recommendation for medical marijuana. I would have to continue to see him 4 times a year to just qualify for the next year's license. It would seem that the new law should contain an exception to people that are taking strong medication for their pain but can't afford to see a doctor 4 times in a year just to be able for him to recommend marijuana.

I have cronic pain that surgery did little to improve so this suggestion does not apply to me. I would like to know why PTSD is not a valid reason. If the armed forces will discharge you for this medical reason how can we deny these individuals medical assistance. Marijuana is extremely effective at treating PTSD. Patients suffering from this disorder suffer from panic attacks and other symptoms that medical marijuana can help. I do not understand why the refusal to help these individuals.

I am a prospective patient, but I am wondering why I should have to pay 160.00 to register. A smaller fee would be acceptable and more reasonable. I am not required to pay a registration fee to pick up my prescription of Vicodin.

I think that a medical director shouldnt have to be a physician. There are plenty of other healthcare professionals who would be perfectly acceptabel in this role. Not just physicians. Also a big big part is nowhere in the rules have you addressed paraphenalia. Pipes, papers, vaporizers, etc etc. Yes we cant get in trouble for possessing our allotted amount of medical marijuana but can we still be arrested or fined for paraphenalia possession? This is a HUGE are that needs to be addressed.

Please provide a provision for non affiliated cultivation sites for those of us that do not wish to sell medical grade marijuana to individuals. I have no desire to sell marijuana to individuals nor do I have a need to use marijuana. I am not trying to grow marijuana on a large scale. I see no need to cultivate more than 20 - 25 plants. There are others who wish to grow on a large commercial scale measured in acres.

There are probably a few areas the rule that stands out to me is the random selection of a dispensary applicant if there are more than one applicants in a particular zone. I know a random selection process would be easier for the department, but the fact is a random selection doesn't ensure the best applicant. I would think the state would want the most qualified applicants now a randomly selected one.

I have spoken with a law firm and confirmed that it would be illegal and complete discrimination to require any amount of residency for starting a business period. There is no way around that. I understand what is trying to be avoided, but that can be done by the background checks. I am a [REDACTED] that is not an Arizona resident, but I will be applying for a dispensary license. If I am denied my license for not being a resident, I will file a law suit immediately. I have already started investing in the set up and operations management, etc... There is no legal reason that I would be denied. So my one problem so far is the residency issue. Thank You

Medical director. Even with all the comments you received there seems that none were taken seriously. No definition of exactly who qualifies as a medical director, the the glaring omission of having Pharmacists as medical directors. A physician has little or no real skills in this area. Foolish and arbitrary requirement the way it is presented. Pharmacists would be a much more natural director as this is what they already do every day.