Do you have any specific language to improve the rules? Please include where the language could be incorporated.
Open-Ended Response
R9-17-316. A.3 Needs several improvements: 1. No substances themselves "cause" addiction; substances can be addictive, due to inherent genetic and environmental predispositions of an individual. 2. "Smoking marijuana can cause addiction" should be changed to "Marijuana use can become addicting" since the current sentence structure seems to imply through omission that smoking marijuana is somehow more addicting than other methods of consumption (e.g. vaporization or edibles). 3. "Smoking marijuana can cause ... cancer" should be changed to "Marijuana smoke contains carcinogens" since there are anti-cancer cannabinoids present in marijuana that may prevent marijuana smoke from causing cancer in certain (i.e. marijuana smoke only) instances. Additionally, vaporization, which is similar but not the same as smoking marijuana can cut down on carcinogens. 4. The word "cause" in the other parts of this statement should be changed to "may lead to increase of ..." since it's not entirely scientific valid use the word cause; causation DOES NOT always equal correlation! 5. The last part of the sentence about driving should be associated with any form of marijuana use. Eating edible products is a much stronger high than smoking or vaporization. In all, the sentence would read "Marijuana use can become addictive and can impair one's ability to drive a motor vehicle or operate heavy machinery; marijuana smoke contains carcinogens and may lead to an increased chance of heart attack and lung infection." R9-17-108.A.1.b.iii should be changed to "... is using the medical marijuana not as recommended" since inappropriately is not easy to define and may be subject a doctor's own biases.
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 the law we voted for was originally penned!
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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 Commerceâ€™s Business Luncheon on February 17,2011, AZDHSâ€™s main motivation behind the current system of choosing a lottery system was to â€œensure an equal opportunity a license award for those individuals who have money and those who do not have moneyâ€. 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 critera 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.

R9-17-303 A -1 A principal officer or board member may only serve for one (1) entity with an active Dispensary Registration Certificate. (This will limit the multiple applications from the same entity or different entity with same officers. Without this language and with only 124 licenses and a lottery system, you will ensure that the deepest pockets, regardless of best qualifications or intentions, will receive a license.)

YES! First and foremost, I want to start by commending you and your team for your continued effort to revise the draft rules and your dedication to public service as exemplified by the 2nd draftâ€”you listened to what the public had to say! Iâ€™ve studied the Medical Marijuana Act thoroughly from different perspectives. Iâ€™ve waited until now to ask the questions that have not been answered in addition to offering my input. Iâ€™ll start with the questions then move on to my recommendations and suggestions. Question 1. Will one entity be able to acquire more than one dispensary license? orâ€” Question 2. Would the entity have to file under a different name, different principals and different board members? Question 3. Can you have a licensed dispensary in one CHAA and your cultivation site in another CHAA? I feel the following recommendations are consistent with the current draft rules and are crucial to the success of the Medical Marijuana Act in Arizona. SECTION ON ALLOCATING A DISPENSARY CERTIFICATE The Department should modify R9-17-101 (4) to specify the quantity or number of plants in a batch (underlined indicates language to be added; strike-through indicates language to be removed): 4. "Batch" means a specific lot of medical marijuana containing twenty-five plants grown from one or more seeds or cuttings that are planted and harvested at the same time. Someone will suggest numbering each plant in order to accurately track inventory from the time the seed or cutting is planted to the time it is dispensed. It may be suggested to modify the definitions in R9-17-101 (4)-(5) replacing â€œbatchâ€ with â€œplantâ€ and replacing â€œbatch numberâ€ with â€œplant numberâ€ throughout the rule. Plant numbers are a great idea, but you still want to keep them in a batch as it is defined above and identified using a batch number as defined in R(-17-101 (5). I believe tracking on the individual plant level will provide statistical data to be analyzed over time making it beneficial to the business. Itâ€™s also practical when acquiring product from a designated caregiver or qualifying patient, but it is impractical when

applied to another situation. Hereâ€™s an example: I work at a cultivation site that provides medical marijuana to multiple dispensaries and food establishments which makes the shipments significantly larger than what you would dispense to a qualified patient or caregiver. 1.) I plant two batches (25 plants = â€œbatchâ€ as defined above for a total of fifty plants) and each batch is numbered and data is logged according to R-17-315 (B) (4) (a)-(e). 2.) Each of the 25 plants in the batch are also numbered for accurate tracking of inventory (males removed, failed plants, number of females grown to maturity). 3.) During the Harvest each plantâ€™s product is weighed. This along with other required data is recorded as defined by R-17-315 (B) (4) (f)-(h). Then all of the product for that batch is placed in one hopper (hereâ€™s where the plant number ends) mixed. 4.) From here the product is weighed and packaged for shipment to another dispensary or food infusion center requiring large quantities. Are you going to assemble large packages plant by plant? Will you have the space and more importantly the time necessary to keep the product of each plant separated until dispensed? It doesnâ€™t matter if youâ€™re inventory system is manual or electronic. The effort required to commit fraud is the same regardless which type of system used. R9-17-303 (B) (3) (b) reads: b. An attestation signed and dated by the principal officer or board member that the principal officer or board member is an Arizona resident and has been an Arizona resident for at least two three consecutive years immediately preceding the date the dispensary submitted the dispensary certificate application; Are you taking the applicantâ€™s word for it? Require members to supply an Arizona Tax Return for the previous three years. All documents you allow for current residence verification can be easily forged or fabricated. This is a fact. It's much tougher to duplicate a State tax return w/ W-2s attached. Not impossible, but very tough on short notice--especially if you are not from Arizona. You would first need to acquire a copy of an Arizona residents return. Then you must to have skills. Proof is required to prove youâ€™re a current Arizona resident. Why wouldnâ€™t you follow suit regarding the three year rule? You must provide one of the following listed documents to prove you are a current Arizona resident under R9-17-303 (B) (3) (d) as stated below. d. A copy of one of the following containing the principal officer's or board member's name and current residence address: i. A non-expired Arizona driver's license; ii. A non-expired Arizona identification card; iii. A current lease agreement; iv. A mortgage statement for the most recent tax year; v. A tax statement issued by a governmental agency for the most recent tax year; vi. A utility bill dated within 60 calendar days before the date of the dispensary application; vii. A paycheck or statement of direct deposit issued by an employer dated within 60 calendar days before the date of the dispensary application; viii. Current motor vehicle, life, or health insurance policy; or ix. Any other document that demonstrates that the principal officer or board member is an Arizona resident; Insert two additional requirements in R9-17-317. (D) (1)-(4) to read: D. During transportation, a dispensary agent shall: 1. Carry a copy of the trip plan in subsection (C)(1) with the dispensary agent for the duration of the trip; 2. Use a vehicle without any medical marijuana identification; 3. Have a means of communication with the dispensary; and 4. Ensure that the marijuana, marijuana plants, or marijuana paraphernalia is not visible; 5. Vehicles used to transport marijuana must be equipped with a tracking system (GPS) and the ability the disable the vehicle via remote in the event the vehicle is hi-jacked or stolen. Insert additional security requirements in R9-17-317. (G) (1) (c) (viii) shown below: viii. Video cameras and recording equipment with sufficient battery backup to support at least five minutes of recording in the event of a power outage; Add: R9-17-317. (G) (1) (c) (ix) ix. Facility must be equipped with backup power generator capable of providing power necessary to operate the security system, computer systems and backup emergency lights.

I believe that there needs to be a scientific study of the effects of the substance and the long term study of chemicals in marijuana and how they affect the persons health over years of patient use.
Limit the number of prescriptions for medical marjuana that can be written in one year to 100 by each doctor.
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
Yes: Marijuana is illegal. That should go in the title.
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
R9-17-317(H) (add): â€œA dispensary shall have only one public entrance and shall have a separate secure entrance for deliveries of all marijuana, marijuana plant, and marijuana paraphernalia and may have as many secure emergency exits as are necessary to for the safe operation of the dispensary.â€ R9-17-101(15) (modify): "Enclosed" means: a. A building or greenhouse with four walls and a roof or an indoor room or closet; or b. An area surrounded by four solid 12-10 foot walls constructed of metal, concrete, or stone that prevent any viewing of the marijuana plants, with a one-inch thick metal gate and a barrier covering the top of the area that is: i. Translucent roofing material, comprised of any or a combination of the following; Polycarbonate, Acrylic, Corrugated Vinyl Resin, Plexiglas Acrylic, Corrugated Fiberglass with a nominal thickness no less than 1.2mm. R9-17-303(B) Insert: (9) A letter from a licensed financial institution indicating that the entity applying for the license has an open account with not less than $500,000.00 in cash (this is an estimated average cost 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) in an account. The letter must be updated one time and provided to the Department at the time the Department requests it prior to final approval of any Application. If the letter is not timely updated pursuant to this section then the application will be deemed incomplete. Rule R9-17-303(B)6: The dispensaryâ€™s by-laws containing provisions for the disposition of revenues

and receipts including: a. a description of the formula used to calculate excess revenues and receipts totaling the amount that will be donated to a local charitable organization b. the identity of a local charity, medical research institute, or other philanthropic community based organization that will benefit from the dispensaryâ€™s donations of excess revenues and receipts
!. 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.
!. 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.

See "How can the draft rules be improved" for full comments.
R9-17-302 B (b) ...the Department shall accept competitive bidding among all complete and in compliance applicants in a specific CHAA in increments of 7% excise tax payable to the State General Fund. The successful bidder shall be entitled.to reduce the amount of excise tax by the amount of tax imposed by any other taxing entity.
Not specific language, but it really should be clarified that it is okay to operate as an LLC, with appropriate nonprofit bylaws. It would be unreasonable to wait until the final draft before revealing something that indicates a preference will be given to one entity structure over another. In fact, it would be very much appreciated by many stakeholders if DHS would outline a clear set of rubrics by which applications will be judged. A lot of people have expressed that the CHAA / lottery combination is not the best idea available.
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
R9-17-101(15) (modify): "Enclosed" means: a. A building or greenhouse with four walls and a roof or an indoor room or closet; or b. An area surrounded by four solid 12-10 foot walls constructed of metal, concrete, or stone that prevent any viewing of the marijuana plants, with a one-inch thick metal gate and a barrier covering the top of the area that is: i. Translucent roofing material, comprised of any or a combination of the following; Polycarbonate, Acrylic, Corrugated Vinyl Resin, Plexiglas Acrylic, Corrugated Fiberglass with a nominal thickness no less than 1.2mm. R9-17-317(H) (add): â€œA dispensary shall have only one public entrance and shall have a separate secure entrance for deliveries of all marijuana, marijuana plant, and marijuana paraphernalia and may have

as many secure emergency exits as are necessary to for the safe operation of the dispensary.â€ OR (whichever section DHS deems more appropriate) R9-17-320(E) (add): â€œA dispensary shall have only one public entrance and shall have a separate secure entrance for deliveries of all marijuana, marijuana plant, and marijuana paraphernalia and may have as many secure emergency exits as are necessary to for the safe operation of the dispensary.â€ Rule R9-17-303(B)6: The dispensaryâ€™s by-laws containing provisions for the disposition of revenues and receipts including: a. a description of the formula used to calculate excess revenues and receipts totaling the amount that will be donated to a local charitable organization b. the identity of a local charity, medical research institute, or other philanthropic community based organization that will benefit from the dispensaryâ€™s donations of excess revenues and receipts
Reduce the cost
No comment.
See language in questions #2
The language is fine. It is the content and flavor of the draft that is bad. It does not sound as if the state is trying to help sick people but instead trying to control us instead. Are you sure you don't need to tattoo a number on our arms?
Our planned community association is very concerned about qualified patients smoking marijuana on our common areas. Therefore we submit that "common areas of planned communities" be included in definition of "public place". This affects all of the common areas in planned communities throughout the state. Draft Rule R9-17-101(21)

You need to address delivery from dispensaries and caregivers to patients ,and caregivers and patients taking their excess medicine to dispensaries. Delete the requirement for a medical director. We are already collaborating with another group which includes a number of Doctors and plan to form a class action lawsuit if you do not cast out this ridiculous position that medical marijuana requires more restrictions that codeine, Oxycontin, adderall, little alone alcohol! This is an absolutely ludicrous position and you must realize that you will fail abysmally to prove it remotely necessary!
Add Depression, Anxiety, appetite loss, and 'any that a doctor determines is appropriate' to the list of qualifying medical conditions. Scratch the 70% requirement for dispensaries regarding their inventory and cultivation. Allow free market principles to govern the MMJ market in our state.
I spoke on February 16, 2011 at Tucson, AZ and addressed the panel to lower the age limit from 21 to 18. But instead I would propose the age requirement be lowered from 21 to 19. For the reason of comparing this to the service and selling of alcohol in Arizona. As it says in the DLLC website (link provided below), â€œNineteen years of age for an on-sale establishment and nineteen years of age for an off-sale establishment that sells primarily spirituous liquor [A.R.S. 4-244(10)(11)].â€ Also I would like to point out, it would eliminate high school students from applying for the certificates and identification cards. [redacted]
Some general comments before I get into the specifics. I want to thank the panels this last week for their commitment into the evenings to listen to public comment. I will also state that whichever the direction the State of Arizona decides to go for the final rules I would recommend special consideration of the industry laws that will apply. In the example at the Tucson session there was specific references to the recommendation of existing ARS inclusion of Agriculture and OSHA standards for cultivation. Recommendation, seek to use as many existing Arizona Statues as reasonably possible. Keep enforcements cost down. We are of the opinion this is patient driven business but the State should be able to make income to sufficiently provide for enforcement growth and regulating the industry expansion. Since this is a Medical operation and there will be Medical Records I would recommend changes that support HIPPA compliance, as well as, DEA guidelines in regards to electronic prescriptions. Although the Marijuana recommendations are not prescriptions there are electronic medical record solutions I believe this industry can adopt. An example is [redacted] This is a free service for doctors and provides a centralized record keeping system for doctors and patients. I believe it would be in the industry and the stateâ€™s best

economic interest to provide rules to Physicians that aide them in qualifying for American Reinvestment and Recovery Act funds under the meaningful use rules for electronic medical records for Medicare and Medicaid. If not this round the next. From what I watched in Phoenix and then in Tucson patient affordability of medication is a concern, I am expecting the demographics of the majority of patients fall under Medicare / Medicaid but today this is only a theory. In summary, whatever our endeavors are in working with the state we want to ensure our risk is mitigated at the Federal Law Level as much as reasonable possible when considering a state law. Thank you for all your teamsâ€™ efforts. R9-17-101Definitions Recommended definition additions: Caregiver, Caretaker Qualifying patient Healthcare worker R9-17-102 Fees Recommendation is for a lowering of the feeâ€™s for patients be considered. The dispensaries are non-profitsâ€™ they should be able to bare the burden of cost subsidy but not for the first year as these new ventures get up and running. As well patients will go multiple quarters without the ability to use their recommendations until the first crops arrive. R9-17-103 Application Submission The department provided format needs more information, the state needs to release a draft of all areas where â€œdepartment provided format is listed in the current draftâ€. As the information systems are designed this information is needed to build databases, interface with records systems and developing the portal to comply with the rules. R9-17-107 Time Frames Please clarify the agencies where communications should be directed for a dispensary is ready for the inspection. Clarification or a checklist is what is required is also anticipated in this request. We would also recommend having the Agriculture agency participate in the cultivation inspections. R9-17-301 Individuals to Act for a Dispensary Regarding Requirements Department provided format release recommended. R9-17-302 Dispensary Registration Certificate Allocation Process I called AZDHS on Thursday and when I asked regarding the Business Entity for a dispensary the office told me emphatically a non-profit. Non-Profit law in concert with IRS is complicated and we are working our way through but this section seems conflicting with Non-Profit organizations. Specifically section â€œAâ€. R9-17-303 Applying for a Dispensary Registration Certificate Plenty of other comments here from the public, we are not in support of a lottery system. We believe that although it is a low cost alternative for the State to allocate the License but it not in the best interest of the public to allocate these license. Additionally, we believe the lottery creates an opportunity for corruption and unfair practices. We are in support of the AMMP recommendations for liquidity and net worth minimums in line with a franchise model. The amounts should not be restrictive to eliminate mid-market entrepreneur but high enough to ensure ongoing operations. I would suggest considering ARS statutes that incorporate Franchise law elements. I have not done the research here this is a hypothesis for a solution. R9-17-304 Applying For Approval to Operate a Dispensary R9-17-305 Changes to a Dispensary Registration Certificate R9-17-312. Medical Director We would propose the Medical Professional also be required to ensure all prescribing physicians be required to have access to a centralized database portal with 24/7 user authorized access requiring all prescriptions are entered into the system specifying the dispensary of choice in order to regulate patient usage. R9-17-314. Qualifying Patient Records The very nature of Prop 202 is a healthcare application and the state should be considering how this becomes Electronic Health Records System which could give the state access to the American Reinvestment and Recovery funds. I believe the cards issued to patients should leverage the states investment in the Motor Vehicles system card based system to aid in the data collection process. This would also leverage existing states investment. Governance, Risk and Compliance (GRC) are the primary drivers to solve with a complete archiving solution. You can achieve this with a solution that increases your end-usersâ€™ operating efficiency, solves their regulatory compliance concerns and decreases their costs of electronic disclosure. I would propose the consideration of compliance with Federal Rules of Civil Procedure to Electronic Stored Information to show good faith toward the Federal Mandates. The term has

become a legally defined phrase as the U.S. government determined for the purposes of the FRCP rules of 2006 that promulgating procedures for maintenance and discovery for electronically stored information. Electronically stored information, for the purpose of the Federal Rules of Civil Procedure (FRCP) is information created, manipulated, communicated, stored, and best utilized in digital form, requiring the use of computer hardware and software. Recommendation: Provide rules that comply with HIPPA, FRCP, and Meaningful Use requirements and open the doors to physicians for application for meaningful use funds for medical records. R9-17-315. Inventory Control System We recommend a specific amount of 1g weight be implemented for tracking inventory tracking purposes with clarification on acceptable disposal methods. The 2006 production report of seized marijuana I have talks about seized plants which consisted of billions of dollars estimated street value even though it was primarily male plants which will cold be a majority portion of the disposed remnants. I would recommend a SOX compliance statement on record keeping be referenced as a guideline for tracking inventory. Initial acquisition of seeds and cuttings is going to be very tricky here for the State to Avoid breaking Federal Law. I would recommend the state work with the DEA in determining the method for acceptable acquisition of initial production. In the interest of the patients waiting to fill their recommendations I would recommend the State considers a method to import for the first 90 days to bridge the gap for initial inventories to meet demand. We also recommend a tax guidance range to aid in the development of the business plans. R9-17-316. Product Labeling and Analysis We propose a State Requirement for a bar code identification and data collection system required for cultivation sites and items sold at a dispensary. â€œThink seeds to cash" traceability with automation requirements with 24/7 access with local, state and federal access similar to video Surveillance. R9-17-317. Security Clarification regarding contractor requirements to enter building needs to exist. Recommendation that a statement not requiring contractors like electricians, city workers, police, outside security, and similar type of short term contract workers be required to enter the property. Dispensary and cultivation site owners should be prepared to be audited and with documented visits for Non-Card Holders. R9-17-318. Edible Food Products We agree with the statements made in the Public Comment session that edibles require are larger amount to be consumed than smokers but this needs to be medically proven and dosage difference guidelines published. Our recommendation for the State is to go with the original recommendation of 2.5oz to establish a baseline with consideration in the future once empirical data is made available to State satisfaction increasing the amount. R9-17-320. Physical Plant More specific clarification to avoid unhealthy working conditions should be clarified. Potentially existing agriculture statues for the State. Agriculture is in our roots in AZ letâ€™s have the professionals guide the industry here to ensure consistent quality product and safe working conditions. R9-17-321 Denial or Revocation of a Dispensary Registration Certificate/ R9-17-321 Denial or Revocation of a Dispensary Agent Registry Identification Card We spoke on February 16, 2011 at Tucson, AZ and addressed the panel to lower the age limit from 21 to 18. But instead I would propose the age requirement be lowered from 21 to 19. For the reason of comparing this to the service and selling of alcohol in Arizona. As it says in the DLLC website (link provided below), â€œNineteen years of age for an on-sale establishment and nineteen years of age for an off-sale establishment that sells primarily spirituous liquor [A.R.S. 4-244(10)(11)].â€ Also I would like to point out, it would eliminate high school students from applying for the certificates and identification cards.

[redacted]

ARTICLE 1. GENERAL R9-17-101 Definitions 25. â€œMedical Marijuana Infusion Facilityâ€ means a facility that incorporates medical marijuana by means of cooking, blending or incorporation into

goods and products or the like. This addition of the definition allows for infusion of many different types of products and doesnâ€™t limit it just to food products. ARTICLE 3. DISPENSARIES AND DISPENSARY AGENTS R9-17-309. Administration A. 1. c. v. Disposing of unusable marijuana, which may include submitting any unusable marijuana to a local law enforcement agency or medical marijuana infusion facility. Infused products can contain medical marijuana that are not usable by a medical marijuana dispensary, but are still good for use by a medical marijuana infusion facility. An example of this is the clippings which are disposed of by a dispensary are usually used in a medical marijuana infusion facility. ARTICLE 3. DISPENSARIES AND DISPENSARY AGENTS R9-17-309. Administration A. 4. d. Have access to medical marijuana at a food establishment contracted to infuse medical marijuana into edible food products for the dispensary medical marijuana infusion facility, or This addition allows for infusion of many different types of products and doesnâ€™t limit it just to food products. ARTICLE 3. DISPENSARIES AND DISPENSARY AGENTS R9-17-309. Administration A. 5. d. Has access to medical marijuana at a food establishment contracted to infuse medical marijuana into edible food products for the dispensary medical marijuana infusion facility, or This addition allows for infusion of many different types of products and doesnâ€™t limit it just to food products. ARTICLE 3. DISPENSARIES AND DISPENSARY AGENTS R9-17-315. Inventory Control System B. 6. For providing medical marijuana to a food establishment for infusion into an edible food product medical marijuana infusion facility: a. A description of the medical marijuana provided including he amount and strain, and batch number. b. The name and registry identification number of the designated agent who: i. Provided the medical marijuana to the food establishment medical marijuana infusion facility on behalf of the dispensary, and ii. Received the medical marijuana on behalf of the food establishment medical marijuana infusion facility; and c. The date the medical marijuana was provided to the food establishment medical marijuana infusion facility; and B. 7. For receiving edible food products infused with medical marijuana from a food establishment medical marijuana infusion facility: a. The date the medical marijuana used to infuse the edible food products was received by the food establishment and the amount and batch number of medical marijuana received; a. b. A description of the edible food products received from the food establishment medical marijuana infusion facility, including total weight of each edible food product and estimated amount and batch number of the medical marijuana infused in each edible food product; c. Total estimated amount and batch number of medical marijuana infused in edible food products; d. A description of any reduction in the amount of medical marijuana; e. The products received from the medical marijuana infusion facility must have a label on the product listing the weight and the date the final product was made. f. e. For any unusable marijuana disposed of at the medical marijuana infusion facility food establishment: i. A description of the unusable marijuana, ii. The amount and batch number of unusable marijuana disposed of, iii. Date of disposal, iv. Method of disposal, and v. Name and registry identification number of the dispensary agent responsible for the disposal at the food establishment medical marijuana infusion facility; g. f. The name and registry identification number of the designated agent who: i. Provided the edible food products to the dispensary on behalf of the food establishment medical marijuana infusion facility, and ii. Received the edible food products on behalf of the dispensary; and h. g. The date the edible food products were provided to the dispensary. This addition allows for infusion of many different types of products and doesnâ€™t limit it just to food products. We added e. because we believe that it is unsafe and unhealthy for a product not to be labeled with the weight and production date of the product. The date will also allow for tracking of a product if there is a need to do so. R9-17-316. Product Labeling and Analysis C. If medical marijuana is provided as part of an edible food product a medical marijuana infusion facility, a dispensary shall, in addition to the information in subsection (A), include on the label: 1. The total weight of the edible food product. 2. The date the final product was made This addition allows for

infusion of many different types of products and doesnâ€™t limit it just to food products. We added e. because we believe that it is unsafe and unhealthy for a product not to be labeled with the weight and production date of the product. The date will also allow for tracking of a product if there is a need to do so. R9-17-317. Security B. A dispensary agent may transport marijuana, marijuana plants, and marijuana paraphernalia between the dispensary and: 4. A food establishment medical marijuana infusion facility contracted with the dispensary to prepare edible food products infused with medical marijuana. This addition allows for infusion of many different types of products and doesnâ€™t limit it just to food products.
eliminate the pot doc and allow AZ DHS to control this industry
See corresponding sections above. Section C. R9-17-102 A. An applicant submitting an application to the Department shall submit the following REFUNDABLE fees: 5(a). Qualifying patient, except as provided in subsection (B), see household income-based scale HOUSEHOLD INCOME SCALE---Qualifying Patient Salary Fee Under 15,000 per annum ----- $20 15,001â€”30,000 per annum--- $40 30,001â€”60,000 per annum--- $80 60,001â€”80,000 per annum--- $110 80,000 & up per annum--------$160 5(b). Designated caregiver see household income-based scale HOUSEHOLD INCOME SCALE---Designated Caregiver Salary Fee Under 15,000 per annum ----- $20 15,001â€”30,000 per annum--- $40 30,001â€”60,000 per annum--- $80 60,001â€”80,000 per annum--- $110 80,000 & up per annum--------$160 6(a). Qualifying patient, except as provided in subsection (B), see household income-based scale HOUSEHOLD INCOME SCALE---Qualifying Patient Salary Fee Under 15,000 per annum ----- $20 15,001â€”30,000 per annum--- $40 30,001â€”60,000 per annum--- $80 60,001â€”80,000 per annum--- $110 80,000 & up per annum--------$160 6(b). Designated caregiver see household income-based scale R9-17-102 B. A qualifying patient may pay a reduced fee of $20 if the qualifying patient submits with the qualifying patientâ€™s application [...] Section D. R9-17-202 F(5)(k)(i) Included within this statement may be an exemption from the two and a half ounces during any 14-calendar-day period, as long as a particular amount and time frame are designated by the physician. R9-17-202 (G)(11)(g)(i) Included within this statement may be an exemption from the two and a half ounces during any 14-calendar-day period, as long as a particular amount and time frame are designated by the physician. R9-17-313 5. Verify that the amount of medical marijuana the qualifying patient or designated caregiver is requesting would not cause the qualifying patient to exceed the limit on obtaining no more than two and one-half ounces, or other amount if specified by the certifying physician, during any 14-calendar-day period; and R9-17-204 (A)(4)(k)(i) Included within this statement may be an exemption from the two and a half ounces during any 14-calendar-day period, as long as a particular amount and time frame are designated by the physician. R9-17-204 (B)(4)(g)(i) Included within this statement may be an exemption from the two and a half ounces during any 14-calendar-day period, as long as a particular amount and time frame are designated by the physician. Section E. R9-17-202 (F)(6)(k)(iii) No applicant shall be disqualified from serving as a Designated Caregiver on the basis of any conviction disclosed by a criminal history record background check conducted pursuant to this section if the individual has affirmatively demonstrated to the department

clear and convincing evidence of rehabilitation. In determining whether clear and convincing evidence of rehabilitation has been demonstrated, the following factors shall be considered: (i) the nature and responsibility of the position which the convicted individual would hold, has held, or currently holds; (ii) the nature and seriousness of the crime or offense; (iii) the circumstances under which the crime or offense occurred; (iv) the date 1 of the crime or offense; (v) the age of the individual when the crime or offense was committed; (vi) whether the crime or offense was an isolated or repeated incident; (vii) any social conditions which may have contributed to the commission of the crime or offense; and (viii) any evidence of rehabilitation, including good conduct in prison or in the community, counseling or psychiatric treatment received, acquisition of additional academic or vocational schooling, successful participation in correctional work-release programs, or the recommendation of those who have had the individual under their supervision. R9-17-202 (G)(9)(c) No applicant shall be disqualified from serving as a Designated Caregiver on the basis of any conviction disclosed by a criminal history record background check conducted pursuant to this section if the individual has affirmatively demonstrated to the department clear and convincing evidence of rehabilitation. In determining whether clear and convincing evidence of rehabilitation has been demonstrated, the following factors shall be considered: (i) the nature and responsibility of the position which the convicted individual would hold, has held, or currently holds; (ii) the nature and seriousness of the crime or offense; (iii) the circumstances under which the crime or offense occurred; (iv) the date 1 of the crime or offense; (v) the age of the individual when the crime or offense was committed; (vi) whether the crime or offense was an isolated or repeated incident; (vii) any social conditions which may have contributed to the commission of the crime or offense; and (viii) any evidence of rehabilitation, including good conduct in prison or in the community, counseling or psychiatric treatment received, acquisition of additional academic or vocational schooling, successful participation in correctional work-release programs, or the recommendation of those who have had the individual under their supervision. R9-17-203 (A)(2)(k)(iii) No applicant shall be disqualified from serving as a Designated Caregiver on the basis of any conviction disclosed by a criminal history record background check conducted pursuant to this section if the individual has affirmatively demonstrated to the department clear and convincing evidence of rehabilitation. In determining whether clear and convincing evidence of rehabilitation has been demonstrated, the following factors shall be considered: (i) the nature and responsibility of the position which the convicted individual would hold, has held, or currently holds; (ii) the nature and seriousness of the crime or offense; (iii) the circumstances under which the crime or offense occurred; (iv) the date 1 of the crime or offense; (v) the age of the individual when the crime or offense was committed; (vi) whether the crime or offense was an isolated or repeated incident; (vii) any social conditions which may have contributed to the commission of the crime or offense; and (viii) any evidence of rehabilitation, including good conduct in prison or in the community, counseling or psychiatric treatment received, acquisition of additional academic or vocational schooling, successful participation in correctional work-release programs, or the recommendation of those who have had the individual under their supervision. R9-17-204 (A)(5)(k)(iii) No applicant shall be disqualified from serving as a Designated Caregiver on the basis of any conviction disclosed by a criminal history record background check conducted pursuant to this section if the individual has affirmatively demonstrated to the department clear and convincing evidence of rehabilitation. In determining whether clear and convincing evidence of rehabilitation has been demonstrated, the following factors shall be considered: (i) the nature and responsibility of the position which the convicted individual would hold, has held, or currently holds; (ii) the nature and seriousness of the crime or offense; (iii) the circumstances under which the crime or offense occurred; (iv) the date 1 of the crime or offense; (v) the age of the individual when the crime or offense was committed; (vi) whether the crime or offense was an isolated or repeated incident; (vii) any social

conditions which may have contributed to the commission of the crime or offense; and (viii) any evidence of rehabilitation, including good conduct in prison or in the community, counseling or psychiatric treatment received, acquisition of additional academic or vocational schooling, successful participation in correctional work-release programs, or the recommendation of those who have had the individual under their supervision. R9-17-204 (B)(6)(c) No applicant shall be disqualified from serving as a Designated Caregiver on the basis of any conviction disclosed by a criminal history record background check conducted pursuant to this section if the individual has affirmatively demonstrated to the department clear and convincing evidence of rehabilitation. In determining whether clear and convincing evidence of rehabilitation has been demonstrated, the following factors shall be considered: (i) the nature and responsibility of the position which the convicted individual would hold, has held, or currently holds; (ii) the nature and seriousness of the crime or offense; (iii) the circumstances under which the crime or offense occurred; (iv) the date 1 of the crime or offense; (v) the age of the individual when the crime or offense was committed; (vi) whether the crime or offense was an isolated or repeated incident; (vii) any social conditions which may have contributed to the commission of the crime or offense; and (viii) any evidence of rehabilitation, including good conduct in prison or in the community, counseling or psychiatric treatment received, acquisition of additional academic or vocational schooling, successful participation in correctional work-release programs, or the recommendation of those who have had the individual under their supervision. Section F. R9-17-202 (F)(1)(f) [...] that the qualifying patient resides at least 25 miles from the nearest operating center, or that the qualifying patient lives too far or will be income-prohibited from utilizing the nearest operating center; R9-17-202 (G)(1)(l) [...] that the parent or legal guardian of the qualifying patient resides at least 25 miles from the nearest operating center, or that the qualifying patient lives too far or will be income-prohibited from utilizing the nearest operating center; R9-17-203 (B)(5) [...] that the qualifying patient resides at least 25 miles from the nearest operating center, or that the qualifying patient lives too far or will be income-prohibited from utilizing the nearest operating center; R9-17-203 (C)(4) [...] that the qualifying patient resides at least 25 miles from the nearest operating center, or that the qualifying patient lives too far or will be income-prohibited from utilizing the nearest operating center; R9-17-204 (A)(1)(g) [...] that the qualifying patient resides at least 25 miles from the nearest operating center, or that the qualifying patient lives too far or will be income-prohibited from utilizing the nearest operating center; R9-17-204 (B)(1)(l) [...] that the parent or legal guardian of the qualifying patient resides at least 25 miles from the nearest operating center, or that the qualifying patient lives too far or will be income-prohibited from utilizing the nearest operating center; Section G. R9-17-202 (F)(5)(h)(i) REMOVED R9-17-202 (G)(11)(e)(vi)(i) REMOVED R9-17-204 (A)(4)(h)(i) REMOVED R9-17-204 (B)(4)(f)(vi)(i) REMOVED R9-17-317 (G)(1)(c) REMOVED R9-17-317 (G)(1)(d) Re-named as R9-17-317(G)(1)(c) Section H. R9-17-306 A REMOVED R9-17-306 B Re-named as R9-17-306 A

Warning Label Current verbiage: R9-17-316 A 3. Arizona Department of Health Services Warning: Smoking marijuana can cause addiction, cancer, heart attack, or lung infection and can impair oneâ€™s ability to drive a motor vehicle or operate heavy machinery. Suggestion for revision: R9-17-316 A 3. Arizona Department of Health Services Warning: Consuming marijuana can impair oneâ€™s ability to drive a motor vehicle or operate heavy machinery. Chronic marijuana use can lead to the development of tolerance and/or mild dependence. Smoking marijuana carries a low risk of cancer, tachycardia (fast heart rate), hypertension, and/or lung infection. The word â€˜smokingâ€™ was replaced with â€˜consumingâ€™ to include the use of medibles that CAN impair oneâ€™s ability

to drive or operate heavy machinery. Obviously, if one were to use Cannabis topically, there would be no risk of impairment so the word â€˜canâ€™ is used to qualify that. I also replaced the word â€˜heart attackâ€™ with â€˜tachycardia (fast heart rate), hypertensionâ€™. Please consider the following quote from the cancer booklet available at the Americans for Safe Access website: â€œâ€¦ the side effects associated with cannabis are typically mild and are classified as "low risk." Euphoric mood changes are among the most frequent side effects. Cannabinoids can exacerbate schizophrenic psychosis in predisposed persons. Cannabinoids impede cognitive and psychomotor performance, resulting in temporary impairment. Chronic use can lead to the development of tolerance. Tachycardia and hypotension are frequently documented as adverse events in the cardiovascular system. A few cases of myocardial ischemia have been reported in young and previously healthy patients. Inhaling the smoke of cannabis cigarettes induces side effects on the respiratory system. Cannabinoids are contraindicated for patients with a history of cardiac ischemias. In summary, a low risk profile is evident from the literature available. Serious complications are very rare and are not usually reported during the use of cannabinoids for medical indications.â€ I removed the word â€˜addictionâ€™ and replaced it with â€œChronic marijuana use can lead to the development of tolerance and/or mild dependence.â€ It is generally known that marijuana carries a relatively small to no rate of physical addiction. The Benowitz and Henningfield Rating systems, comparing the addictiveness of heroin, alcohol, cocaine, nicotine, marijuana and caffeine both rank marijuana dead last in the categories of tolerance, reinforcement and dependence. Please see the following link for more information:

[redacted] Quoted from the ASA website: The National Academy of Sciences noted in a 1999 report that, "millions of Americans have tried marijuana, but most are not regular users [and] few marijuana users become dependent on it." They conclude that, "athough [some] marijuana users develop dependence, they appear to be less likely to do so than users of other drugs (including alcohol and nicotine), and marijuana dependence appears to be less severe than dependence on other drugs." King LA, et al. "Cannabis Potency in Europe." Addiction. July 2005; 100(7):884-6. Municipal permits and pre-registration Many of the municipalityâ€™s ordinances are somewhat vague in their language and require some translation by local building officials and planners within the municipality. Some municipalities have a permitting process in place for new businesses and have used or even slightly modified this process to pre-permit or permit potential medical marijuana dispensaries. We suggest that for municipalities with these systems in place, rather than a sworn statement, you require documentation from the municipality on the status of the applicants pre-registration or permit. The current verbiage reads as follows: R9-17-303 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. We would suggest the following text: R9-17-303 5. If the physical address of the proposed dispensary in R9-17-303B 1 b is in a municipality or county with a pre-registration or permitting system for medical marijuana, a document from the municipality detailing the permitting or pre-registration status of that proposed dispensary. If the physical address of the proposed dispensary in R9-17-303B 1 b is NOT located in a municipality or county with a pre-registration or permitting system for medical marijuana, 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. We believe that the inclusion of such a clause would greatly reduce confusion and and potential conflicts between your license process and those permitting processes already going on of the local municipalities.

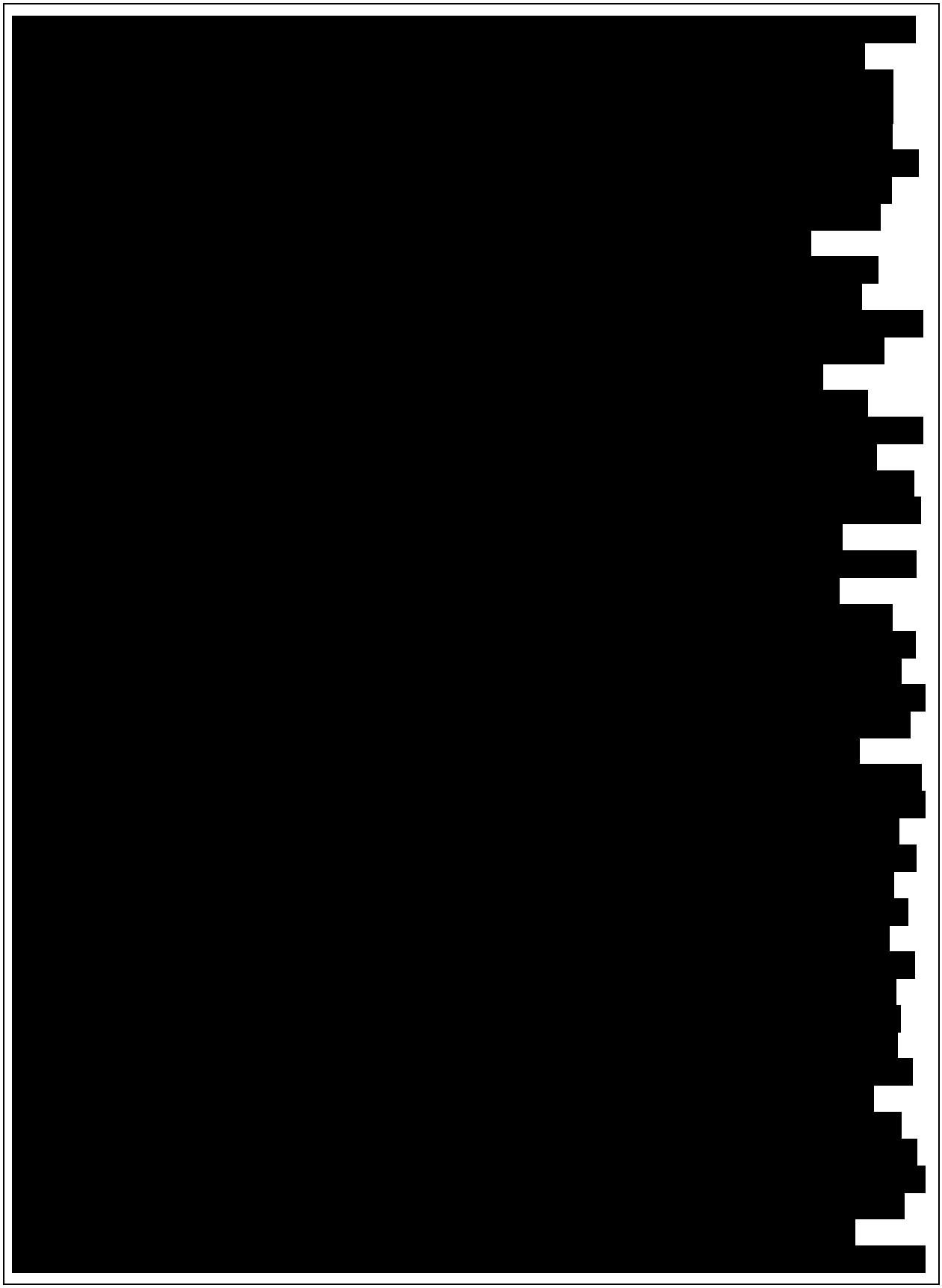
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
The following comments were faxed to your office on 2/18 at 3:39 PM Eastern time. However, I was told by your office that only comments submitted electronically would be reviewed and considered. Accordingly, I am uploading the text of the letter that has been faxed, with formatting revisions to comply with the requirements for electronic submissions. Note that the fax version of this letter contains strike-throughs and underscores that make it easier to follow. Will Humble Director Arizona Department of Health Services 150 North 18th Avenue, Suite 500 Phoenix, AZ 85007-3247 Re: Comments on 1/31/11 Draft Rules for the Department of Health Services Medical Marijuana Program Dear Mr. Humble: I am writing as legal counsel for a group of Arizona residents and registered pharmacists who intend to apply for a dispensary permit. I am also a pharmacist, and teach pharmacy law at the University of Illinois â€“ Chicago College of Pharmacy. I am familiar with the vital role that pharmacists fulfill as a member of the health care team, and on behalf of my clients, am submitting these comments with the hope that the draft rules will be amended to add requirements designed to protect the health and well being of Arizona residents who seek treatment with medical marijuana. My clients applaud the efforts of the Arizona Department of Health Services (â€œDepartmentâ€) to draft rules that will be effective in furthering the purpose of Proposition 203, while protecting the health and well being of Arizona residents to the fullest extent possible. We believe that the Department has done an excellent job in many respects, but also believe there are areas where the proposed rules can be improved. Specifically, we advocate an approach that will ensure, through regulation and enforcement, that the lawful use of marijuana in Arizona will truly be for medical purposes, and will not be used to promote the illicit use of marijuana under the guise of treatment of a debilitating condition. We are concerned that the current draft rules do not go far enough to advance the therapeutic use of medical marijuana, or to require dispensary operators to provide a truly integrated, clinical approach to patient care. The draft rules can be improved by requiring that dispensaries be operated in a manner that places a value on clinical care, as opposed to treating medical marijuana as a commodity that can be purchased and used with little or no ongoing clinical oversight. As now written, the draft rules require only that an applicant for a Registry Identification Card submit a â€œstatement, initialed by the physician, that the physician agrees to assume responsibility for providing management and routine care of the qualifying patientâ€™s debilitating medical condition after conducting a full assessment of the qualifying patientâ€™s medical historyâ€, and that the â€œphysician plans to continue to assess the qualifying patient and the qualifying patientâ€™s use of medical marijuana during the course of the physician-patient relationshipâ€. See, Title 9, Ch. 17, Section R9-17-202(F)(5). However, there is no requirement of ongoing assessment or oversight by a health care practitioner at the point of care, as is provided, for example, when a pharmacist counsels a patient, or provides medication therapy management services

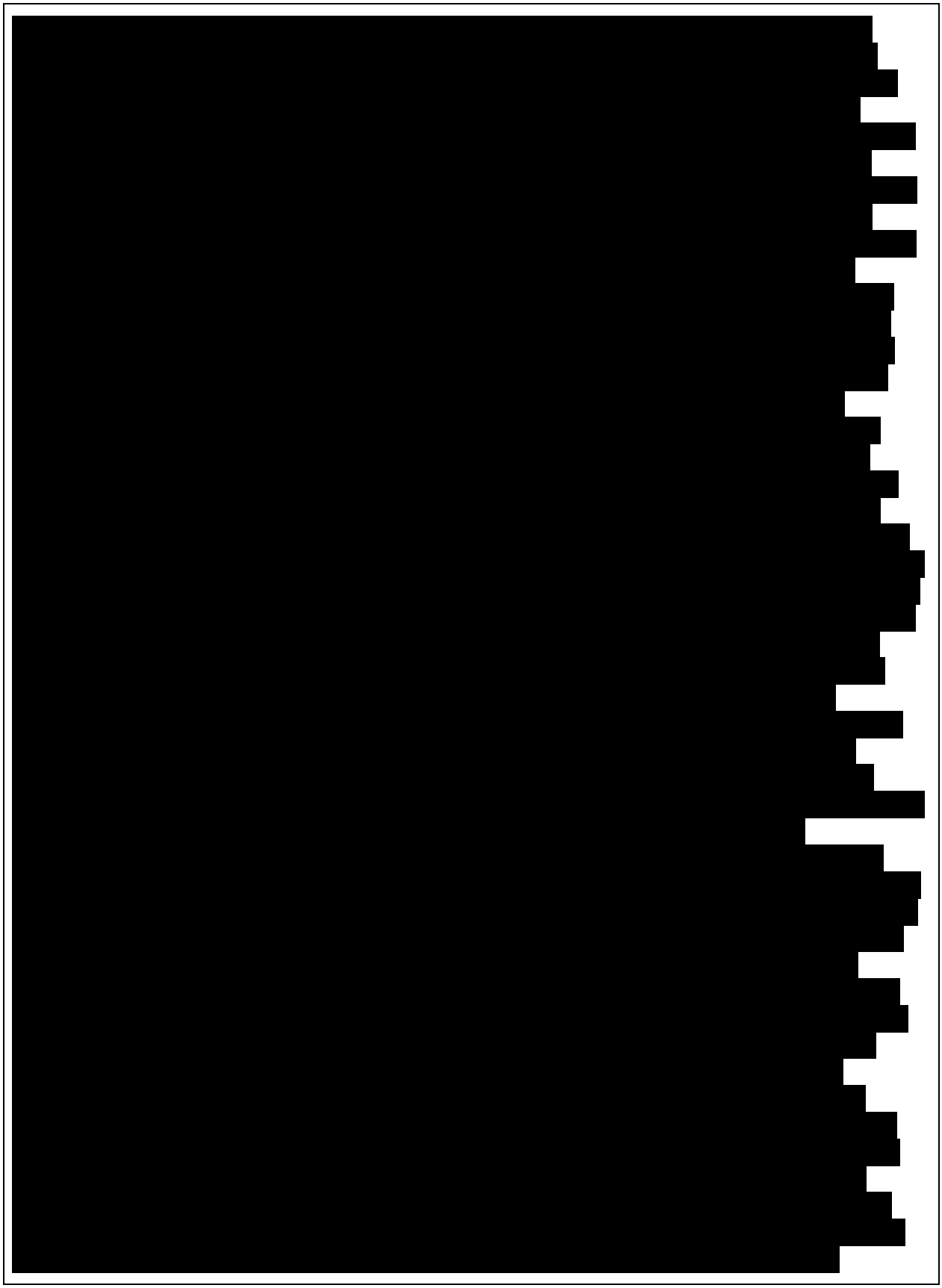
at a pharmacy. We believe that it is the duty of the Arizona Department of Health Services to see that Proposition 203 is implemented in a manner that will best protect the health and well being of Arizona residents. We urge the Department to amend the draft rules to either require that dispensaries employ or consult with a clinical pharmacist who will be available for counseling, and responsible for providing medication therapy management services to dispensary patients. We recognize, however, that such a requirement may be viewed as too burdensome, and that there may be other ways to ensure that marijuana dispensaries are operated in a manner that emphasizes a robust, science based, clinical approach to patient care. Therefore, as an alternative, we request that the Department incentivize proposed dispensary operators to provide ongoing pharmaceutical/clinical care by utilizing application evaluation criteria that rewards applicants that will include pharmacy services as part of the services it will provide. In that regard, we agree with certain comments to the original draft submitted by the [redacted]. Specifically, the [redacted] identified pharmacists as medication experts, who are uniquely positioned to recognize and provide solutions to the problem of medication misuse. As pointed out by the [redacted] engaging the pharmacist as a resource for ensuring safe medication use will greatly improve the health of a patient. Pharmacists should be retained to perform an initial, comprehensive medication review, and to provide ongoing clinical pharmacy services in collaboration with the patientâ€™s primary physician, or the facilities medical director. The Department should give preference to applicants that will offer an on-site or telephonic consultation with a pharmacist, who can monitor the patientâ€™s drug therapy, and evaluate potential interactions or contraindications with other prescribed medications. Section R9-17-302(B)(15) of the original draft rules included as part of the application process a requirement that the applicant state â€œwhether a registered pharmacist will be onsite or on call during regular business hoursâ€. That requirement was removed from the current draft. We ask that that requirement be reinstated into the final rules, and that greater weight be given to the evaluation of applications that include pharmacy services as part of its business plan. â€ƒ We propose the following specific revisions to the proposed rules. R9-17-312. Medical Director We recognize the value of having a physician serve as medical director to oversee certain aspects of a dispensaryâ€™s operations. We further recognize that the Department rejected suggestions made in several comments to the original draft, which urged the Department to allow other, non-physician health care practitioners to serve as the medical director. However, we are concerned that the removal of the â€œthree dispensaryâ€ limit contained in the original draft could lead to a scenario wherein a single director overseas the operation of so many dispensaries that the effectiveness of such oversight will be severely diminished. We also believe that even if a medical director oversees the operation of a single dispensary, the scope of services to be provided by the medical director may require the expertise of a pharmacist or other qualified health care provider. For those reasons, we urge the Department to consider the following revisions: R9-17-312.C. A medical director shall: [Add new sub-paragraph C.3.]: 3. Consult with a pharmacist to provide medication therapy management (â€œMTMâ€) services, patient counseling, drug utilization review (â€œDURâ€) and other patient care services designed to foster the safe and efficacious use of medical marijuana. This requirement shall be waived if the dispensary for which the physician serves as medical director independently provides these services and requires its pharmacist employee or consultant to provide reports to the Medical Director and to the patientâ€™s certifying physician when counseling, MTM or DUR services are provided, or as otherwise requested by the certifying physician or Medical Director. , or. R9-17-302. Dispensary Allocation The current draft rules provide for a random selection method in cases where multiple complete applications are received. We do not believe that a random process is the best method for allocating dispensary registration certificates, and request the following revisions: R9-17-302 (B) (2) If the Department receives: [add

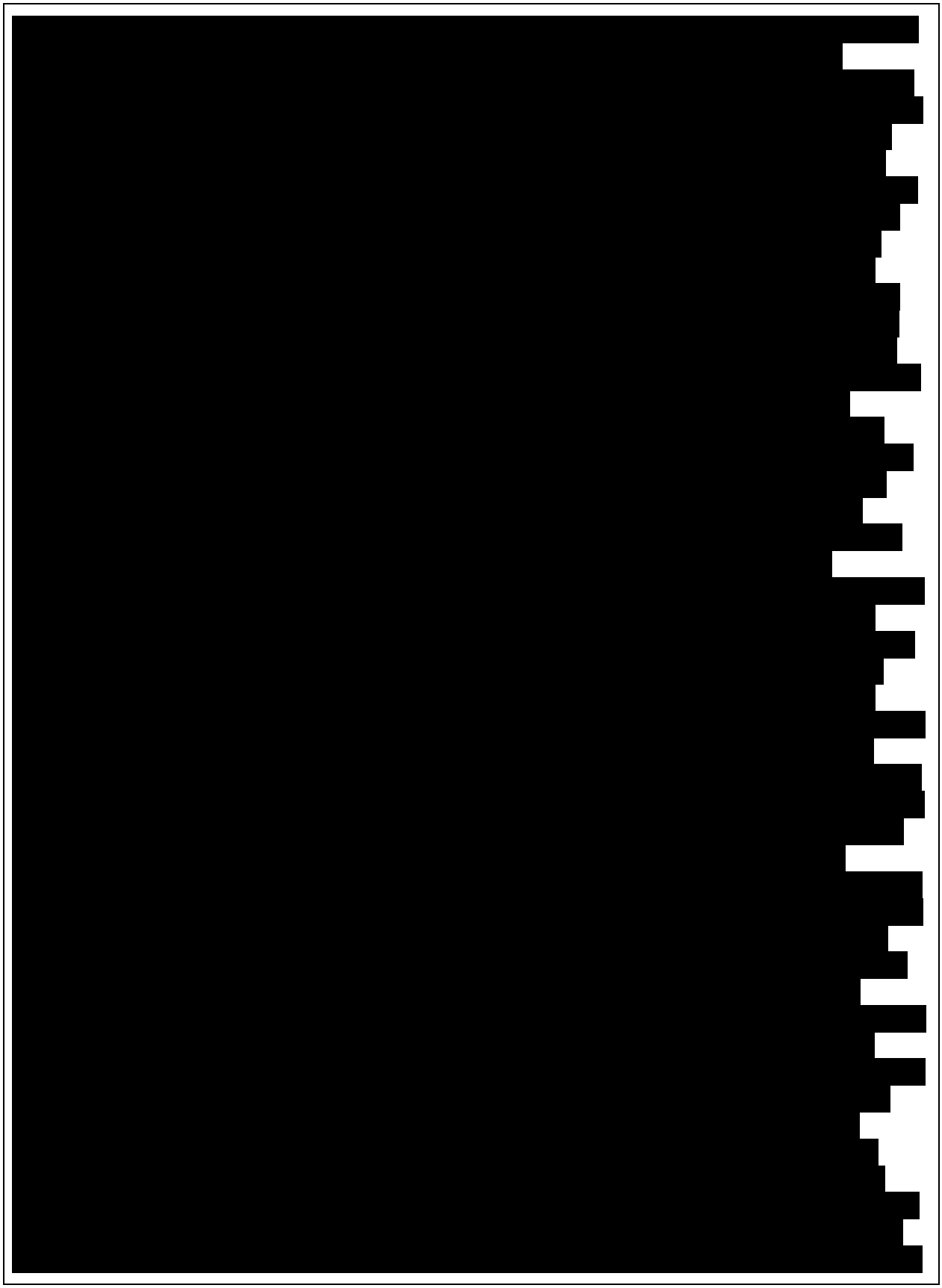
new langauge to sub-paragraph (B)(2)(b)]: b. More than one dispensary registration certificate application for a dispensary located in a CHAA that the Department determines are complete and are in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter by 60 days after May 1, 2011, the Department shall xxxxx select: i. xxx The dispensary registration certificate applicant that includes as part of its application policies and procedures the use of a qualified health care practitioner, such as an employed or consultant pharmacist, to provide ongoing patient assessment, patient counseling, medication therapy management and drug utilization review services, as part of an integrated, collaborative practice arrangement with the dispensaryâ€™s Medical Director or with the certifying physicians for the dispensaryâ€™s patients, and allocate the dispensary registration certificate for the CHAA to that applicant; or ii. As many dispensary certificate applicants as there as dispensary registration certificates 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), provided that if the number of applications 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, exceeds the number of allocated CHAA certificates, the Department shall select the dispensary registration certificate applicant in accordance with the same procedure identified in sub-paragraph (b)(i), above, R9-17-303. Applying for a Dispensary Registration Certificate As previously stated, we believe that the Department should reinstate, and strengthen, the requirement that the applicant state whether a registered pharmacist will be onsite or on-call during regular business hours, which was included as Section R9-17-302(B)(15) of the original draft rules. Since the section numbering for the new rules has been changed, this language should be added as sub-paragraph (B)(8) to Section R9-17-303, as follows: R9-17-303(B) To apply for a dispensary registration certificate, a person shall submit to the Department the following: * * * * 8. Whether a registered pharmacist will be onsite or on-call during regular business hours to offer ongoing patient assessment, patient counseling, medication therapy management and drug utilization review services, as part of an integrated, collaborative practice arrangement with the dispensaryâ€™s Medical Director or with the certifying physicians for the dispensaryâ€™s patients. 9. The applicable fee in R9-17-102 for applying for an initial registration of a dispensary. R9-17-309. Administration A clinical and science based approach to medical marijuana requires that dispensary operators be committed to continuous quality improvement in the medicinal products it dispenses and in the services it provides, and should be required to demonstrate that commitment. Accordingly, we ask that Section R9-17-309 be strengthened to require a continuous quality improvement program that includes patient care, laboratory services, and recordkeeping practices that will improve the quality of care provided to dispensary patients. We recommend the following revisions to Sections R9-17-309 and R9-17-303: R9-17-309 (A) A dispensary shall: [add new sub-paragraphs R9-17-309(A)(1)(f) through (i)]: 1. Develop, document, and implement policies and procedures regarding: f. Procedures to allow patients to obtain medication therapy management services, counseling and drug utilization review from a pharmacist, including, whenever a pharmacist is not physically present and on duty, telephonic access to a pharmacist via local, toll free or collect telephone service; g. Procedures for ensuring that any pharmacy services or interventions performed by an employee or consultant pharmacist be communicated to the dispensaryâ€™s Medical Director or certifying physician; h. Laboratory services available at the dispensary, either directly or under contract, to perform, among other services: analysis of product batches, including an analysis of percentage of active components contained in each batch; identification of the strains of medical marijuana, by batch, in order to provide recommendations to patients concerning which batch of marijuana is best suited to treat the patientâ€™s condition; testing product for molds and pesticides in order to identify potentially harmful contaminants, and to quarantine batches determined to be unfit for particular patients; the

retention of batch samples for future analysis in the event that a patient experiences an adverse event; and i. a continuous quality improvement program that includes ongoing review of records, patient interventions, and product sample data by a continuous quality improvement committee. In addition, section R9-17-303 should be revised to ensure that the policies and procedures submitted as part of its application include policies and procedures addressing items contained in sections R9-17-309 (A) (1) (f) through (i), above. Accordingly, the following revision to section R9-17-303(B)(4) is requested: [add new sub-paragraphs R9-17-303(B)(4)(e) through (g)]: R9-17-303(B) To apply for a dispensary registration certificate, a person shall submit to the Department the following: 4. Policies and procedures that comply with the requirements in this Chapter for: e. Access to pharmacy services, f. Laboratory services, and g. A continuous quality improvement program. In conclusion, my clients believe that medical marijuana has a role in patient care, but advocates that dispensaries be required to adhere to a science based, clinical approach to patient care services. We believe that if adopted by the Department, the revisions proposed herein will help protect Arizona residents who will seek treatment in one of the stateâ€™s registered medical marijuana dispensaries. â€ƒ We would welcome the opportunity to meet with Department officials to discuss further our proposals. Sincerely, [redacted]

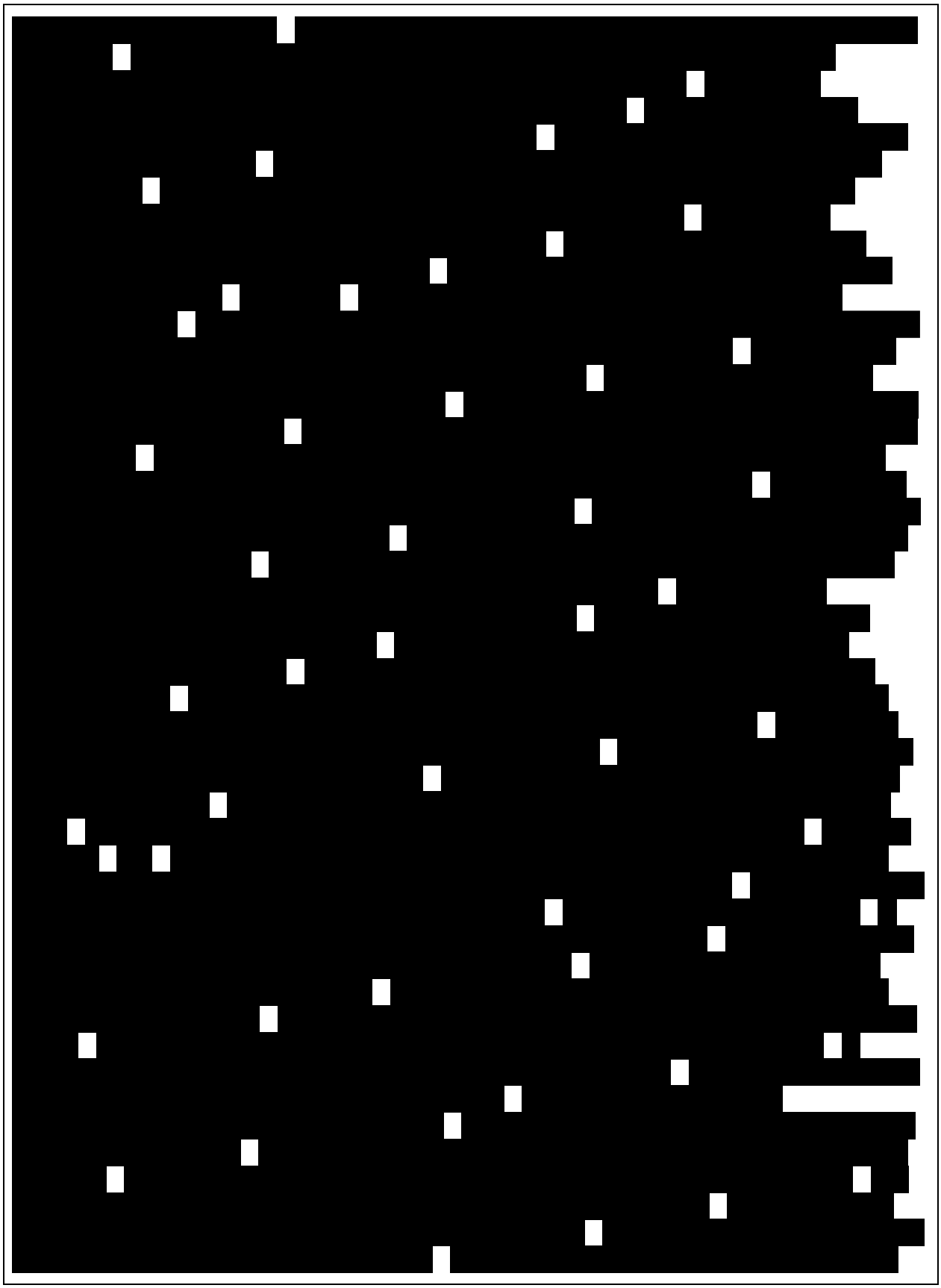
R-9-18-102.B say "A qualified patient may pay a (educed fee of $40... (retain current language through"Program" add a person's whose sole scoure of taxable incomce consists of payments fronm the the U.S. Social Security Administration

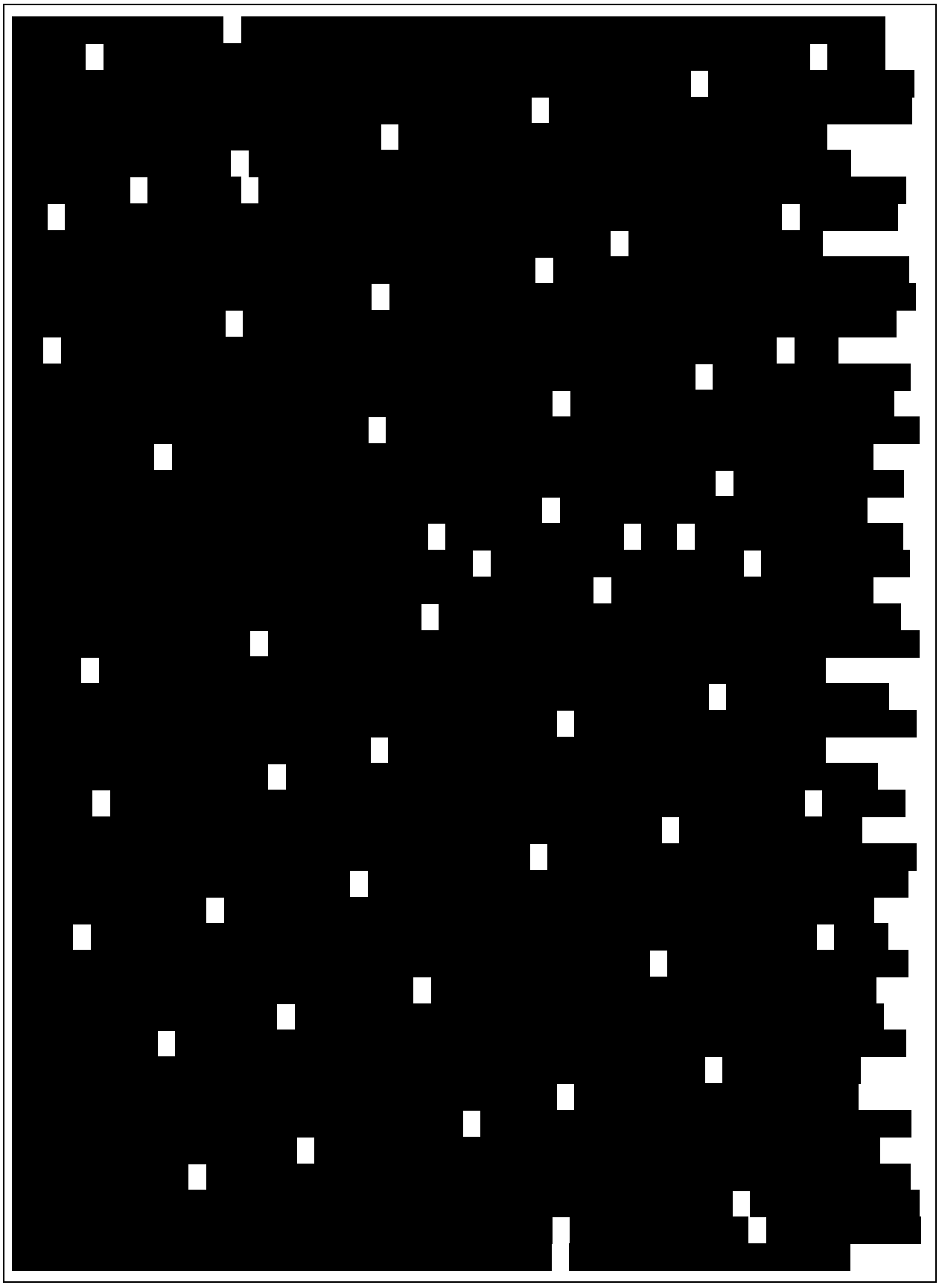


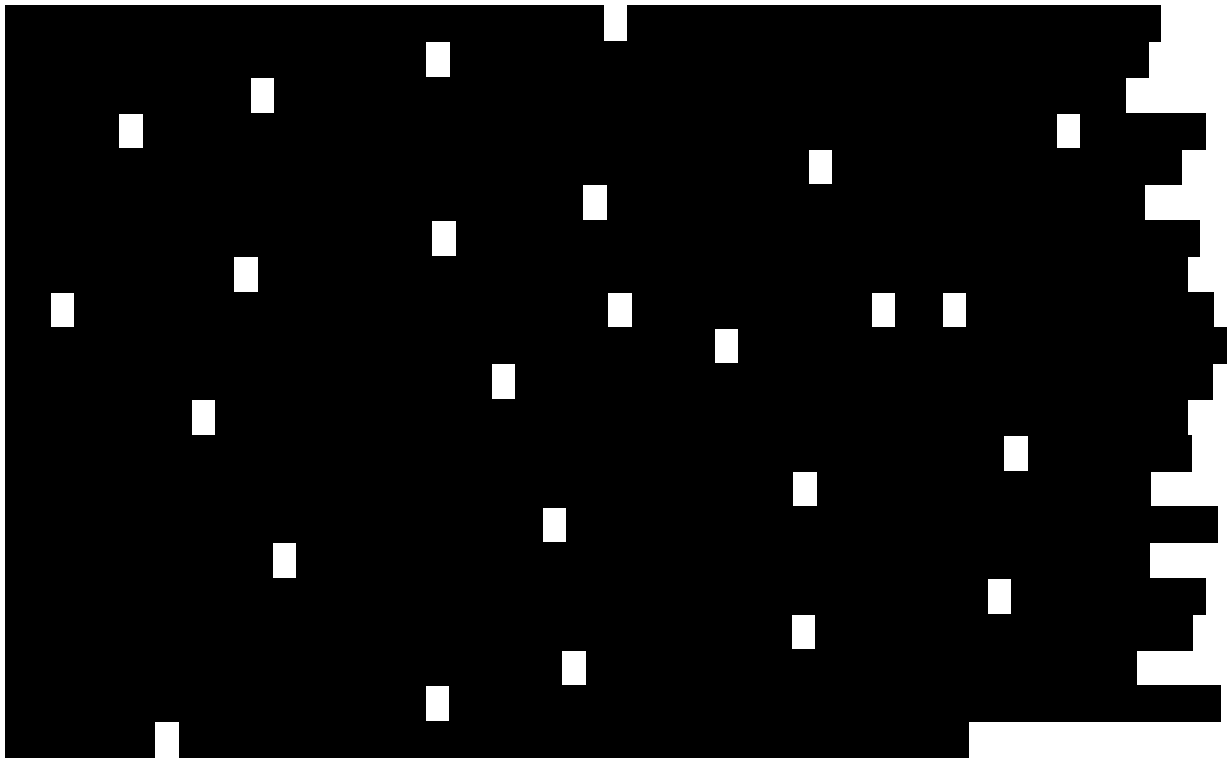




The fact u must be withthe same doctor for one year. When the insurance stopped paying many of the pcp's their money many pcp' including my own,left town. With as many complex medical problems as I have and the fact I have lost a lot of weight and vomiting all the time I can't afford to w ait 9 more month till I have been with the same doctor for over a year.







[redacted] diagnosed cases of coccidioides to the list of illnesses that qualify. Please include coccidioides meningitis. The anxiety of carrying and living with this endemic disease is great and the only option currently is psycotropic medications.

In R9-18-101.101.b add "children's playgrounds" and; in R9-19-101.21 c. include, " viii. Property

located within Home Owners Associations including, boat docks, boats or rafts, greenbelts, lounges intended prinarily for persons 18 years of agr o, and parks intended primarily for use by adults.
We recommend that a provision be added that allows dispensaries to submit medical marijuana to qualified laboratories for the purposes of testing and disposal. Specifically, we propose that a new rule be adopted, R9-17-309(C), to provide that a dispensary must submit a sample from each batch of marijuana to a qualified laboratory for the performance of testing as defined below and for the disposal of any unusable marijuana. All testing completed should meet or exceed the standard of â€œnecessary testingâ€ as defined below. In addition, we recognize that safety standards set in place by agricultural and drug safety regulators do not exist for medical marijuana. However, simply because cannabis has long been an illegal product, no reasons exist that the Department should not adopt standards that consumers can rely upon for their protection. In the interests of patients, the Department should adopt standards, perhaps based on requirements for tobacco and produce, that establish testing guidelines for medicinal marijuana to determine its suitability for human consumption by inhalation or as a foodstuff. The tests to be run should include: 1. Pesticide Screening to screen for pesticides such as DDE/DDT, Pyrethroids and Dspinosyns; 2. Microbiological Screening to ensure that plant material is free of bacteria, mold, and fungus; 3. Foreign Matter Inspection, to test for mold, insects, and other foreign matter; 4. Moisture Content Analysis to provide patients with a more consistent product; 5. Chemical Composition analysis to provide patients with quantitative assessment for primary cannabinoids such as CBC, CBD, CBN, THC and THCV.
Just don't make it SO complicated you have to be a LAWYER to understand it, that's all! Speak "English," like you're telling the legal and "illegal" immigrants THEY have to do!
All chronic pain conditions that result in Doctors vists spanning at least 5 years should be accepted.
The language would include all of those who are 21 years or older and live with an AUTISTIC SPECTRUM DISORDER
1. Keep it SIMPLE & MINIMUM on language and 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 RECCOMMENDING MARIJUANA PHYSICIAN TO SEE GET THEIR RECCOMMENDATION 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, Iâ€™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 patientâ€™s condition before a physician can hand out a recommendation. I donâ€™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.
Limit number of patients per doctor to 100 per year
R9-17-308(B): Except as provided in subsection (D), an on-site inspection of a dispensary or cultivation site shall occur at a date and time agreed to by the licensee and the Department that is no later than five working days after the date the Department submits a written request to the dispensary to schedule the certification or compliance inspection, unless the Department agrees to a later date and time. The Department shall conduct at least one (1) inspection of each dispensary during each calendar year. At the conclusion of each inspection the Department shall issue a written certificate of inspection to the licensee indicating that the site was either in compliance with Arizona law at the time of the inspection or that the dispensary was operating in violation of Arizona law and, in the case of a violation, indicating the specific grounds for such violation
R9-17-309(A): (8) Require its customers to utilize credit or debit cards such that not less than ninety percent (90%) of all sales to patients are done with credit or debit cards and shall save records of such transactions that are subject to Department inspection. (9) only purchase medical marijuana from any cultivator not sharing the same license as the dispensary by way of check or wire transfers.
R9-17-303(B): (9) A bank statement evidencing that the entity applying for the license has deposited not less than $750,000.00 in cash (this is an estimated average cost 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) in an account in the

name of a financial institution to be held for the benefit of the applicant and to be released to the applicant only upon issuance of a license from the Department to the applicant or upon the applicant being denied a license or withdrawing its name from consideration for a license. Provide that credit or debit cards be the primary currency in transaction involving medical marijuana.
While I do not have any specific language for DHS to adopt, I yield to the [redacted] for their input so that our state can have the highest possible standards in order to avoid corruption in the industry and assure safe and easy access for qualified patients, as well as a healthy future for Arizona. I trust the founders of this initiative and the Department of Health Services to make good choices for our state's posterity.
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 the law we voted for was originally penned!
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You could accomplish this by adding the reference to child care facilities to page 56 or perhaps adding a definition of public or private school that would include licensed child care facilities (which ever is the clearest way to ensure that the 500 feet prohibition includes child care)
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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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available only by prescription at regular established pharmacies-just as all other drugs are sold.
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Under R9-17-102 for A-1 should be as follows: Application should be 4 step process â€“ 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 â€“ 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 â€“ 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.

Extend the timeline table 1.1 process for Caregivers and Qualified Patients to receive their cards. There won't be a dispensary ready with any inventory for several months and it seems that with the unknown number of home growers that would be created, there would be great difficulty informing them that there was now a dispensary in their CHAA and they would have to stop any home cultivation (impossible to moniter compliance). A new card would have then have to be re-issued, etc. Would they be allowed to use up their inventory (which could be an indefinite amount of time) or donate it to a dispensary?
The physician could not develop a physician/patient relationship as a result of his or her position as the Medical Director of a dispensary.
AS I SEE THERE ARE NO REAL RULES
Delete any rules relating to allowing growing medical marijuana on private property.
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
Applications shall be selected based on their proximity to the greatest concentrations of the population within the respective CHAA within a 10-mile radius. Population concentrations shall mean the total population of the census block in which the subject facility is located and all census blocks with boundaries located within a 10-mile radius of the parcel for the subject facility's.

Activity that does not include marijuana cultivation or dispensary operations but does engage in botanical research and product development, natural and chemical compound or cell measurements, specimen collection for analysis, transfer or disposal, data recording and associated activities are exempt from the regulations when the activities conform to established State and Local statutes, codes, rules and policies.
Please see above.
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SEE ABOVE
Pg 34 of draft rules: R9-17-302, D1b: ".....the Department shall award the dispensary registration certificate based on the following criteria: Non - profit experience Knowledge of local community needs Expertise of key personnel and Board of Directors Efficacy of the business plan The Offerorâ€™s responses should be in the form of a written narrative following each question. The response should be limited to facts with sufficient detail to allow adequate evaluation of the proposal. Restate each question and directly beneath the question, submit the written narrative. Name the files attached. â€œOffer Attachment 01 Service Implementation Questionnaireâ€. 1. Specify how you propose to serve the target population (medically involved patients who require medical marijuana). 2. Describe your organizationâ€™s capacity, knowledge of, and experience in

addressing the needs of medical marijuana patients you listed to serve, especially individuals with most significant disabilities. 3. Describe how linguistically and culturally appropriate services and materials will be provided to meet the needs of persons using medical marijuana and accommodate their diverse languages, cultures, and geographic locations. 4. Describe the techniques, tools, and resources to be used in providing services listed below. Include how you will ensure the client successfully reaches the service outcomes and an average estimated timeframe for service completion: *patient care *hospice *rehabilitation *medication *state procurement processes *indoor cultivation *retail experience *experience working with disabled 5. Describe the Quality Control mechanisms that you plan to apply in order to determine the effectiveness of your program in meeting the objectives of this contract and carrying out the service provision. 6. Describe how you will measure and monitor clients and inventory.
A licenced physician is allowed to have a maximum of 100 patients to whom he/she is providing a recommendation for medical marijuana.
I don't know exactly how I would write it, but I urge you to have your lawyers look at these issues and put it into proper rule language.Â Unfortunately as a layman I donâ€™t effectively speak legalese.
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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) donâ€™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

1) Within Article 3 'Dispensaries & Dispensary Agents' (R9-17-301A,B) Should include some language to the the long list 'regarding requirements' in Part A to the effect of recognizing any non profit organization which is clearly registered with the (ACC) State Corporations Commission for the sole purpose of distributing medicinal marijuana. With this recognition comes the opportunity to broaden the definition of Dispensary Agent. The key here is to give more latitude to those non profit organizations that do not have the capital to start a physical dispensary congruent with azDHS rules and regulations. ****AND THIS IS A GOOD STANDARD! Don't get me wrong. Although I initially set up my non profit for the acquisition of one of the 124 permits, I now don't feel an enterprise of this magnitude can not be achieved by even the best intended small Non Profit Organizations. Also...the designation of 5 patients per caregiver is not needed because the distribution of such treatments should be administered by some entity no matter what the limit is. The idea is to not have as many store fronts on our streets which publicly sell medicinal marijuana. This is a logistical nightmare for the state and should be handled by private organizations. Also, some patients cant afford medicinal marijuana and need the assistance of non profits like mine that are able to provide for low income patients.
ADD MIGRAINES TO THE LIST OF ACCEPTABLE REASONS
Not at this time.
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
AFTER you have what you think is the final draft of the rules set up; PLEASE have an English teacher or professor read it for understanding. Many times what you have written is not what you intended to say. In proofreading, it is easy to read what you think you wrote, instead of what actually is on the paper.

I believe the draft rules can be improved in the area of cargivers... I was wanting to know why there is such a limitation on who can actually grow without being 25 miles away from a dispensary? I believe that there shouldn't be such a limitation to who can grow if qualified but just by doing background checks making sure the caregivers are qualified and could be held to higher standards if they were to break rules.
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
Submitted by [redacted]. This is specifically related to the change of Definition of R9-17-101 "Enclosed" means: We would ask the Director to consider the definition of â€œenclosedâ€ under R-17-101 to reflect the idea that some crops may be grown horticulturally in greenhouses instead of indoors, hydroponically with sodium lights. The future of growing marijuana will be in greenhouses. The newest form of success in growing marijuana crops from Californiaâ€™s experience is in natural light i.e. hydroponically in enclosed greenhouse production. This is expanding rapidly and replacing the use of artificial lighting to be the leading way with new technology to grow the many quality strains of medical marijuana. I think that this definition is very confusing. Are we to understand that

you want metal wire mesh on top of the outside perimeter wall or over the entire structure starting from the outside barrier over the top of the growing structure. If so, the Department of Health will be absolutely eliminating the possibility of growing medical marijuana in a greenhouse structure. This being said: 15. a. A building with four walls and a roof or an indoor room or closet; or (in an outdoor greenhouse setting the four walls can be made of opaque, light translucent Lexan to allow for light penetration). This should be added to the definition as it still allows the crop to be â€œhiddenâ€ from sight. 15. b. An area surrounded by four solid 10 foot walls constructed of metal, concrete, or stone that prevent any viewing of the marijuana plants, with a one-inch thick metal gate and a barrier covering the top of the of the area that is: (unacceptable for greenhouse growing. In the winter months a wall like this will keep the sun from ever reaching the crop. I would propose using a prison grade chain link fence with razor wire and the inner greenhouse structure will be used to secure the â€œhiddenâ€ crop from the outside world.) It is my opinion that growing marijuana as a horticultural crop instead of an indoor crop will decrease the crop production costs thus decreasing the overall price to the card holder for use. i. Welded or woven metal wire mesh, with minimum wire thickness of 0.25 inches and maximum gap between wires of 1 inch (This should be removed since it produces too much shade for the greenhouse crop and creates too much weight for a commercial greenhouse roof structure.) ii. Welded metal wire grid, with minimum wire thickness of 0.25 inches and maximum gap between wires of three inches. (This should be removed since it produces too much shade for the greenhouse crop and creates too much weight for a commercial greenhouse roof structure.) iii. Metal chain-link weave with gauge no less than 9 and no more that 11.5: (This should be removed since it produces too much shade for the greenhouse crop and creates too much weight for a commercial greenhouse roof structure.) iv. A panel of metal vertical bars, with a minimum bar thickness of 0.5 inches and maximum gap between bars of 6 inches; (may be fitting if you used it on the outside of the chain link fencing to add additional security to outside structure.) v. Strike Growing medical marijuana in a commercial, well secured greenhouse structure allowing year round crop production without the addition of artificial lighting is a very cost effective and sustainable option. Ultimately the addition of being able to grow in a greenhouse structure under the guidance of a trained horticulturalist will dramatically reduce the price per ounce of the finished product and assure a quality and consistent product. The objective of legalizing medical marijuana is to sell it for a reasonable price.
Fingerprinting is insane. I was on prescribed opiates for 5 years, never once got fingerprinted.
I don't know exactly how I would write it, but I urge you to have your lawyers look at these issues and put it into proper rule language. Unfortunately as a layman I donâ€™t effectively speak legalese.
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Please limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
R9-17-302. Remove all of R9-17-302 as relates to the CHAA and reassign based on the 1 dispensary per number of pharmacies as provided by the citizenâ€™s initiative. This is going to be more reflective of demographics and demand and supply. Compliance with local zoning regulations (as is in effect in Colorado) should be the primary basis for a medical marijuana dispensary location. Add language to the effect: Selection of dispensary applications is on a point based system. Applicants will be judged on their business plan, non-profit model, viability as an ongoing business operation, business experience of dispensary agents, security plan, inventory control system, local zoning compliance, and goodwill towards the community. The amount of financing behind an enterprise should not enable them to be placed ahead of smaller, local business models. Opportunity should be available to all economic levels not simply the highest bidder. Multiple applications from the same individuals, entities will not be accepted. If an individual or business entity submits multiple applications all applications are automatically denied. R9-17-302 a. If only one dispensary registration certificate in compliance with local zoning is submitted that is deemed complete and is in compliance with ARS and this chapter in the initial application time of 30 days after May 1, 2011 the Department shall then have an additional 30 days to allocate the dispensary registration certificate to the sole complying applicant.

Limit the mumber of patients a physician can recommend for medical marijuana to no more than 100 per year.
Make sure it is in the English language.
Prop 203 originally said a doctor will be required to provide a "certification" for medical marijuana. Now the draft says "recommend" medical marijuana. A certification has more merit in my opinion than a recommendation does and I believe this wording should be changed back to how it was originally presented. I can recommend that part is a good part to put in your car OR I can "certify" that part is good for your car. Which of these two do you believe has more weight?
I'm not an attorney.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
They should have to carry this card at all times and they should not be allowed to drive.
i was able to speak at both meetings and stay through out both meetings. the duplicity of the get rich, we want a dispencary and the rules are fines but must evolove was certainly eposedby 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 adressed that wih the various size plants can get and what they will yeild. personally,,, if these owner's can't see far enough ahead to produce the 8'-12' type plants that produces 2-40 pounds a year each i would rather not be forced to do ny thing 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 medcade. the testing and all can be done in home. they are now producing in pharmacy analizers,,, later as the rules revision continue allow pharmicies to provide those services. if the patient has no controll 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 any thing but what it should,,, be does away with iat someones expense and incoveinance. again a way to jerk around the state and patients. if these practices were commited against a racial group or religious group or an alt. life style group thould be ht crimes. they should be hat crime protection guarenteed 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 comparrsion feeling of rights and freedoms grant 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 contide with if other states practices are allowed to cause influence hu an open giftfud to be spent as the director sees fit. iit's the hought 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.
Reciprocity; If you have already be Dr. Certified in another state and have the credentials from that state that allow you to purhase medical marijuana then State of Arizona allows for Reciprocity to do so without incurring all of the additional expense. . thank you

25 MILE RULE The statute and the rules specify that a patient who lives more than 25 miles from the nearest dispensary may grow their own medical marijuana. The rules should specify that the distance between a patientâ€™s home and the nearest dispensary should be measured â€œas the crow fliesâ€. The rules donâ€™t currently specify this. If it is not specified, and law enforcement wants to charge a patient with violating the statute, there could be a dispute, in a close case as to whether the patient lives more than or less than 25 miles from the nearest dispensary. In such a case, the patient would inevitably contend that the distance should be measured by the distance by road between the 2 locations. In every close case it would be necessary to drive the distance (or try to determine it by some other method). A dispute could arise concerning the patientâ€™s choice to drive a different route that they might choose for some reason. All of this could be put to rest by specifying that the distance is determined â€œas the crow fliesâ€. With modern GPS technology, the boundary of the 25 mile radius from the middle or edge of the dispensary location and the patientâ€™s home could be determined down to the fraction of a foot. This is a very simple solution that could avoid significant future problems for law enforcement and give everyone involved predictable rules to go by.
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Yes, eliminate the pot doc and have the AZ DHS control this industry.
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The rule regarding the need to see a Doctor for one year is wrong. For instance my previous physician is on suspension (no not Dr [redacted]) and I have 5 years of medical records regarding my sever chronic pain, I have hep c, chronic sever muscle spasms, zero appitite w/o marijuana, and I'm sure that whenever I can afford to go to the eye doctor I'll be treated for glaucoma (my mom has it). yet I still, by the draft rules, have a one--on--one relationship with a doctor (after I find out whether or not they will do a recommendation)--REDICULAS!!!
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.
Change the word "physician" to "medical provider". This will allow inclusion to all medical providers that are licensed to prescribe narcotics such as Nurse Practitioners. Nurse Practitioners in Arizona are currently allowed to prescribe narcotics including Morphine and Marinol. Nurse Practitioners should be allowed to prescribe medical marijuana as well.
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

In R9-17-303 I think the requirements B.1.b. "The physical address of the proposed dispensary", B.1.e. "The name and license number of the dispensary's medical director", and B.2.c."a copy of the business organization's articles..." should be deleted. This information is better left until the second part of the dispensary application and in fact the first two items are already included in R9-17-304 "Applying for approval to operate a dispensary" It is an unnecessary burden on prospective dispensary operators to have to go out and lease a site and contract with a medical director when the chance of getting a license remains rather small. Under your review policies, I fail to see how the address or the name of the medical director con enter into your selection process. The name of the CHAA should be sufficient for the first part of the process.In small towns that might have many applicants and limited vacant physical locations for a dispensary, they could all be tied up by the first applicants! If the department is worried about people making numerous submissions and not following through, then perhaps charge the same $5,000 fee (with $1,000 refundable in the event you are not chosen) but add in a $5,000 performance bond that is immediately refundable if the applicant is denied, but if granted a Dispensary Registration Certificate, the applicant would not get the performance bond back until gaining approval to operate his dispensary. I'd rather deposit the money with ADHS than pay a landlord to tie up a space I would never use if I was not granted a Dispensary Registration Certificate.
Delete section R9-17-101 7. Leave the CHAA's out. Leave the zoning laws to the cities which already took the initiative to pass zoning laws to protect where the Dispensaries can actaully be located at. I think all of cities of Arizona has done an amazing job keeping them away from schools, churches, and parks. R9-17-102.5 Qualifying patient should not have to pay more then 75 dollars. Most patients are on a fixed income where they only get 600-700 a month to survive off of. With the price of the current card, I feel that they will go elsewhere. They will got back to the black market, where the drug cartels have been lining their pockets for years R9-17-102.6 Designated caregiver, $200 has to be cut down to at least 75. Reason being is that if you charge people to help out patients, most will not pay that much money to help out other people. Unfortunately which the current economy it puts that extra strain on the will of the citizens. The Caregiver is the next step in line to getting immobile patients the medicine they need

Cross out the 25 mile rule and add this provision, Qualified registered patients under the prop 203 rules are allowed to cultivate their own medical marijuana within reasonable limits where it would only produce up to 2 and half ounces of dried cured medical marijuana for their own personal consumption only.
Should any governemental entity become adversarial in position to legalized medicinal cannabis or to qualified patients and caregivers, they shall not be allowed to use any records to pursue the patients or caregivers. Information provided by patients and caregivers during registration and in any other dealings with AZDHS (i.e. names, home addresses, facility locations, etc) shall be kept completely private, and not available to law enforcement.
page 37: "5. A sworn statement signed and dated by the +dispensary's local zoning jurisdiction+ certifying that the dispensary is in compliance with local zoning restrictions;"
Page 35: R9-17-303 B. 3. ADD IN "e. An attestation signed and dated by the principal officer or board member that the principal officer or board member has submitted, and will only submit one dispensary certificate application;"
Pg.35 - R9-17-303. Applying for a Dispensary Registration Certificate A. Each principal officer or board member of a dispensary is **A PERMANENT** Arizona resident and has been **A PERMANENT** Arizona resident for the three years immediately preceding the date the dispensary submits a dispensary certificate application.
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 Arizonaâ€™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 AZDHSâ€™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 Arizonaâ€™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 Arizonaâ€™s total non-Indian Reservation population. Under the AZDHS proposal group 1, representing 18% of Arizonaâ€™s population will receive 54 dispensaries. Group 2, representing 82% of Arizonaâ€™s population will receive 53 dispensaries. I have also looked at how dispensaries would be distributed among Arizonaâ€™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 Stateâ€™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 Countyâ€™s 41 dispensaries and those of smaller rural Counties. Maricopa Countyâ€™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 Propâ€¦ 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 Countyâ€™s 60% share of Arizonaâ€™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 Propâ€¦ 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 Propâ€¦ 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 Propâ€¦ 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 Arizonaâ€™s land that will be covered by â€œgrow your own exclusion zonesâ€ 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 â€œgrow your own exclusion zoneâ€ 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 Countyâ€™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 â€œgrow your own exclusion zoneâ€ 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 â€œ25 mile radius grow your own exclusion zoneâ€ 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.
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"; CHANGE TO: 3. The following statement "Keep out of reach of children."
R9-17-315. Inventory Control System B.4.i. The disposal of medical marijuana that is not usable marijuana including the: i. A description of and reason for the marijuana being disposed of including, if applicable the number of any male, failed, or other unusable plants; ii. Date of disposal; iii. Method of disposal; and iv. Name and registry identification number of the dispensary agent responsible for the disposal; Because this will mostly include leaves and stalks and roots and stems and possibly males or moldy, pest ridden, etc, change to: i. A description of and reason for the marijuana being disposed of including the weight; ii. Date of disposal; iii. Name of composting facility or landfill; and iv. Name and registry identification number of the dispensary agent responsible for the disposal; v. Chain of custody document showing transfer of the cultivation center's unusable marijuana waste to the transporter for the medical marijuana composting facility or landfill, if the facility generates more than 50 pounds of waste a month.Under 50 pounds of waste a month may be composted by the cultivation center.
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) donâ€™t require a doctor for a dispensary (4) keep delivery costs down. Thanks. The patient should always come first.
I'm sorry, but I don't have the section in front of me, but where rules mention "lottery", it should be ONLY ONE APPLICATION FOR A GROUP OF INVESTORS. APPLICANTS MUST LIST THE NAMES OF ALL INVESTORS (SO WE DON'T HAVE 10 INVESTORS LISTING 2 SITES FOR THE SAME GROUP) That would be unfair and unjust. Everybody understands you must not be partial, but a level playing field that does not favor the "deep pocket" investors is only just.
R9-17-309. Administration A. A dispensary shall: 1. Develop, document, and implement policies and procedures regarding: c. Inventory control, including: v. Disposing of unusable marijuana, through medical marijuana composting facility; (or they could compost themselves if a small dispensary, and they wanted to.)
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. Â§ 36-2801 for the qualifying patient; Hoping you'll scare off some doctors from providing recommendations? ========== change to: G.1. h. The name, address, and telephone number of a physician who has a physician patient relationship with the qualifying patient and is recommending medical marijuana by providing the written certification for the qualifying patient;
R9-17-202.F.1. e. The name, address, and telephone number of a physician who has a physician patient relationship with the qualifying patient and is recommending medical marijuana by providing the written certification for the qualifying patient; should be: R9-17-202.F. e. The name, address, and telephone number of the physician who recommended medical marijuana to provide relief for the qualifying patient's condition;

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
A physician can only recommend for medical marijuana to no more than 100 patients per year.
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
The referring physician must have had an ongoing doctor patient relationship for a year or records from a prior physician or documentation of a new condition for the referred patient to justify writing the prescription for medical marijuana. Smoking of marijuana on dispensary grounds shall result in immediate revocation of the license.
Proposed changes to the Draft of 1/31/11 Title 9. Health Services Chapter 17, Department of Health Services- Medical Marijuana Program Whereas the State of Arizona has seen fit to create licensure for physicians licensed to practice medicine who graduate from allopathic, homeopathic, naturopathic, and osteopathic medical schools and, Whereas the State of Arizona is on record in the creation of the four schools of medicine as not favoring one school over another school; see ARS-32-1554 and ARS-32-1852 and, Whereas monopolistic practice of one school of medicine over another by a state authority when the people of the State of Arizona through Proposition 203 said all four schools of medicine are to be treated equally in the administration of the law would be against the will of the people and the law of the State of Arizona and, Whereas the patient may not be able to afford the services of a naturopathic or homeopathic physician for their management and routine care since most of the insurance industry products, both state and federal, do not include either in their definition of physician and therefore most patients can not afford to be seen for their management and routine care by their choice of a naturopathic or homeopathic physician and, Whereas the use of the words management and routine care will create what one could term a monopoly of care where the physicians licensed to practice allopathic or osteopathic medicine would be the only physicians that most patients could afford for their medical management and routine care of a long term debilitating condition. In regards to R9-17-202, C, 5, e. and R9-17-204, A, 4, e. A statement, initiated by the physician, that the physician agrees to assume responsibility for providing management and routine care of the qualifying patientâ€™s debilitating medical condition after conducting a full assessment of the qualifying patientâ€™s medical history. Problem is the use of the words management and routine. Solution is to replace the words management and routine with cannabis or marijuana. If the words management and routine care were replaced throughout the entire draft in all of the rules with the word Cannabis or marijuana the entire issue of a State of Arizona provision of monopolistic entity creation would be solved with no monopoly being created

and the people of the State of Arizona will have full freedom of choice of school of medicine in which they want their physician to be trained. If these changes cannot be accomplished then the Department of Health Services must join with the Department of Insurance in going to the legislature and seeing to it that all of the appropriate statutes are rewritten to allow the insurance industry to include all four schools of medicine in their definition of physician and issue payment equally for same care provided to the patient regardless of type of physician. If this cannot be performed at this time then the rules must eliminate the chronic care phrase as well. Either will allow the law to be satisfied by the administrative rules implementing the 2010 proposition 203. Respectfully submitted by [redacted]

January 14th, 2011 RE: Proposed Draft Legislation concerning Medical Marijuana or Cannabis To Whom It May Concern: Proposed draft legislation is needed in order to avoid the California experience of doctors: â€¢ Easily qualifying patients without performing an adequate examination â€¢ Where the patientâ€™s regular treating physician is uninformed about the patientâ€™s choice to use medical marijuana, and therefore is unable to advise his or her patients about adverse reactions, side effects, or alternative treatments. My proposed draft legislation is as follows: That any practitioner recommending Medical Marijuana must complete and accurately record a minimum level 4 or 5 (E/M) Evaluation and Management service as described in the CPT - Current Procedural Terminology coding of the American Medical Association; and which has been adopted into common use by the United States Department of Health and Human Services, Center for Medicare & Medicaid Services. â€¢ Whereas a level 4 or 5 visit commonly includes: The presenting problem(s) are of moderate to high severity and the physician â– â– typically spends 45 to 60 minutes face-to-face with the patient and/or family. E/M requires the following three key components: Comprehensive history.â– â– Comprehensive examination.â– â– Medical decision making of moderate to high complexity.â– â– o With the only acceptable modification being: in those case whereby the patientâ€™s diagnosis was made by another practitioner (i.e. glaucoma) and cannot easily be verified by the recommending physician, only 2 (HPI) History of Present Illness elements need to be identified. o And whereby the patientâ€™s treating physician and/or primary care physician receives a consultation report detailing the report of findings, including a copy of the comprehensive examination and any recommendations made. Sincerely, [redacted]

R 17 302 Multiple applications will be awarded to those entities and persons most qualified to administer the program in a clinical manner, as directed by DHS, for the Citizens of the State of Arizona in a successful compassionate manner. No lottery methods will be used. R 9 17 312 Medical Director - Each MJD Clinic will have close Physician oversight by a Medical Director who is an Arizona Licensed Physician, either an M.D. or a D.O. This requirement will be reviewed in three years at which time it "may be removed as a requirement".

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Chronic pain should have a history of at least 2 years in order for the physician to recommend the use of marijuana.
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....
I think anywhere the rules refer to a Physician initialing forms and documents, etc., it should be changed to require the Physicianâ€™s signature and date. Example: Page 15, 5. e. through page 16, 5. l.. I think the term â€œpledgingâ€ used throughout the rules is to loose. I believe language should be changed to state that the individual SHALL NOT. Example: Page 17 h.ii..
There needs to be a final correction the requirement for a surety bond. It was taken out in one place, but left in the application process requirement section.
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
Common area of planned communities be included in the definition of "public place"
No

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 a year.
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
I believe that, as to the draft itself, it should be cut into 3 distinctive parts (separate from each other), 1. Dispensaries, 2. Doctors, and 3. Patients. The rules for the recommendation from a doctor needs to be relaxed so that they have a a better feeling about using a natural form of pain treatment instead of all the other chemicals they prescribe for the same treatment (keeping it out of Big Drug companies greedy grasp)
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.
R9-17-315B.7.e.The rule regarding the method of disposal of unusable marijuana should be consistent with R9-17-309 1.c. â€œDisposing of unusable marijuana , which may include submitting any useable marijuana to a local law enforcement agency;
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 patients per year.
Language in time-frames should be more specific: Table 1.1 Overall Timeframe (define) Should be 90-120 days Time-frame for applicant to complete application - Should be 15 days Administrative Completeness Time-frame - OK Substantive Review TimeFrame - Should be 45 to 60 days Applying for approval to operate - Should be 60 to 90 days Making these changes will accommodate for zoning enforcement and special use permit hearings. Special use permits are being required by nearly all Citys and Towns.

Changes: Strike R9-17-306 A - there is no legitimate regulatory reason for limiting the movement of dispensaries. The Department cannot predict changes in zoning, community reaction, force majeure events or simple changes in business fortunes - any of which could necessitate a change in location within a CHAA. Removing the flexibility to move locations serves no positive purpose for the public, patients or dispensaries. Modify R9-17-202 F 5 e. - add â€œprimary or secondaryâ€ as shown below. There is no basis in the Statute to force the recommending physician to provide primary care of the listed conditions. Although the language was struck regarding providing â€œprimary careâ€, the state should further clarify that the physician recommending medical marijuana need not be the primary caregiver for the qualifying conditon. This clause disrupts the normal patient/doctor relationship in complex medical care, decreases the likelihood that eligible patients will be able to get relief from the program, and would be subject to legal challenge that might delay the implementation of the dispensary component of Prop 203. Proposed language: â€œA statement, initialed by the physician, that the physician agrees to assume primary or secondary 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 historyâ€ Modify R-9-17-302 B 3. The allocation of dispensary licenses strictly by CHAA will result in poor coverage of population centers, with too few dispensaries spread too far apart for the expected demand. In addition, many dispensary licenses would be allocated to geographies that cannot support a single dispensary. Strike existing language and substitute: â€œ3. The Department shall allocate dispensary registration certificates as follows: a. For those CHAA zones with fewer than 50,000 people, the Department will: i. Set aside one dispensary registration certificate for each multiple of 50,000 people across all of those CHAA zones. ii. From this pool of certificates, the Department shall allocate dispensary registration certificates to the most populated CHAA zones in this group, until all dispensary registration certificates in the pool have been allocated. For each CHAA with greater than 50,000 population, the Department will allocate one dispensary registration certificate for each whole multiple of 50,000 in population. In the event that there are unassigned dispensary registration certificates after this process, they will be allocated by the Department so as to provide for the best geographic and population coverage across the state. Strike R9-17-303 B 1 b. This clause plus the prohibition against an address change is no different in practice than requiring a certificate of occupancy, and presents the same competitive problems. This favors the politically connected and the owners of real estate to the detriment of other applicants and ultimately to the patients whose choices in dispensaries will be limited. There is no legitimate reason to specify the specific address of the dispensary at the time of the application. Suggested language: ; b. The CHAA of the proposed dispensary; Strike R9-17-303 B 5. Once again, there is no legitimate reason to have to specify the location of the dispensary prior to the awarding of licenses. Any language in the final regulations that limits the ability of an applicant to apply without specifying a specific address will be challenged legally and will likely result in the delay of the dispensary licensing
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. Â I want to suggest these applicant show 3 years Arizona Â tax returns as proof of residency. Â 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. Â If a physical location is not required as part of the initial application prospective dispensaries would lock up a CHAA and potentially never perform. Â 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. Â Opening and operating a dispensary and cultivation warehouse will be costly. Â Many people who do not have the proven track record in business management will fail for a variety of reasons. Â Initially the largest factor will be the lack of capital. Â 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. Â 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. Â 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. Â 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. Â If this isn't the case please save me $95000 in application fees and clarify how multiple applications will be dealt with. Â Also in order to provide transparency to the process, I suggest a system be set forth for the procedures of the lottery. Â For example applicants should be present to accept if there name is drawn, and a runner up in case the first dispensary cannot perform or if more investigation confirms the winning applicant falsified there application.Â My next comment has to do with the lottery option itself. Â I spoke with Mr. Humble at the maricopa bar association continuing law education class a few weeks ago. Â 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. Â 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.Â 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. Â 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 there 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

R9-17-320 A and R9-17-321 A 1 state "within 500 feet of a public or private school". Please, let logic prevail; 500 feet is a joke. The distance needs to be within 1 mile. As most of AZ is laid out on a grid street system and schools are typically nestled inside a neighborhood (off an arterial street), 500 feet doesn't even get you out of the neighborhood and onto the arterial street.
The rules do not state a restriction of using marijuana in a "public place", in fact, other than in the definition, the draft rules use "public place" only once (R9-17-309 A 1 e iv) and this only relates to having policy and procedure documentation, not verbiage pertaining to actual restrictions.
Limit the number of patients a physician can recommend for medical marijuana to no more than 200 per year.
The 70% self cultivation rule was too restrictive, but eliminating it altogether goes too far the other direction. If a dispensary is not able to cultivate at least 40% of its own medicine, then it may not be managed by a group of professionals with the required ability to succeed long term.
R9-17-306 Should be modified as follows: Replace three years with one year. Also, there should be a clause added that allows a move without a waiting period should the following occur: Building is sold Building is destroyed Building is made unusable for dispensary purposes based upon electricity, water or security. Lease is cancelled.
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year

I currently am getting treatment for my eattin disorder - bulumia. The only medication that seems to work without any side effects is medical marijuana. That is the only thing that does not cause me to purge. The SSRI make me more depressed and increase my nausea. I am an athlete and don't like smoking marijuana but the edibles have changed my life. So was hoping it could be added to the medical conditions. thanks i would prefer anything natural verses a prescription!
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.
A qualifying patient shall be permitted to cultivate in their home irregardless of being within 25 miles of a dispensary.
My concern is the enforcing of these rules. It seems like it will be too easy for someone to get "a prescription." As a mother of a 30-year-old who has been in treatment twice, now clean for almost 1 1/2 years, I constantly hear from her, counselors, and others in the field of "recovery," that almost all drug users STARTED WITH MARIJUANA. I'm afraid there are not the "teeth" in these rules to insure the safety of those of acquire it.

No
These dispenseries must be monitored by the State and DEA
As a primary 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.
See above
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.
R9-17-107.H (added) The department will provided the proper Federal agencies a list of all qualified medical marijuana patients for proper placement on the lists prohibiting purchase or ownership of guns. R9-17-202.F.1.m; R9-17-202.G.1.p (added); and R9-17-204.1.m (added): The patient will sign an aggreement to allow the department to provide his or her name to federal agencies for placement on the list prohibiting gun purchasing or ownership because of known drug use. R9-17-205.I (added): The Department will revoke the ID card if the patient is found to be in possession of a firearm. R9-17-315.B.2.e (added): A laboratory report of analysis confirming the quality of the medical marijuana received.

Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year
Yes! My request for improvement is to change the following section to add the word "caregiver's." As the law is currently written, if a patient lives outside the 25 mile radius they or their caregiver can grow marijuana. However, it seems that the law does not sitpulate that the caregiver must also reside outside the 25 mile radius in order to be able to home grow. As they can grow up to 60 plants, this is very important. Add the word "caregiver's" to 36-2804.02 3.(f) 36-2804.02. Registration of qualifying patients and designated caregivers 3.(f) A DESIGNATION AS TO WHO WILL BE ALLOWED TO CULTIVATE MARIJUANA PLANTS FOR THE QUALIFYING PATIENT'S MEDICAL USE IF A REGISTERED NONPROFIT MEDICAL MARIJUANA DISPENSARY IS NOT OPERATING WITHIN TWENTY-FIVE MILES OF THE QUALIFYING PATIENT'S or Cargiverâ€™s HOME.
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.
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
After a dispensary is approved, a change in location may be permitted after review of the AZ Dept of Health. The change in location of an approved dispensary may be approved upon the needed demonstration of extenuation of circumstances to include natural disaster,fire, or relief of community disturbance.
Only the extreme penalties that should accompany any abuse of this law by dispensaries or patients by whatever legaleze language the lawyers choose.
Per the preceding comments, the [redacted] proposes that Part A of Â§R9-17-106 â€œAdding Debilitating Condition,â€ be amended to read as follows: â€œ(A) . . . (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; and (6) A summary of the evidence, including any published scientific journal articles, that the use of marijuana will provide therapeutic or palliative benefit for the medical condition or the treatment of the medical condition.
N/A
no
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 â€œâ€¦assume responsibility for management and routine careâ€ 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 canâ€™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 canâ€™t write them a medical marijuana recommendation and they canâ€™t see a medical marijuana physician for â€˜management and routine careâ€™, because it wonâ€™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.
ARTICLE 2. QUALIFYING PATIENTS AND DESIGNATED CAREGIVERS R9-17-202. F. 1. f. G. 1. l. H. R9-17-203 B. 5. C. 4. R9-17-204 A. 1. g. B. 1. l. Strike all language that would only allow cultivation for qualified patients, caregivers, and agents that are greater than 25 miles from nearest dispensary. All qualified patients, caregivers, and agents should be allowed to cultivate regardless of geographical relationship to nearest dispensary.
UPDATEDRE: 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.
Eliminate the residency requirements, they are not part of the proposition.
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. Thank you.
"The Rules, fees, and registrations of the ACT are entirely VOLUNTARY, with absolutely NO PENALTIES for ANY non-compliance; to penalize would be to deny the community standards and referendum intention, i.e., to remove [both] the government's & concomitant criminals' influences on any use or culture by reverting control and liberty of cannabis to the citizens." Reconcile this, if you can, or insert it into EVERY part.
No
No person may, directly or indirectly, alone or in combination with other individuals or entities, apply for more than a total of two dispensary, cultivation and/or infusion licenses.
Yes you left out the significant role of the human/plant relationship. I am an Earth Goddess, and

practicing Wiccan, a horticulturist and farmer here in Arizona, with extensive practices and sensitivity of our natural collective. My lifestyle allows me to work both physically and spiritually with no harmful additives to provide fruit, vegetables and herbs to the people that enjoy alternative food production. I was very excited by the new initiative to possibly include medical marijuana in my gardens, and to bring the highest quality medicine for an inspirational healing experience.
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.
The number of individuals that are interested in dispensary licenses seems to be high. There will most likely be several applications that do not result in a license. Please consider requiring a medical director to be listed after the registration certificate is issued, but during the "approval to operate" application process. delete: R9-17-303, e It is also required in R9-17-304, d
Yes. R9-17-317(H) "A dispensary shall have only one secured patient entrance, but may have other service entrances as long as they are secured and NOT used by patients."
Should a patient wish to petition to add a covered condition he may do so by providing his evidence as to the benefit of medical marijuana to three separate doctors. After reading said evidence and his record,if those three professionals agree it is in the best interests of the patient and other patients with similar condition to add that condition to covered conditions ADHS will do so within 60 days of receiving said medical recomendations.
Provide dialogue as to how the license may be sold or transferred.
The Defination of the 25 mile distance from a dispensary is to be defined as "further then 25 miles by the closest all weather navigable route to the nearest dsipensary."
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.
Sorry, I'm a computer mechanic, not a lawyer.
Nothing to add in this section at this time. Please see below or additional comments.
English
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year

Eliminate the lottery. Choose applicants based on quality, professionalism and fiscal soundness
Pg 34 of draft rules: R9-17-302, D1b: ".....the Department shall award the dispensary registration certificate based on the following criteria: Non - profit experience Knowledge of local community needs Expertise of key personnel Efficacy of the business plan The Offerorâ€™s responses should be in the form of a written narrative following each question. The response should be limited to facts with sufficient detail to allow adequate evaluation of the proposal. Restate each question and directly beneath the question, submit the written narrative. Name the files attached. â€œOffer Attachment 01 Service Implementation Questionnaireâ€. 1. Specify how you propose to serve the target population (medically involved patients who require medical marijuana). 2. Describe your organizationâ€™s capacity, knowledge of, and experience in addressing the needs of medical marijuana patients you listed to serve, especially individuals with most significant disabilities. 3. Describe how linguistically and culturally appropriate services and materials will be provided to meet the needs of persons using medical marijuana and accommodate their diverse languages, cultures, and geographic locations. 4. Describe the techniques, tools, and resources to be used in providing services listed below. Include how you will ensure the client successfully reaches the service outcomes and an average estimated timeframe for service completion: o patient care o hospice o rehabilitation o medication o state procurement processes o indoor cultivation o retail experience o experience working with disabled 5. Describe the Quality Control mechanisms that you plan to apply in order to determine the effectiveness of your program in meeting the objectives of this contract and carrying out the service provision. 6. Describe how you will measure and monitor clients and inventory.
Pg 34 of draft rules: R9-17-302, D1b: ".....the Department shall award the dispensary registration certificate based on the following criteria: Non - profit experience Knowledge of local community needs Expertise of key personnel Efficacy of the business plan The Offerorâ€™s responses should be in the form of a written narrative following each question. The response should be limited to facts with sufficient detail to allow adequate evaluation of the proposal. Restate each question and directly beneath the question, submit the written narrative. Name the files attached. â€œOffer Attachment 01 Service Implementation Questionnaireâ€. 1. Specify how you propose to serve the target population (medically involved patients who require medical marijuana). 2. Describe your organizationâ€™s capacity, knowledge of, and experience in addressing the needs of medical marijuana patients you listed to serve, especially individuals with most significant disabilities. 3. Describe how linguistically and culturally appropriate services and materials will be provided to meet the needs of persons using medical marijuana and accommodate their diverse languages, cultures, and geographic locations. 4. Describe the techniques, tools, and resources to be used in providing services listed below. Include how you will ensure the client successfully reaches the service outcomes and an average estimated timeframe for service completion: o patient care o hospice o rehabilitation o medication o state procurement processes o indoor cultivation o retail experience o experience working with disabled 5. Describe the Quality Control mechanisms that you plan to apply in order to determine the effectiveness of your program in meeting the objectives of this contract and carrying out the service provision. 6. Describe how you will measure and monitor clients and inventory.

AZDHS rules require a physician conduct a thorough and in-person examination, along with maintaining an ongoing doctor-patient relationship in terms of the diagnosed debilitating medical condition. AZDHS should establish a system that closely monitors physicians writing medical marijuana certifications.
The rules as written now say that a dispensary owner can not owe any taxes. However some tax payers may owe taxes on a payment plan, which is not so uncommon in this economy. If a tax payer is on a tax payment plan and is not in arrears on that payment plan, I feel that should be considered compliant.
RE: R9-17-202, Paragraph F, section 5, subsection e, Please clarify the difference in your first draft rules which state..."Has assumed primary responsibility..." vs. your most recent draft rules which state "...the physician agrees to assume responsibility...". This section e, if no further clarification of PRIMARY RESPONSIBILITY vs. RESPONSIBILITY is provided, should be deleted altogether.
Limit the number of patients a physician can recommend for medical marijuana to no more than 100 per year.
We do feel that Â§R9-17-302 should be deleted entirely. Remove the CHAA zones allowing one dispensary per zone. The selection process to become certified as a medical marijuana dispensary should be based on the proposed application guidelines. Applications should be reviewed by the DHS. Operating and dispensing licenses of medical marijuana dispensaries should be awarded and judged based on the experience and qualifications of the applicant.
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.
A physician cannot recommend medical marijuana to more than 100 patients per year.
I do not have specific language to use that would improve the rules.
See above
See above
See above
Wherever it says "physician," when referring to the provider who will certify the patient who qualifies for medical marijuana, it should read "physician or nurse practitioner."
Located in the dispensary placards that raise awareness to any adverse side effects and to contact their physician with these concerns.. Placards warning against impaired driving Placards that identify patients responsibilities to abide by laws dictating exposure of marijuana to the general public.
Please remove item below. leases usually are for 1 year. you have requirments to change address, this provides nessassary tracking 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.

--- R9-17-106-A-7: Delete. Alternatively, change R9-17-106-A-7 text to read "Articles, published in peer-reviewed scientific journals, reporting either a) the results of research on the effects of marijuana on the medical condition or the treatment
Social anxiety disorder article, [redacted]
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.

Do you have any specific language to improve the rules? Please include where the language could be incorporated.
Open-Ended Response
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.
• R9-17-312 – “Clarify Physician” . Should be just MD & DO. as the medical director will need to review traditional medicine care and history, western medicine knowledge is necessary.
R9-17-106 A 5: Availability of more expensive & dangerous prescription drugs ought not affect access to this beneficial herb. R9-17-312 D 2 a and 313 6: If a log book or electronic verification system is not required for more dangerous prescriptions, it ought not be here either. R9-17-315 B 4 f: Outlawing non-organic additives would be healthful, but I am glad at least for labeling. R9-17-202 F 1 h (and other spots): E-mail address IF patient has one. ii & iii: excessive, increasing cost to patient. G 11 e vi, ii, & iii: It is inappropriate to require more stringent physician oversight than for more dangerous prescription drugs because that would be unequal enforcement of the laws, discrimination against the medically disabled by ADA standards, and probably a violation of patient/doctor confidentiality. TYPOS: R9-17-3171 C iii (2) resolution of AT LEAST & R9-17-309 A 1 e: Education, ADD "as data becomes available"
I have included this as well as a need to include substance abuse professionals in the education, organization, and ongoing supervision of each dispensary in lieu of medical directors
Qualified patients wll be able to maintain thier caregiver, as long as the site is 10 miles away from a dispensary.(If this is not done or something similar protecting caregiver's patients it will create a monopoly for the dispensaries, who already charge substantialy more than caregiver will and even more than black market) Caregivers who sell their excess crop should be able to get a reasonable rate, caregivers time is not worthless.(and the dispensaries will make up to 4 times the amount for the same meds, monopoly plain and simple, and only available for the rich to own or shop at these dispensaries). CHAA should have no bearing on dispensary locations (this is little more than attempt

to eliminate caregivers and support big buisness, and with the unemployment rate as high as it is why would you not let people work)
R9-17-302 B.2.a If more than one dispensary registration certificate application for a dispensary located in a CHAA that the Department determines is complete and in compliance with A.R.S. Title 36, Chapter 28.1 the Department shall award the certificate to the applicant(s) providing the most detailed proposal for community outreach, physician education, patient support and charity care.
Strike the requirements for the Medical Director to be a physician. Change the current proposal to read as follows R9-17-312. Medical Director A. A dispensary shall appoint an individual to function as a Medical Director.
Make it so ANY patient can grow there own medication. Insurance will not cover marijuana and it will be far to expensive to purchise from a despencery.
i do not want medical marijauna to be smoked in public places. they can smoke it at home. why should i be exposed to that awful sickening smell. i do not smoke, but i am sure most smokers do not want that smell on them. who wants to be accused of smoking pot!?
The rules state that medical mj can be transported between a dispensary and qualifying paitent (please add their caregiver to that). Also the rules provide for a number of processes to verify the ID of the patient. I would suggest adding a statement that would specifically state that deivery is provided, it must be done so by a licensed/registered agent of the dispensary and not a third party. I would also suggest adding that the delivery must be made by a qualified delivery personnel trained in the dleiery of medical substances and/or pharmaceuticas. Also, that the delivery company must be in excess of $1MM in annua lrevenue with more than 60% of its business dleiverying medical products. the point is that we don't need one man bands on bikes delivering this stuff. It needs to be done by reuptable, legitimate businesses.
Well my proposed changes would make somebody go through the whole document and separate the cultivation from the dispensary aspects. This would take many hours and I don't want to spend the time unless it's a willing change.

Tighten up the criteria.
1. "Debilitating" means any disease or condition or treatment of the disease or condition that impairs the strength or causes weakness in a person.
Batch? What? Sounds like we're mixing something up. How about "lot number"
See above comments please. Thank you.
eliminate the Random selection portion from the dispensary permitting section
remove anything relating to "Random" choosing for permitting and implement a scientific review for each 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.

These two conditions should be allowed for the use of Medical Marijuana: *Migraines with or without nausea. There is no cure for Migraines. Individuals, including myself, are prescribed many combinations of drugs, both prophylactic and abortive. Sometimes they help, other times they do not. And in most cases they have negative downsides. Migraine patients also utilize many alternative therapies to augment their drugs. Just look at all of the numerous Migraine/Headache sites and blogs and you see the need for additional help. Everyone is different. What works for one person, may not work for the other. I am not under the illusion that Marijuana will eliminate the pain and nausea, but it most certainly will help in the management of this insidious disease. And with the anxiety and depression that this chronic illness causes, just knowing that there is another possibility out there in the medical arsenal does help with the anxiety and depression that accompanies many migraine/headache sufferers. Yes, we have many anti-anxiety drugs and many anti-depression drugs, but why not add another potentially promising natural drug that may ameliorate the need for so many other combinations of drugs that we migraine sufferers must take.? Many Migraine patients take many, many harmful drugs, and by doing so contribute to Rebound Headaches--and the Migraine/Headache cycle continues unabated. By either eliminating some and/or lessening the dosage of other drugs, the addition of medical marijuana would be a blessing to all of us sufferers. Give us the chance to the see if it helps. Please include Migraines/Headaches in the list of acceptable conditions/diseases that allow for Medical Marijuana. *Restless Leg Syndrome Unless you experience it first hand, it seems like a condition that the drug companies made up to boost their sales. This is far from the truth. It is an insidious disease and drastically interferes with sleep. Even with medications, there are many nights that I have to pace the floor until the very unpleasant condition stops. I have tried many sleeping medications, but I have had very unpleasant reactions to them. Medical Marijuana would be very helpful in the restoration of sleep, which the lack of or poor sleep may have direct effect on my migraines.
I strongly suggest that "common areas of planned communities" be included in the definition of "public places." Reference page 5, number 21. "Public Place" Private planned communities have common areas where children play. There should be no use in these common areas.
As a physician I find that the approved diagnosis are very broad, which may or may not be what was intended.
a dispensary can not contract with a infusion facility that co-mingles its kitchen with food sold to the general public, delivery to and from the infusion facility must be done by the dispensaries agent the

infusion facility can not sell its products to anyone other than a dispensary the infusion facility must have qualified chefs and bakers on staff and on duty , who have shown at least 3 prior years, at least one chef supervisor per shift in the baking and production of food to the general public the heath certificate for the facility must remain in good standing at all times food is prepared a limited caregiver certificate or card should be issued to all employees who handle marijuana for infusing in edible products. (limited,,,allowing only the ability of handling the marijuana product for the purpose infusion of edible products). all products leaving the infusion facility should be individually wrapped in (one dose) packaging, the infusion facility should set standards for the meaning of (one dose) for consistency. the infusion facility must have a gated and secure area for loading and unloading products the infusion facility needs steel doors and bars on all widows. the infusion facility must verify by standard control method where the product was produced, how much product was delivered, if the product is suitable for consumption, how much product was produced, all leftover leaves and unusable product must be disposed of according to hazmat standards
Consider the word adulterate, because adding marijuana makes the food product less pure.
I would propose adding language regarding the specifics on how law enforcement may forward police reports regarding problems at dispensaries, as well as infractions committed by qualified pateints and caregivers to DHS. I also believe language specifying that law enforcement can conduct a walk through of dispensaries or cultivation sites during normal business hours (much like that done in bars) would be effective in assisting DHS with insuring that agents at these locations are following rules. Finally, I believe access to a data base where law enforcement can ascertain whether an individual is approved to cultivate their own marijuana is instrumental in assuring officers and the public are protected.
r9-17-101 section 17 should specifically include "pharmacies" as a public place. Often considered a health care facility,it should not be assumed that pharmacies are included due to the nature of business.
R9-17-316 E. Any dispensary, dispensary agent, designated caregiver, or reistered qualifying patient may submit samples of 5 grams or less of cannabis or edible food product to a bona fide analytical laboratory for the purpose of testing the product for potency or contamination. Any analytical laboratory within the State of Arizona that holds a license from the federal government to possess controlled substances shall be permitted to conduct analyses of medical marijuana or edible food products containing medical marijuana on the behalf of licensed dispensaries, dispensary agents,

designated caregivers, or registered qualifying patients. Any analytical laboratory that provides analytical services of medical marijuana or edible food products shall maintain secure storage of medical marijuana products prior to and after analysis. In addition the laboratory shall be responsible for keeping complete chain of custody records that identify the sample by batch number, source, the amount received, secure storage location within the laboratory, the amount extracted for analysis, and the amount of product returned to source or destroyed, with dates and certifying signatures for each of these events. Medical marijuana remaining in the custody of an analytical laboratory subsequent to analysis shall be returned to the original provider or destroyed by the laboratory at the option of the original provider. The laboratory shall provide a printed report of the analytical results to the dispensary, dispensary agent, designated caregiver, or qualifying patient who has requested analysis of medical marijuana or edible food product. All records concerning handling and analysis of each sample shall be kept on file at the laboratory, available for inspection for a minimum of 3 years.
"common areas of planned communities" be included in the definition of "public place".
ADHS should immediately drop the lottery system for deciding the license recipients for multiple applications in the same CHAA to avoid probable "Organized Crime" influences in our State.
-

Define terms "not for profit" company-is this a non profit company?
Suggest a more detailed and focused method of reviewing and issuing dispensary certificates
Yes. Please include in Rule R9-17-101 (21.b.) "planned communities". I have copied section 21 and included in capital letters the location of and specific language to be added. 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, PLANNED COMMUNITIES, 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
R9-17-316. Product Labeling and Analysis A 3. The following statement "ARIZONA DEPARTMENT OF HEALTH SERVICES' WARNING: Smoking marijuana may be habit forming, cause lung irritation and can impair one's ability to drive a motor vehicle or operate heavy machinery";

See above
Common areas of planned communities shuld be included in the definition of "public place".

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. Subsequent to discussions with the [redacted] 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.
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.

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
Please make sure the rules prohibit smoking marijuana in public places where others can be exposed to the second-hand smoke, such as public parks, common areas in subdivisions, and public parking areas.
25 miles caregiver distance needs to be eliminated if not reduced.
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.

Who are licensed food establishments allowed to acquire the medical marijuana from? i.e. if a caregiver owns a licensed food establishment has excess marijuana, can they use it to make baked goods, candy, etc. to sell to the dispensaries? i.e. Dispensaries to someone that does not have the license to possess it- would the food est. be required to be a dispensary agent, caregiver, or patient?
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.
See above.
R9-17-302. Dispensary Registration Certificate Allocation Process A. 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 employ an objective "points" system that evaluates financial resources, years of relevant experience, educational background, business history, efforts to address law enforcement concerns, past criminal activity, surety bond, assets currently on deposit in arizona addressed account and the length of time those accounts have been existent. this point system will be applied to all applicants equally and the applicant with the highest aggregate point score will receive the dispensary registration certificate for the CHAA to that applicant

Wish I did..
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.
25 miles is quite a distance to go even if yo have a car, what happens next year when gas is $5.oo a gallon, and you have to go to one store in town and your physically handicapped and are targeted by criminals because you go to one store in the middle of town? You don't have any extra money and can't defend your self, what then carry a hand gun to get some pot, these people aren't violent type people, they are already suffering, and this or other towns want you hearded into one place to be robbed. A few dispensaries won't hurt anyone, plus it will be extra money for the program. I hope I'm making sense as I'm in quite a bit of pain having to sit here and write this, and am not sure if it's in the right place you want it written in.
Be more specific about indoor/outdoor growing restrictions
Add PTSD and any language to insure no monies or tax are added to the cost of the process in which prop 203 becomes law to include any process involving marijuana, its production, cultivation, dispersal, purchase, or movement or any other situation which would force the patient to incur more cost as a result of any taxation.

None at this Time.
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.
Addressing cultivation only operations
no one using medical marijuana may operate a motorized vehicle and said person may not carry or have in there possession a fire arm of any caliber for any purpose
Instead of saying that a "physician" needs to write the certification, perhaps you could change it to "qualified health-care professional" throughout and then define that term at the beginning where all the other definitions are. My list above includes licensed acupuncturists, licensed naturopathic physicians, osteopaths, licensed chiropractors, and nurse practitioners, but other health-care professionals could also be included.

Marijuana should be prohibited in public places including common areas of planned communities, 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.
The state must identify the approved chemicals used to cultivate and prevent unnecessary contanimation of communities. The option of organic growth products must be considered.
Those qualifying persons on S.S.D. (with incomes of $17,000 or less), S.S.I. or Medicare are exempt of the fee.
No
“common areas of planned communities” be included in the definition of “public place.”
SAME AS ABOVE.
NO TAXATION WHAT SO EVER LIKE THE LAW SAID AND ADD PTSD
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: According to this, a patient cannot apply for registration until AFTER their physician sends in written certification. Patients should be allowed to send the certification in with their application, and not be made to wait any longer than necessary for approval.

No where did I read where people have to carry their card with them on their person. Just that they have to have one. If they are traveling they should have their card on their person.
Relating to the caregivers:Do not allow CHAA as a violation of Prop. 203, which specifies individuals rights to a caregiver and most importantly the patient's right to have a caregiver. Caregivers should be allowed to sell their excess stock to dispenseries. Caregivers patients should not have to live 25 miles from Tucson.
Recommend that “common areas of planned communities” be included in the definition of “public place.”
I would like to request that "common areas of planned communities" be included in the definition of "public place!! [redacted]
I would like to see a better definition of "public place". I would like to see planned community common areas added to the definition of public places. In other words, I do not want it to be legal to use in common places. I would also like to see the use of it restricted to indoors only. Not in front or back yards, porches or balconeys.
Please ensure that "common areas of planned communities" are included in the definition of "public place."
Could a Medical director be available to ALL 124 dispensaries on a 24 hr basis via phone? (Similar to a Poison Control Line)
THE DEPARTMENT OF HEALTH SERVICES NEEDS TO HAVE THE LOCAL JURISDICTIONS USE APPROVAL AT THE TIME OF APPLICATION FOR THE DISPENSARY REGISTRATION CERTIFICATE ON MAY 1, 2011. OTHERWISE, CURRENT CITY PROCESSES FOR CONDITIONAL USE PERMITS AND OTHER USE ACCEPTANCE APPROVALS WILL BE MEANINGLESS. THE STATE COULD POTENTIALLY SELECT AN APPLICANT THAT HAS EITHER NOT ATTEMPTED A REVIEW BY A CITY PROCESS OR THAT WAS REJECTED BECAUSE OF SEPARATION REQUIREMENTS FROM ANOTHER CITY APPROVED DISPENSARY. Please

modify accordingly, thank you.
Persons qualified to use medical marijuana may not smoke it in common areas, to include common areas of planned communities.
Common Areas of Planned Communiteis should be included in the definition of "Public Places".
Please include "common areas of planned communities" in the definition of "public places". Thanks!
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.” so William go get your 3/4 vote in state government if you are even thinking of tweaking the Law voted in by the Voters of our great state in November of 2010.
I request that "common areas of planned communities" be included in the definition of "public place".
In public areas with no-smoking policies, this should be maintained. As in my community (gated) we have a NO smoking policy and this should be maintained. It appears that people will be allowed to smoke marijuana in public areas currently prohibited to smoke a regular cigareete or cigar. Smoking is smoking and ALL FORMS should be prohibited from all public areas.
R9-17-302 B2b: I would cross randomly select and change the words to " the Department shall award a dispensary certificate based on the merrit of the application.

You need to have a better definition of physician who is making the recommendation for medical marijuana usage. The revised draft wording would imply that the physician making the recommendation would be the main managing entity for the underlying condition. In the real world the management of a complicated diagnosis such as multiple sclerosis may involve several different health care professionals managing different aspects of the underlying condition. For example to a physician may be involved with the management of spasticity related to multiple sclerosis but not necessarily be providing treatment for the underlying condition.
Strike all of R9-17-312.
Please include the following language in definition of "Public Places", part B. Common areas of Planned Communities
Instead of saying random drawing it should read towns choice in case of more than one applicant.
Yes! In the "Article 1 General." In section R9-17-101, in number #21, "Public Place." I believe "Public transportation facilities" should be more clearly worded to be interpeted as "not including personal transportation vehicles", which could possibly be interpeted "technically" as public transportation facilities by any harrassing law enforcement agency. Without this "correct" interpetation, a legal marijuana patient would not be able to transport his or her medical marijuana from a dispensary to their residence. I believe if there are "ANY" loopholes, that some law enforcement people and/or agencies will try to stop the true and legal spirit of this medical marijuana law. Thank you for giving me the opportunity to explain this and for the time you took to review this.
Patients living at or below 250% of the Federal Poverty Level (FPL) be waived of all associated state sales tax and registration fees. Our organization has worked with the Colorado Department of Public Health and Environment (CDPHE) to ensure patients demonstrating the most need have access to affordable medicine. We will be testifying in response to CO-HB1043 to include language adopting the Colorado Indigent Care Program's standard of indigent assistance when waiving all sales tax and state fees for patients who have the least amount of financial resources.

add ptsd and limit taxation of any association or variation of wording that refers to medical marijuana and its persfcription
ADD PTSD
Add ptsd
Add ptsd
Add ptsd
R9-17-106 Section A be consistent with term of person or individual, currently mixing both. R9-17-106 Section B after Section 1. Add 1.a. 'FDA approval of marijuana for medical use required and must not conflict with Federal Law' R9-17-201 add phrase '…at least one of the following conditions for a minimum of one year consistently' R9-17-202 Section F.1.f. change to 'qualifying patient is not allowed to cultivate marijuana plants for their own medical use even if they reside at or greater than 25 miles from the nearest operating dispensary.' R9-17-202 Section F.5.g. add in '…has conducted an in-person yearly physical examination of the qualifying patient….' R9-17-203. Section A.2.h. add iii ' Designated caregiver has the right to refuse assisting patient due to own health considerations and personal beliefs.' R9-17-204 Section B. change to 'A qualifying patient under 18 and younger shall not be able to obtain a registry identification card even with custodial parent or legal guardian consent.' Remove all other language. R9-17-205. Add Section I. The Department may deny or revoke registry identification card if the qualifying patient or designated caregiver uses marijuana while a minor is present.' R9-17-205. Add Section J. The Department may deny or revoke registry identification card if qualifying patient or designated caregiver uses marijuana outside causing restriction of fresh air for their neighbors, neighbors file complaint with Arizona law enforcement or security, or they negatively impact the health of the persons in their neighborhood or workplace or breaks the Smoke Free Arizona law. R9-17-205 Add Section K. The Department may deny or revoke registry identification card if the qualifying patient or designated caregiver are convicted of a minor or major offense while under influence of marijuana. ' R9-17-304 Add Section 1.m formal registration to be in compliance with federal law R9-17-306. Add Section B.4. a. dispensary or dispensary cultivation site must be at least 100 miles away from any public, private or charter school. R9-17-312. Section A. add 'Medical director of a dispensary may not also issue prescriptions to a qualifying patient or designated caregiver. Medical director must be Arizona state board certified.' R9-17-313 Add Section 7. 'verify no conflicting issues with other prescription or non-prescription drugs qualifying patient takes.' 'verifes that the marijuana is pure and not altered with other drugs' R9-17-315 Section B.1.a. proper disposal procedure of marijuana whether usable or unusable.
Public place includes . . . common areas of apartment complexes and planned communities and common elements and limited common elements of condominiums, including patios and balconies, . .
See above
See above

Do not prescribe; retail sales through tobacco and alcohol.
My wife and I live in an HOA with common areas. Additionally, I represent community members in our HOA as a member of the board. I would like to suggest that “common areas of planned communities” be included in the definition of “public place.” The proposed rules prohibit smoking marijuana in a “public place" and our common areas are places where our kids and neighbors play and mingle. Thanks.
IMPORTANT: The state rule requirements need to have, as part of the dispensary certificate registration process ("R9-17-303, page 35"), an application requirement that also provides the local jurisdictions copy of a use permit or land use acceptance, or as adopted by the local jurisdiction (no certificate of occupancy). The second component of the process to apply for the full dispensary application should then include the Certificate of Occupancy or any related clearances required by the local jurisdiction. These modification procedures would coincide with municipality processing: an approval letter with conditions, and then final permits (CofO) to occupy the site.
Add common areas of planned communities to the defination of public places prohibiting the smoking of medical marijuana.
We would ask that you add “common areas of planned communities” to the definition.
"common areas of planned communities" be included in the definition of public places.

please include COMMON AREAS OF PLANNED COMMUNITIES in the definition of PUBLIC PLACES.
Add PTSD
none
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 three years immediately preceding the date the dispensary submits a dispensary certificate application. (Pg:35) ---------- 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, immediately preceding the date the dispensary submits a dispensary certificate application. (NO RESIDENT TIME FRAME RESTRICTION)
Add ptsd to the ailments section
"Privacy" doesn't appear. "Prescription" needs to appear in appropriate places.
R98-17-102 (B) Add reduced fee for Social Security recipients.

I request that "common areas of planned communities" be included in the definition of "public place".
The language must be clear that medical marijuna users can only smoke or ingest by any other method ONLY INSIDE their residences or within the boundaries of their back yards, if and only if, they own the property.
As a board member of an large HOA, I request that “common areas of planned communities” be included in the definition of “public place.”
please remove the bankruptcy rule for potential dispensary owner applicants, anyone with a bankruptcy should be allowed to apply for a dispensary license.
Strike all references to dispensaries being allow to contract with licensed food facilities for the purpose of infusing medical marijuana into food products. R9-17-318 (throughout) Should this contracting of licensed food facilities be retained, a listing of public places needs to be easily available noting the name and address of the facilities through the ADHS website. Maricopa County would view any and all medical as well as illegal marijuana as a drug and an adulteration of the food product which could result in Enforcement actions being taken should the establishment elect to add product into a food product. Require that if and when medical marijuana is being infused into food that it is done in the dispensary and all portions of the facility are permitted and inspected by ADHS including the food infusion process and equipment. This would ensure a better accounting of the medical

marijuana seeing it would all stay within the dispensary unit. Maricopa County would not accept the delegation agreement pertaining to dispensary food service operations.
remove R9-17-305 A.
Thank you for allowing the citizens of AZ who voted for this intiative to become law to voice/add their input: I just want to say that WE THE PEOPLE must srtive to keep the INTENT of this soon-to-be law in mind; that we must make it as EASY AS POSSIBLE FOR THOSE ARE: QUALIFYING PATIENTS, QUALIFYING DISPENSARIES, ETC. TO RECEIVE/DISPENSE MEDICAL MARIJUANA IN A TIMELY, SAFE, AND AFFORDABLE MANNER, AND: TO ACCOMODATE THOSE QUALIFYING PERSONS WHO ARE UNINSURED (I AM CURRENTLY ONE OF THOSE PEOPLE). Thanks again, concerned citizen.
redefine "public places"to include those common areas of communites, such as parks, playgrounds, etc. Most HOA's define these areas as private property, for use only by the residents of the community. What we do not need is people smoking pot in these "common areas", around children.
eNGLISH SHOULD BE THE ONLY LANGUAGE BECAUSE THAT ID THE OFFICIAL LANGUAGE OF THE UNITED STATED. MAKE THEM GET WITH THE PROGRAM OF THE ENGLISH LANGUAGE.
R9-17-312 is objectionable in its entirety. the ADHS has no authority to require a medical director, much less to define or restrict a physician's professional practice. has no authority. read prop 203 again. the people of arizona voted for fair elections in 1998. prop 203 made this paticular case well known in the law. the arizona medical marijuana act 2010. prop 203
I would like to include " all common areas in planned commuities" added for Public Area's
See item 1) of the email with Pinal County inserted in "How can the draft rules be improved?"

common areas of planned communities should be included in the definition of public place.
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 SCHOOLS, 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
drop the 25 mile grow rule and let us decide what we want to do. not all patients will be able to afford the prices dispensaries will be charging. smoking areas need to be opened up!!!! parks,lakes,campgrounds,hotels basically anywhere adult smokers can smoke now. and price protection from the dispensaries need to be a must!
The areas of a Planned Community are included in the definition of Public Places
"common areas of planned communities" are included in the definition of "public place."
let multiple cultivation sites in one area, so the police can patrol the area easier.
How can the draft rules be improved?Do you have any specific language to improve the rules? Please include where the language could be incorporated. Cultivation sites can be as close as they want to be, as long as it is a industrial area. so to ensure to keep crime against cultivation sites is easier to police. Cops will have a easier time driving around one area to thwart crime than having to go all over the valley, just to keep a eye on the cultivation sites
Cultivation sites can be as close as they want to be, as long as it is a industrial area. so to ensure to keep crime against cultivation sites is easier to police. Cops will have a easier time driving around one

area to thwart crime than having to go all over the valley, just to keep a eye on the cultivation sites
Add PTSD to illnesses
In the description of " public place",the language" the common areas of planned communities" should be spelled out
Delete bankruptcy rule.
R9-17-302 (B) 2 b ii Use an arbitrary lottery "unless a local selection option has been enacted."
I would keep whatever language is appropriate as concise as possible, relating it to the public restriction, without any dissertations or expressions of individual or group philosophy either pro or con.
The Arizon Medical Marijuana Act protects medical marijuana users who comply with its requirements from sate and criminal prsecution for production, possession or delivery of a controlled substance.
Public Areas of planned communities should be included in the areas where smoking marijuana is prohibited.
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. doesnt 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!
Common areas of planned communities"be included in the definition of public place".
We request that "common areas of planned communities" be included in the definition of "public place". Respectfully, [redacted]
Comments by: [redacted] Ref: DRAFT 01/31/11 TITLE 9. HEALTH SERVICES CHAPTER 17. DEPARTMENT OF HEALTH SERVICES – MEDICAL MARIJUANA PROGRAM Nowhere in the draft is it stipulated the source or registration, acquisition and distribution of the seeds or cuttings for the first permitted cultivation operations. Those rules should also be stipulated. Arizona must avoid implementation problems that have occurred in other states that have led to so many abuses. Many of those states have refined or are in the process of refining definitions of ‘qualified physician’ and ‘qualified patient’ with

requirements designed to curb or mitigate abuse. It is crucial for Arizona to implement rule that avoid those problem for the start. Protections need to be established prevent forged physician name, signature, and license information recommendation certificates. Stipulate the definition that "Physician" means Arizona Medical Board Certified "medical doctor" or "doctor of osteopathy" holding "Active license", and excludes nurses, physician's assistants and "homeopathic physician" unless also a MD or DO. Physicians must hold a license that is not restricted from prescribing pharmaceuticals. Stipulate the definition that "Active license" means a valid license to practice medicine and includes the license of a licensee who has been placed on probation or on whose license the board has placed restrictions. Rules should stipulate a max ratio of qualified patients to a qualified physician (i.e. 100:1) Rules should stipulate a max ratio of qualified patients to a qualified care giver (i.e 3:1) DHS should establish rules for advertising medical marijuana R9-17-102. Fees As that proposition did not provide funding for administration, the fee structure 'must' cover all of the real costs of administration. Administration of this program must not come at the expense of other programs. The rules should stipulate that DHS must use collected fees to offset the costs of program administration, and to help keep fee structures as reasonable as possible. The rules should stipulate that all fees for which DHS is not at fault, "non-refundable". Applications not fully complete within stipulated time-frames from the notification date of deficiency in application are considered withdrawn. The rules should stipulate that non-medical marijuana retail dispensary transactions, are not exempt from State, County, or municipal sales taxes. The rule should stipulate that time-of-sale 'administration fee' of $10.00/ounce (amount subject to annual review) will be required to be paid by the dispensary for dispensary patient medical marijuana transactions. The time-of-sale 'administration fee' will be paid via electronically or telephonically to DHS at the time-of-sale for on premise transactions, and for all others, no later than the end of the next business day. R9-17-107. Time-frames For 'dispensary is ready for an inspection by the Department', the rule should stipulate criteria to include certification (zoning, use or special permit, business license or other requirements) from County and/or municipality, or tribal government. Rule should stipulate annual renewal for all registry applicants (physicians, patients, care-givers, dispensaries, and cultivation sites). Rule should stipulate physician's medical cannabis recommendation can be valid for no more than one year. R9-17-308. Inspections Department shall not use allegations of a dispensary's or cultivation site noncompliance from anonymous sources as sole justification to conduct an unannounced inspection. Allegations of a dispensary's or cultivation site noncompliance must be accompanied with 'substantial evidence' to cause the Department to conduct an unannounced inspection. Nothing in this section shall preclude the use of any substantial evidence or information, regardless of source, that is relevant to a dispensary's or cultivation site compliance with applicable requirements. The Department decision process to act upon an allegation of noncompliance from anonymous sources must be defensible to standards of review, including abuse of discretion, arbitrary and capricious and substantial evidence standards. Rule for 'certification or compliance inspection', criteria should include inspection of certification (zoning, use or special permit, business license or other requirements) from County and/or municipality, or tribal government. Rules should stipulate that the Department shall perform Fraud and Abuse Audits in qualified Physician Offices, in dispensaries and cultivations sites, either routinely or when indicated by substantial evidence of noncompliance. R9-17-309. Administration A.1. Rule should stipulate 'employee inventory accounting and employee theft prevention' policy R9-17-321. Denial or Revocation of a Dispensary Registration Certificate Either this rule should include, or another rule created to address temporary suspension of certificate, criteria for suspension (substantial noncompliance not rising to the level of revocation), requirements for challenging a suspension, requirement of reinstatement, reinstatement fee, requirements for number of suspensions (per year and per Certificate) before revocation. Denial, Suspension or

Revocation of certification should be automatic for revocation or suspension of certification (zoning, use or special permit, business license or other requirements) from County and/or municipality, or tribal government. Upon Denial, Suspension or Revocation of or change in the status of certification, DHS will notify the designated representative(s) of the County and/or municipality, or tribal government that holds jurisdictional authority over the premises subject to the Certificate. Rule should stipulate that knowingly failing to report fraud involving medical marijuana is grounds for Denial or Revocation of a any registry certificate (physician, care giver, patient, dispensary or cultivation site) R9-17-202 Applying for a Registry Identification Card for a Qualifying Patient or a Designated Caregiver F.1.b., G.1.b. and G.1.f. should stipulate …"The Arizona residence address and mailing address" F.1.c., G.1.c. and G.1.g. should stipulate …"The Arizona county where the" F.1.e. and G.1.h should stipulate an …"Arizona physician providing the written certification"… F.1 should also stipulate "The Arizona residence address and mailing address and Arizona County of cultivation location if applicable. Stipulate that the cultivation must be where patient resides. F.2, F.6.i. and G.6. should stipulate a "valid State of Arizona" drivers license or identification card, reflecting the address where the qualifying patient 'currently' resides, and that must correspond to the address provided on the application. When the valid State of Arizona" drivers license or identification card does not match the current address of residence, or when the valid identification used is a U.S. passport, then section F.2 should provide the standards for additional documents that can be used as proof of residency. Acceptable forms of identification without a photograph that bear the name and address of the applicant (two required): * Utility bill of the applicant that is dated within 90 days of the date of the application. A utility bill may be for electric, gas, water, solid waste, sewer, hard line telephone, or cable television * Bank or credit union statement that is dated within 90 days of the date of the application * Valid Arizona Vehicle Registration * Indian census card * Current year property tax statement of the applicant's residence * Tribal enrollment card or other form of tribal identification * Current Arizona vehicle insurance card * Recorder's Certificate * Valid United States federal, state, or local government issued identification F.5.a.ii. and G.11 should stipulate " Arizona License number"… F.5.a.iii. and G.11 should stipulate " Arizona Office address"… F.5.a.iv. and G.11 should stipulate " Arizona Telephone"… Signature of Qualifying Patient or a Designated Caregiver or custodial parent or legal guardian, should stipulate "Notarized Signature of"… Apply the same changes, suggested above for R9-17-202, where appropriate to R9-17-203, R9-17-204, R9-17-303, R9-17-304 and other rules as appropriate. R9-17-303. Applying for a Dispensary Registration Certificate The rule should stipulate the standard for proving Arizona Residency, and should stipulate "three full years (1095 days)" R9-17-303 Applying for a Dispensary Registration Certificate (and R9-17-306 Applying for a Change in Location for a Dispensary or a Dispensary's Cultivation Site and R9-17-307. Renewing a Dispensary Registration Certificate) B.5 should stipulate "…is in compliance with applicable County and/or municipal zoning restrictions, permits and occupancy requirements". 4. Should stipulate "The each distance to the closest • residential district • public or private preschool, kindergarten, elementary, secondary or high school, college or university • seminaries or place of worship • libraries • public park • community center • athletic fields • other existing businesses or play-place type establishments, jungle gyms type businesses, etc. • facilities of service agencies whose focus is on minor children • hospitals, urgent care centers, pediatric clinics • drug or alcohol rehab facility • halfway houses • jails or detention centers • another adult business establishments R9-17-309. Administration A.1.e. Should also stipulate "Individual and business private property right to prohibit consumption or bringing marijuana onto their property or into their business. Should also include landlord and tenant rights in regards to consumption storage. R9-17-313. Dispensing Medical Marijuana Rule should be expanded to specify standard for verification of qualifying patient's or designated caregiver's identity. Rule should anticipate that the recommending physician,

qualifying patient's or designated caregiver's status will periodically create the situation where the presented registry identification card is no longer valid (revoked, lost, stolen), could be forged, or could be presented to several dispensaries, or the qualifying patient is receiving medical marijuana from multiple designated caregivers, or the recommending physician of record in no longer in good standing with the Arizona Medical Board. In order for dispensaries properly dispense, and not become a facilitator of fraud and abuse, DHS must impose a requirement that the dispensary verify with the DHS the current validity of presented registry identification card prior to each dispense transaction. R9-17-314. Qualifying Patient Records Rule should stipulate notification requirements in the event of loss or compromise patient records, and should also stipulate that copies of patient records will be provided to the qualifying patient's or designated caregiver's upon request, within a reasonable time-frame, and allow a reasonable fee to be charged for that service. R9-17-315. Inventory Control System B.5. Rule should stipulate "For providing medical marijuana to another "Arizona" dispensary:" Rule should prohibit providing medical marijuana to another dispensary outside the State of Arizona. Rules should be established for dispensing in a food establishment, including record keeping, storage, security, marking, prep, quantifying and tracking against patient quantity limits, etc. Rules should stipulate that dispensary stock shall never exceed 20% more than the total monthly demand. Rules should stipulate that the dispensaries cultivation site have growing and stock limits that correspond to the dispensary stock limits. Dispensary and cultivation site stock that exceeds the specified limits must reduce the excess stock via transfer to another Arizona Dispensary or be disposed of IAW B.4.i. Rule should stipulate that in the event that DHS revokes a dispensary and/or cultivation certificate, all medical marijuana stock and food products will not be transferred to another dispensary of cultivation site, and will be disposed of IAW B.4.i. Also in the case of revocation, the dispensary agent will deliver copies of all dispensary and cultivation site inventory management records, and patient records. R9-17-316. Product Labeling and Analysis C. Rule should stipulate "The total weight of the edible food product and the total weight of the medical marijuana before addition to the food product in the package". Food product dispensing must comply with patient product weight and time restrictions. R9-17-317. Security Rule should stipulate that before transport in a motor vehicle, the medical marijuana must to placed in a container that will prevent any marijuana, or seed could be left undetected in the vehicle. The rule should stipulate that an operator of a vehicle that has be used for authorized transport, that when used for other purposes, is not immune from sanctions of possession and trafficking. Rule should stipulate off-premise monitoring service for panic alarms during occupied hours, and during unattended hours. Rule should stipulate that the trigger of panic alarms or unattended alarms will generate alerting of law enforcement. R9-17-320. Physical Plant Rule should stipulate that unless otherwise restricted by County and/or municipality, or tribal government, a dispensary requesting an initial registration and certificate approval to operate shall be located at least 500 feet from: • residential district • public or private preschool, kindergarten, elementary, secondary or high school, college or university • seminaries or place of worship • libraries • public park • community center • athletic fields • other existing businesses or play-place type establishments, jungle gyms type businesses, etc. • facilities of service agencies whose focus is on minor children • hospitals, urgent care centers, pediatric clinics • drug or alcohol rehab facility • halfway houses • jails or detention centers • another adult business establishments R9-17-321. Denial or Revocation of a Dispensary Registration Certificate Rule should stipulate The Department shall deny an application for a dispensary registration certificate or a renewal if: 1. The physical address of the building or, if applicable, the physical address of the dispensary's cultivation site is within 500 feet (that unless otherwise restricted by County and/or municipality, or tribal government) any of the following that existed before the date the dispensary submitted the application: • residential district • public or private preschool, kindergarten,

elementary, secondary or high school, college or university • seminaries or place of worship • libraries • public park • community center • athletic fields • other existing businesses or play-place type establishments, jungle gyms type businesses, etc. • facilities of service agencies whose focus is on minor children • hospitals, urgent care centers, pediatric clinics • drug or alcohol rehab facility • halfway houses • jails or detention centers • another adult business establishments A.2.g. Rule should stipulate: Is an employee of or a contractor with the Department or any other government entity which exercises jurisdictional authority over the dispensary or the dispensary's cultivation site.
Yeah, right.....
R9-17-302. Dispensary Registration Certificate Allocation Process B. The Department shall accept dispensary registration certificate applications [,with one application being good for up to five potential CHAAs] for 30 calendar days beginning May 1, 2011. 2. If the Department receives: 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 select the most qualified:]
I live in a planned community. I would like specific language to state that common areas of Planned Communities be included in the definition of public place. I do not want marijuana to be used in the common areas of our communtiy.
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.
Please be sure that "common areas of planned communities" be included in the definition of "public place."
Common areas of planned communities should be included in definition of "public places".

The definition of a "public place" should include the language "common areas of planned communities".
I request that "common areas of planned communities" be included in the definition of "public place"
I request that "common areas of planned communities" be included in the definition of "public place." I live immediately adjacent to a common area.
Please place some new language in the rules that specify how individual patients and dispensary owners are to obtain seeds and clones. I know some at the AZDHS believe it is virtuous to prevent patients from growing inexpensive medicine themselves. Almost all the patients will have to grow their initial crop, as the dispensaries that are less than 25 miles away will not exist yet. The patients themselves should not have to wait, and for that matter even be forced to pay more money for thier medicine at a dispensary (along with the new taxes that are about to be attached to medical marijuana). Please remove the 25 mile requirement and arbitrary map scheme. By not including how the patients can legally obtain seeds in the rules, the intent of 203 is circumvented. Also, if medical marijuana is to be taxed, then how are the crops of individual patients supposed to be taxed on the medicine they grow? If one is taxed, then should not all be taxed for the product that is produced? This is not part of what was in proposition 203.

We would like to have the following added to the use of medical marijuana smoking in common areas. The common areas language should include common areas of planned communities be included in the definition of public place.
We would like to have the following added to the use of medical marijuana smoking in common areas. The common areas language should include common areas of planned communities be included in the definition of public place.
No smoking marijuana in the common areas of a planned community.
We request that "common areas of planned communities" be included in the defiition of "public places"
I request that "Common Areas of Sun City Grand type (Planned) communities" be included in the definition of "public place."
Please include "the common ares of planned communities" be included in Planned Communities in the definition of "public place"
No MJ smoking on grounds, premises of any HOA community.
"Common Areas of Planned Communities" should be included in the definition of "Public Places"

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.
Please include the following wording of "common areas of planned communities" in the definition of "public places" in the proposed rules regarding the implementation of the new medical marijuana law. Thank you.
Please exclude the smoking of Marijuana from all places outside the user's home.
The lanugage I have concerning this is not fit for human ears!
The definition of public places should be expanded to include common areas (including golf courses and other outdoor excercise facilities) within Planned Communities. These common areas are private

property within the planned community and predominatley consist of elderly residents. The purported use of marijuana for medicnal purposes will likely cause wafting of this unwanted odor in common areas that are not public property or a public place. To not make this a exclusion will cause winter residents to look to other states for their escape from the cold weather and will not be good for Arizona. [redacted]
I request that common areas of planned communities be included in the definition of public place
Please include common ares of planned communities to be included in definition of public places. I have copd/asthma and do not want to walk through lobby to exercise area through marijuana smoke.
no
"common areas of planned communities" be included in the definition of "public place."
In the definition of "public place", please include the words, "common areas of planned communities".
Please specifically exclude "common areas of planned communities" from 21 B definition of Public Place

that "common areas of Planned Communities" be included in the defination of "public places" .
Add PTSD to the disease and ailments area
Well I am [redacted] and sick with cancer, hep-c, diabetes and chronic pain I have social security disability that gives me 1300.00 a month now I want to know how you and AZ. inspect me to afford all these permits and tax's that I have to pay for when I am eating beans and rice just to live And then tell me I might have to pay 1300.00 for just 2 weeks of relief from all the pain I am in all of the time just be cause I live with in 25 miles of a Dispensary [redacted]
Common areas of planned communities should be included in the definition of "public place."
R9-17-309. Administration B. If a dispensary cultivates marijuana, the dispensary shall cultivate the medical marijuana dispensed by the dispensary in an enclosed, locked facility. Perhaps reworded to: … If a dispensary is also the cultivation site, the dispensary shall cultivate the medical marijuana dispensed by the dispensary in an enclosed, locked facility. The whole question of how a dispensary gets it MM if it does not cultivate itself is in question…If a dispensary does not grow its own, there where does it get it from? I'm assuming the dispensary has a separate cultivation location.
Yes. Please include "common areas of planned communities" in the definition of "public places" where medical marijuana cannot be used.
R9-17-101. Definitions 6. "Calendar day" means each day, not including the day of the act, event, or default from which a designated period of time begins to run, but including the last day of the period unless it is a Saturday, Sunday, statewide furlough day, or legal holiday, in which case the period runs until the end of the next day that is not a Saturday, Sunday, statewide 24. "Working day" a Monday, Tuesday, Wednesday, Thursday, or Friday that is not a state holiday or a statewide furlough day. Recommend combining these to a "Business Day". .Or change "Working Day" to include Saturday and

Sunday.
I would like to have the common areas of planned communities be incuded in the definiton of " public places"
we request the the common areas in planned communittees be considered public places.
Add to the definition of "public places". "Prohibit the 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.
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."
See last question
I would like to see the following language incorporated into the rules: "common areas of planned communities" be included in the definition of "public place."
add "common areas of planned communites" as being places where pot cannot be smoked.

I would like to request that common areas of planned commmunites be included in the definition of public place.
I strongly urge that “common areas of planned communities” be included in the definition of “public place.” We have small children in our complex as well as older homeowners. We want to keep our HOA and our community/common areas enjoyable for all.
See Above
None.
See above
Common areas of planned connunities nees to be included in the difinition of " public place". Appreciate being able to have you consider my view. [redacted]
Planned communities should be in the wording of prohibited places to smoke
Common areas of planned communities should be included in the definition of public places. Thank you
I do not approve of smoking marijuana in our common areas of Sun City Grand. I request that

"common areas of planned communities" be included in the definition of "public place."
Ease, MEDICAL MARIJUANA CAN ONLY BE SMOKED IN THE PRIVACY OF THEIR HOME AND NOT ALLOWED IN ANY PUBLIC PLACE WHICH INCLUDES PARKS, COMMON AREAS, WORKPLACE, GOVERNMENT OFFICES, ETC.
Under the definiation of "public places" add the words "common areas of Planned Communities".
Please make it the same as other no smoking rules.....
We request that "common areas of planned communities" be included in the definition of "public place."
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."
"Common areas of planned communities" should be included in the definition of "public place."

request that “common areas of planned communities” be included in the definition of “public place.”
I do not have specific language, that should be provided by qualified legal personnel.
There are many schemes and scams currently being used to circumvent the current proposed rules. The most egregious of these relates to out of state dispensary operators. Under the current proposed rules any Principal or Board Member must have been an Arizona resident for the preceeding 3 years. However, this rule does not apply to dispensary "agents." This is the loophole that out of state dispensary operators plan to exploit. The position of "agent" is really a term of art for "employee." While I do not think it is prudent to require that all employees be state residents for 3 years, it does make sense that all employees are at least current residents of the state of Arizona. We currently have a situation where out of state operators are providing funding and doing the work of applying for dispensary licenses with the intent of listing a qualifying Arizona resident as a "straw man" on the application. This certainly goes against the intent of DHS's rules. I find it difficult to believe that any legitimate employee/agent of a dispensary is capable of performing legitimate duties if he/she is located out of state. Section R9-17-310 should contain the following addition: #9 A dispensary agent must be a current resident of Arizona. R9-17-306 states "A dispensary shall not change the dispensary's location during the first three years after the dispensary is issued a dispensary registration certificate." I think I understand the intent of this clause. However, as it is written it may prove problematic. For instance if a municipality changes its zoning laws, a dispensary may be forced to move from its current location. There may also be instances where a landlord prematurely terminates the lease of an otherwise responsible dispensary operator. This may put the city and DHS in violation of Proposition 207. To accomplish the goals of dispersal across geographic areas (the stated goal of the CHAA system), the wording of this requirement must be changed. Section R9-17-306 should read: A dispensary shall not change the dispensary's location to another location outside of the intial designated CHAA location during the first three years after the dispensary is issued a dispensary registration certificate. Section R9-17-312 Medical Director has a problematic issue. Letter E reads "A medical director shall not establish a physician-patient relationship with or provide a written certification for medical marijuana for a qualifying patient." I agree completely that medical directors should not be providing written certifications to patients. However, a medical director should be able to have a doctor-patient relationship with a patient, even if that patient is a current medical marijuana patient or potential patient. For example, a doctor may be an emergency room physician. In his course of normal duties he will establish a doctor-patient relationship with hundreds of individuals on a weekly basis. As this rule is currently written, this prohibits that doctor from becoming a medical director. The same argument can be made for geriatric specialists, HIV specialists or any other specialist that would be otherwise entirely capable and desirable as a medical director. Section R9-17-312 E should read: A medical director shall not provide a written certification for medical marijuana for a qualifying patient. R9-17-317 states "A dispensary shall ensure that access to the enclosed, locked facility where marijuana is cultivated is limited to principal officers, board members, and designated agents of the dispensary." This is problematic as it does not make exception for any tradesmen such as electricians, plumbers, cleaning services or otherwise access to the building. I think it is reasonable to ensure that no person is allowed without written permission and must be accompanied by a principal officer, board member or designated agent. R9-17-317

should read: A dispensary shall ensure that access to the enclosed, locked facility where marijuana is cultivated is limited to principal officers, board members, and designated agents of the dispensary. In the event that it is required that a person that is not one of the above listed individuals, then that person must be accompanied at all times with a qualified person.
Please add "common areas of planned communities" to the the definition of a "public place"
qualifying patients should have the right to grow their own saving great amounts of money, AND have access to dispensaries in times of need.
(c) Has not been convicted of an excluded felony offense. 36-2801 I was convected of a stupid felony be cause "I did not know the Law in rifle barrel lengths I missed it by 1" I had it reduced years later. I can not clarifie whether I can or not legaly use Cannabis for my Quailfing conditions.
Just keep the recreational users from being apart of this program
I beleave that people who are homebound and on a fixed income shoud be exempt from the 25mi.pharmacy rules andallowed to grow for them selvise.

yes, lower the tax
AZ. board of pharmacy website it is stated : "Please note the Arizona State Board of Pharmacy is not involved nor will be regulating any part of the Medical Marijuana Act that has recently passed. " AZ LAWS. are as posted ..... MARIJUANA IS NOT A FEDERAL controlled substances act. 36-2602. Controlled substances prescription monitoring program; contracts; retention and maintenance of records A. The board shall adopt rules to establish a controlled substances prescription monitoring program. The program shall: 1. Include a computerized central database tracking system to track the prescribing, dispensing and consumption of schedule II, III and IV controlled substances that are dispensed by a medical practitioner or by a pharmacy that holds a valid license or permit issued pursuant to title 32. The tracking system shall not interfere with the legal use of a controlled substance for the management of severe or intractable pain. 2. Assist law enforcement to identify illegal activity related to the prescribing, dispensing and consumption of schedule II, III and IV controlled substances. 3. Provide information to patients, medical practitioners and pharmacists to help avoid the inappropriate use of schedule II, III and IV controlled substances. 4. Be designed to minimize inconvenience to patients, prescribing medical practitioners and pharmacies while effectuating the collection and storage of information. B. The board may enter into private or public contracts, including intergovernmental agreements pursuant to title 11, chapter 7, article 3, to ensure the effective operation of the program. Each contractor must comply with the confidentiality requirements prescribed in this article and is subject to the criminal penalties prescribed in section 36-2610. C. The board shall maintain medical records information in the program pursuant to the standards prescribed in section 12-2297 36-2606. Registration; requirements A. Beginning November 1, 2007 and pursuant to rules adopted by the board, each medical practitioner who is issued a license pursuant to title 32 and who possesses a registration under the federal controlled substances act must have a current controlled substances prescription monitoring program registration issued by the board. The registration is: 1. Subject to biennial renewal as specified in this article. 2. Not transferable or assignable. 3. Valid only in conjunction with a valid license issued by a professional licensing board established pursuant to title 32, chapter 7, 11, 13, 14, 15, 16, 17, 21, 25 or 29. B. An applicant for registration pursuant to this section must submit an application as prescribed by the board. C. The board shall assign all persons registered under this article to one of two registration renewal groups. The holder of a registration ending in an even number must renew the registration biennially on or before May 1 of the next even-numbered year. The holder of a

registration ending in an odd number must renew the registration biennially on or before May 1 of the next odd-numbered year. The board shall automatically suspend the registration of any registrant who fails to renew the registration on or before May 1 of the year in which the renewal is due. The board shall vacate a suspension if the registrant submits a renewal application. A suspended registrant is prohibited from accessing information in the prescription monitoring program database tracking system. D. A registrant shall not apply for registration renewal more than sixty days before the expiration date of the registration. E. An applicant for registration renewal pursuant to this section must submit a renewal application prescribed by the board by rule. F. Pursuant to a fee prescribed by the board by rule, the board may issue a replacement registration to a registrant who requests a replacement because the original was damaged or destroyed, because of a change of name or for any other good cause as prescribed by the board
Not for recreational use
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.
Remove 1.b from R9-17-304. Applying for Approval to Operate a Dispensary insert a new section 2 move all the other sections down one. And for two (2) say something like the following. 2) Within 30 days of the approval of application for a dispensary the business entity must provide a location within the CHAA and within 60 days of approval of the application the business must be ready for an

inspection of the location by the approval board. 6) which would be changed to 7 should say 7) If applicable ...
price caps on all meds! smoking areas need changing a bit. some of us patients dont have the same private property homes and we have kids.
change smoking areas allow parks, campgrounds, hotels, condos,apartments. we live there and should have the same rights as a homeowner. explain to me where i have to go and smoke if i live in a apartment and have kids? a price cap also needs to be put on the meds from a dis!! remember if the state plans on making money on this then legalize it if not treat it as another script we get from pharmacys.
Simplify the doctors' required statement! Provide a list of unscrupulous doctors I guess.
definition of medical director A person with a minimum valid RN license that has passed a course to be a medical director.
R9-17-302 B.2.a If more than one dispensary registration certificate application for a dispensary located in a CHAA that the Department determines is complete and in compliance with A.R.S. Title 36, Chapter 28.1 and this Chapter by 60 days after May 1, 2011, the Department shall review each application based on how each business plan addresses patient education, medical oversight, quality control, financial transparency, cost containment and community impact.
SUBMITTED 02/02/11 10:40PM (SPECIFIC LANGUAGE TO IMPROVE THE RULES) 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: ... e. 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; SECTION e. SHOULD BE DELETED ALLTOGETHER (AZDHS HAS NOT PROVIDED ANY DEFINITION OF 'RESPONSIBILITY' VS. 'PRIMARY RESPONSIBILITY')
SUBMITTED 02/02/11 10:40PM (SPECIFIC LANGUAGE TO IMPROVE THE RULES) 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: ... e. 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; SECTION e. SHOULD BE DELETED ALLTOGETHER (AZDHS HAS NOT PROVIDED ANY DEFINITION OF 'RESPONSIBILITY' VS. 'PRIMARY RESPONSIBILITY')

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: ... e. 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; THE ABOVE SECTION e. SHOULD BE DELETED AS NO DEFINITION OF 'RESPONSIBILITY' IS PROVIDED VS. 'PRIMARY RESPONSIBILITY.
R9-17-316.A.3 Presently reads "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" Should read: "ARIZONA DEPARTMENT OF HEALTH SERVICES' WARNING: Smoking marijuana can cause addiction or lung infection and can impair one's ability to drive a motor vehicle or operate heavy machinery"; I'm not aware of any validated scientific evidence that marijuana consumption even by smoking has ever caused a single case of cancer or a heart attack! Wouldn't lying in order to scare people be unethical? PLEASE step away from the matforce! Marijuana has not only proven itself beneficial for many serious medical conditions, the will of the Arizona voters has decided this very safe and natural medicine NEEDS to be available to patients who will benefit from it. Your job is facilitating that, everything else is only creating the need for lawsuits to prove that you overstepped your authority. Tobacco warning labels can and should warn of Cancer, strokes, heart attacks, where does the list end? Tobacco is sold on virtually every other street corner for purely recreational use and it is a fools errand to try and argue that cannabis is more addictive, dangerous to users or society, or in fact literally thousands of times more deadly than tobacco. Please pull your heads out of the sand and shake off the rhetoric and lies! Please do the job you have actually been tasked for and responsibly make sure medical marijuana is available to each and every Arizona resident that will benefit from it!

N/A
SIMPLE ENGLISH, OTHERWISE, WHAT ARE YOU TRYING TO HIDE FROM US ?
A qualifying patient or caregiver has the right to grow up to 12 plants.
I would be will ing to work on this, if someone could mail me a copy at [redacted] ...I am running out of ink..... Thank you
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.
I would suggest that you add an "Article 4. What is Considered under the Infulence. Lawful and Unlawful Acts" I understand the law was written and passed for those in TRUE MEDICAL NEED, but there is much, much more to this subject and that has not been addressed.
Hi... No the language is fine. We need to know stuff like can the cultivation site and the infusion location be under the same roof? This will save money and increase safety controls. This alone would help keep the cost of the medicine down for the patient. We just need more info for everything, not just patient & Dr. stuff. Everyone wants this to work correctly for the patients of Arizona. We certainly don't want anyone to get into trouble because the rules weren't completely understood.
Owing back taxes to the State or Federal government should not be an exclusion criteria. In these difficult economic times, many of us are struggling to meet our obligation to the government.

I have not seen specific language regarding where dispensaries can be located. A dispensary in a residential neighborhood can destroy the serenity, security, and property values of those who live nearby. There should be VERY EXPLICIT LANGUAGE (known to all) that forbids the growing or dispensing of marijuana in any residential neighborhood - NO EXCEPTIONS. The public should know that anyone engaging in the growing or selling of MJ that is not officially sanctioned will be charged with a crime and their operation immediately shut down. News media have not made known to the general public that there are the restrictions mentioned above. I would imagine that some people are already gearing up for their growing and dispensing operation in the hopes that the rules will either be too lax or not vigorously enforced. I have read about specific communities in CA where homeowners have had their serenity, security, and property values negatively affected by the proximity of a dispensary. Make place restrictions known to all NOW before there is a rash of unauthorized operations
The entire draft is confusing and redundant. Out Attorney is having a difficult time interpreting the rules. The entire draft needs to be reviewed and re written in layman terms and made much more clear. The objective here is to serve the public and the public should be able to understand the draft.
Remove this added paragraph from the rules. You already have several requirements for recommending physicians which will eliminate abuse of the system.
Do not allow pill-pushers to force their prescription drugs on me but rather they must allow me to make decisions for my personal treatment programs and preferences--that is the constitutional right of the suffering [70 y.o.] senior adult and vet that I am.
I would include extensive language that would require all applicants to submit a thorough and well drafted application, that includes strict guidelines for financial capability to operate, stringent security guidelines, and at the very least; a letter from the appropriate municipalities planning and zoning dept indicating that the site intended for use meets all requirements and is a safe and secure location for patients to receive medicine. Provided the applicant meets all these requirements, I would then distribute certificates based on a scoring system of application thoroughness, with a strong emphasis on site location and security programs. I would encourage the department to create a panel including a medical professional, an industry expert, the state attorney, and a least one member of law enforcement. Each application should first be checked for against a stringent set of requirements, and

then those worthy of further review should be passed on to this panel for approval recommendation. I feel that a system similar to this will be the only way to ensure a safe and productive environment for this implementation of the law, and insure that Arizona is viewed as an industry model; not another example of rampant unregulated operations.
Continue making costs low. Make MJ affordable for the very poor by not overregulating dispensaries.
Nothing that isn't implied by my statements above.
All employers (whether based in Arizona or not) that have employees who work in the state of Arizona have an interest in the rules that will be formulated for the Arizona Medical Marijuana Act by the Department of Health Services. The language in 36-2813 & 36-2814 creates questions for employers such as: “what is the definition of ‘under the influence’”; “what is the definition of ‘impaired’”; and, “what is meant by ‘insufficient concentration to cause impairment’.” The following comments are submitted to ensure the rules in the Arizona Administrative Code (AAC) provide protection to employers from the negative consequences in the workplace that can result from employees who are users of marijuana and have a medical marijuana card. COMMENT 1: The definitions for the terms “under the influence of marijuana”, “was impaired”, and “appear in insufficient concentration to cause impairment” are vital. Defining those terms, particularly “impairment”, should be a priority for the Department. COMMENT 2: The following language is recommended for the rules regarding the medical marijuana act. For the purposes of the Act, “under the influence of marijuana” will be defined as a finding of marijuana metabolites that exceeds the cutoff level of 50 ng/ml based on the results of the initial screening methodology used in a drugs/substances test that was conducted in compliance with ARS 23, Chapter 2, Article 14. For the purposes of the Act, “was impaired” will be evidenced by a finding of marijuana metabolites that exceeds the cutoff level of 15 ng/ml as the result of a gas chromatography-mass spectrometry (GC/MS) confirmatory screening methodology used in a drugs/substances screening test that was conducted in compliance with ARS 23, Chapter 2, Article 14, when the initial sample is positive (non-negative). EXCEPT, consistent with ARS 28-1381, “was impaired” will be evidenced by a finding AT ANY LEVEL as the result of a gas chromatography-mass spectrometry (GC/MS) confirmatory screening methodology used in a drugs/substances test that was conducted in compliance with ARS 23, Chapter 2, Article 14, when the person: 1. Has driving as an essential function of his/her job description; 2. Has operating heavy equipment as an essential function of his/her job description; or, 3. Has operating industrial/commercial machinery as an essential function of his/her job description. For

the purposes of the Act, “an insufficient concentration to cause impairment” will be defined as a finding of marijuana metabolites that is below the cutoff level of 15 ng/ml based on the results of a gas chromatography-mass spectrometry (GC/MS) confirmatory screening methodology used in a drugs/substances screening test that was conducted in compliance with ARS 23, Chapter 2, Article 14. The Act states: 36-2813. Discrimination prohibited B. UNLESS A FAILURE TO DO SO WOULD CAUSE AN EMPLOYER TO LOSE A MONETARY OR LICENSING RELATED BENEFIT UNDER FEDERAL LAW OR REGULATIONS, AN EMPLOYER MAY NOT DISCRIMINATE AGAINST A PERSON IN HIRING, TERMINATION OR IMPOSING ANY TERM OR CONDITION OF EMPLOYMENT OR OTHERWISE PENALIZE A PERSON BASED UPON EITHER: 2. A REGISTERED QUALIFYING PATIENT'S POSITIVE DRUG TEST FOR MARIJUANA COMPONENTS OR METABOLITES, UNLESS THE PATIENT USED, POSSESSED OR WAS IMPAIRED BY MARIJUANA ON THE PREMISES OF THE PLACE OF EMPLOYMENT OR DURING THE HOURS OF EMPLOYMENT. COMMENT 3: A person applying for employment could test positive (non-negative) for marijuana metabolites without ever using or possessing marijuana or being impaired by marijuana on the premises of the place of employment or during hours of employment. Thus, an applicant for employment could test positive (non-negative) and the employer could not withdraw an offer of employment or refuse to hire the applicant (regardless of the quantity of nanograms/milliliter (ng/ml)) since the person did not use or possess marijuana on the employer’s premises and was not impaired on the employer’s premises. This “loop-hole” needs to be fixed. COMMENT 4: Will any applicant who is not hired on the basis of a positive (non-negative) drugs/substances screening test be discriminated against? ARS 23, Chapter 2, Article 14 includes the drugs/substances testing statutes for employers. In section 23-493.05, Disciplinary Procedures, employers “may take adverse employment action based on a positive (non-negative) drug test …” A positive (non-negative) test result allows employers to take any or a combination of the five (5) listed disciplinary or rehabilitation actions, including “refusal to hire a prospective employee” should an applicant test positive (non-negative). In order to reconcile the two pieces of legislation, the definitions recommended in COMMENT 2 are needed. The Act also states: 36-2814. Acts not required; acts not prohibited A. NOTHING IN THIS CHAPTER REQUIRES: 1. A GOVERNMENT MEDICAL ASSISTANCE PROGRAM OR PRIVATE HEALTH INSURER TO REIMBURSE A PERSON FOR COSTS ASSOCIATED WITH THE MEDICAL USE OF MARIJUANA. 2. ANY PERSON OR ESTABLISHMENT IN LAWFUL POSSESSION OF PROPERTY TO ALLOW A GUEST, CLIENT, CUSTOMER OR OTHER VISITOR TO USE MARIJUANA ON OR IN THAT PROPERTY. 3. AN EMPLOYER TO ALLOW THE INGESTION OF MARIJUANA IN ANY WORKPLACE OR ANY EMPLOYEE TO WORK WHILE UNDER THE INFLUENCE OF MARIJUANA, EXCEPT THAT A REGISTERED QUALIFYING PATIENT SHALL NOT BE CONSIDERED TO BE UNDER THE INFLUENCE OF MARIJUANA SOLELY BECAUSE OF THE PRESENCE OF METABOLITES OR COMPONENTS OF MARIJUANA THAT APPEAR IN INSUFFICIENT CONCENTRATION TO CAUSE IMPAIRMENT. B. NOTHING IN THIS CHAPTER PROHIBITS AN EMPLOYER FROM DISCIPLINING AN EMPLOYEE FOR INGESTING MARIJUANA IN THE WORKPLACE OR WORKING WHILE UNDER THE INFLUENCE OF MARIJUANA. COMMENT 5: The Act (at 36-2814.A.3.) does not require an employer “to allow … any employee to work under the influence of marijuana, except …”; in 36-2814.B., the Act states that “nothing … prohibits an employer from disciplining an employee … working while under the influence of marijuana.” Yet, in A.3., the Act states that a “registered qualifying patient shall not be considered under the influence of marijuana solely because of the presence of metabolites or components of marijuana that appear in insufficient concentration to cause impairment.” What is the distinction between “under the influence” and “impairment?” How will an employer determine that the “registered qualifying patient” is “impaired” and subject to discipline? Again, the definitions suggested in COMMENT 2 are needed to guide employers. Those definitions will allow employers to separate those employees who have medical marijuana cards and are “under the influence” or “impaired” from employees who have medical

marijuana cards but are not “under the influence” or “impaired.” COMMENT 6: ARS 28-1381 states that a person who drives or is in actual control of a motor vehicle is guilty of Driving Under the Influence of Drugs (DUID) when there is “any drug defined in section 13-3401 in the person’s body.” AND, the use of a prescription drug/substance is not an allowable defense for DUID. 28-1381. Driving or actual physical control while under the influence; trial by jury; presumptions; admissible evidence; sentencing; classification A. It is unlawful for a person to drive or be in actual physical control of a vehicle in this state under any of the following circumstances: 1. While under the influence of intoxicating liquor, any drug, a vapor releasing substance containing a toxic substance or any combination of liquor, drugs or vapor releasing substances if the person is impaired to the slightest degree. 2. If the person has an alcohol concentration of 0.08 or more within two hours of driving or being in actual physical control of the vehicle and the alcohol concentration results from alcohol consumed either before or while driving or being in actual physical control of the vehicle. 3. While there is any drug defined in section 13-3401 or its metabolite in the person's body. 4. If the vehicle is a commercial motor vehicle that requires a person to obtain a commercial driver license as defined in section 28-3001 and the person has an alcohol concentration of 0.04 or more. B. It is not a defense to a charge of a violation of subsection A, paragraph 1 of this section that the person is or has been entitled to use the drug under the laws of this state. In ARS 1301.4, Cannibis is listed as one of the drugs prohibited by ARS 28-1381.3. In ARS 1301.19, Marijuana is listed as one of the drugs prohibited by ARS 28-1381.3. Thus, under 28-1381.3, a driver is considered to be under the influence of drugs if ANY amount of cannabis or marijuana or their metabolites is present in the driver’s body. Thus, ANY presence of Cannibus or Marijuana in the system of a driver is considered “driving under the influence of drugs.” 36-2814.A.3. is in conflict with the standard for safety in 28-1381.A.3. Surely, the need for on-the-job safety is as important as the need for driving safety. The definitions recommended in COMMENT 2 help ensure on-the-job safety while protecting the rights of employees who have medical marijuana cards.
Multiple Sclerosis is not mentioned as a specific medical condition eligible for medical marijuana, but it is referenced - please add.

May 1, 2011, the Department shall randomly select: Change this wording to select based on best qualified first, second, third so on and so forth. Words like random should not appear on this application process.
It's immoral and unprofessional to leave the licenses to a lottery of any kind. We must attract quality, not quantity in this industry. We don't want to attract anyone with an idea to open a dispensary. We want to attract real business men that have actual funding, a professional and well thought out business plan and the means to execute. I strongly suggest moving AWAY from the lottery. We want quality law abiding leaders to contribute to the community in Arizona. Do you want to leave our future and community in the hands of a bunch of yahoo's with an idea. The lottery is down right irresponsible.
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"; There is no credible medical evidence that marijuana is addictive.
R9-17-102 B: Add "or shows a current letter showing that the patient is receiving Supplemental Security Income benefits"
I propose the new law include language that states; There is no resiprocity between states. Marijuana Medical Cards in other states WILL NOT be recognized in Arizona
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
R9-17-302 (B) 2 (b) ii A random selection from multiple Applicants within a CHAA may well result in undesirable persons in undesirable areas. Why risk it? I would suggest a more discerning selection method than by mere chance. An RFP or other public competitive bidding procedure, better qualifications, a preferred location, more experience, enhanced public benefit, anything, any rational basis other than dumb luck. Try to get the best approach at the best place. I would recommend that a local selection option be included in the event of more than one Applicant within a CHAA. If not a local option, then it should be decided by ADHS by selecting the Applicant by merit on some rational basis in the public interest. As proposed in R9-17-302 (D) 3 – even the prioritization by the greatest population served by the proposed location would do. Any method supported by a rational basis in service to the citizens would do. Anything but arbitrary!
I'll leave the specific language up to the pros....

These are examples of specific language that could be used to define these rules (taken from Colorado states rule) (I) No more than two ounces of a usable form of marijuana "Usable form of marijuana" means the seeds, leaves, buds, and flowers of the plant (genus) cannabis, and any mixture or preparation thereof, which are appropriate for medical use as provided in this section, but excludes the plant's stalks, stems, and roots. (II) For quantities of marijuana in excess of these amounts, a patient or his or her primary care-giver may raise as an affirmative defense to charges of violation of state law that such greater amounts were medically necessary to address the patient's debilitating medical condition. Can be incorporated in requirements for card. In order to be placed on the state's confidential registry for the medical use of marijuana, a patient must reside in Arizona and submit the completed application form adopted by the state health agency. In order to be legally certified in the state of Arizona for Medical Marijuana use, the patient must be an Arizona resident and have applied in the state of AZ for use. No patient shall: (I) Engage in the medical use of marijuana in a way that endangers the health or well-being of any person; or (II) Engage in the medical use of marijuana in plain view of, or in a place open to, the general public. FAQ section (obtained from Colorado state FAQ) Where can I legally use my medicine? No patient shall: Engage in the medical use of marijuana in a way that endangers the health or well-being of any person; or engage in the medical use of marijuana in plain view of, or in a place open to, the general public. Law enforcement has informed the Medical Marijuana Registry of the following: Any place outside of the patient’s home is considered public. “In plain view” also includes the patient’s yard or garage if that patient can be seen using their medicine by neighbors.
(From R9-17-303. B(5)) - Applying for a dispensary registration certificate. -- "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" --- I suggest this should read "A statement signed and dated by the individual or individuals in R9-17-301 AND PROPER LOCAL ZONING AUTHORITIES certifying that the dispensary is in compliance with local zoning restrictions"
I'm not clear about filling out the application/registration form to be in the lottery for dispensary certificates: Does it cost $5,000 just to apply for the certificate? Or do you pay the $5,000 once you have been selected to receive the dispensary certificate for your area? Also, I can't find the application form. Where is it? Please respond to me at [redacted]
R9-17-317.B - a fifth location should be added, something like: 5. An analytical laboratory where quantitative profiling occurs.
R9-17-303(B)5 and R9-17-304(3) Instead of asking that the Applicant certify that the proposed dispensary location is in accord with local zoning, why not a certification from the applicable City or County that the proposed location is in compliance with zoning. The Applicant may not know or may stretch the facts. Why not ask the City or County? I don't think that you want to award the non-assignable registration when in fact the proposed location is not in compliance with local zoning.
Yes, change R9-17-202. to simply require: ""Written certification" means a document signed by a physician stating the patient's debilitating medical condition and stating that, in the physician's professional opinion, the patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition."
The definition of the 25 mile distance to dispensaries is to be determined as follows: the 25 mile distance from dispensaries is to be defined as any patient living over Over 25 five miles from a dispensary as determined by the shortest distance from that dispensary on a passable all weather route.

R.9-17-202;F;5e "A statement, initiated by the physician, that the physician agrees to assume responsibility for providing management, routine care (OR THE TREATMENT OF) the patients debilitating medical condition..." Although "Or The Treatment Of" is assumed in the wording of R.9-17-202;F;5e as written (of the qualifying patients debilitating medical condition) it should be clearly stated to conform with the deffinitions found at R9-17-201 so there is no question. It is noted that a physician may be employed to provide treatment for symptomes (pain management) but may not be solely responsible for the chronic medical condition (Pancreatic Cancer) [redacted]
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
Why don't you put dispensary's" 25 MILES OUT OF CITY LIMITS."
no

With respect to section R9-17-201 (8) the term "Alzheimer's Disease" should be replaced by "Dementia." Currently the only definitive diagnosis of AD is post-mortem. Dementia is an accepted term for several diseases of similar presentation but different underlying causes. See the National Library of Medicine MeSH subject headings for reference.
change everything!!!!!!!
R9-17-203-F.2.e and all similar passages, rules are written to exclude legal US residents, please consider adding iv. proof of legal US residency such as a green card