ARTHUR CHAPMAN
KETTERING SMETAK & PIKALA, P.A.
ATTORNEYS AT LAW

Information on Medical Marijuana in the Workplace

1. Minn. Stat. § 152.22, Subd. 6 & 14 – Definitions of "Medical Cannabis" and "Qualifying Medical Condition"
2. Minn. Stat. § 152.32, Subd. 3 – Discrimination Prohibited
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9. H.R. 1538/S. 683 – CARERS Act
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11. *U.S. v. Marin Alliance for Medical Marijuana*, 2015 WL 6123062 (N.D. Cal. Oct. 19, 2015)
12. 28 Legal Medical Marijuana States and D.C.: Laws, Fees, and Possession Limits
13. Medical Marijuana and Pain, a State-by-State Breakdown
14. THC and "Impairment"
15. Carrie Kirby, *Standford Engineers Develop the "Potalyzer," a Roadside Saliva Test for Marijuana Intoxication*, STANFORD NEWS, Sept. 8, 2016.
16. *Maez v. Riley Industrial*, 347 P.3d 732 (N.M. Ct. App. Jan. 23, 2015)
17. *Cockrell v. Farmers Ins.*, 2015 WL 1577995 (Cal. W.C.A.B. Mar. 13, 2015)
18. *Coats v. Dish Network, LLC*, 350 P.3d 849 (Colo. June 15, 2015)

500 Young Quinlan Building, 81 South Ninth Street, Minneapolis, MN 55402
Phone 612 339-3500 Fax 612 339-7655
www.ArthurChapman.com
Offices in Minnesota and Wisconsin

Information on Medical Marijuana in the Workplace, Cont'd

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1. Shalonda D. Ballard, *Clearing the Haze of Marijuana in the Work Place*, Minnesota CLE Employment Law Institute, May 2015.
2. *Marijuana in the Workplace: Guidance for Occupational Health Professionals and Employers*, JOURNAL OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE, Vol. 57, No. 4, April 2015.
3. *Medi-juana and the Workplace: Examining Employees' Protections Under Minnesota's Medical Cannabis Law*, BENCH & BAR OF MINNESOTA, Dec. 3, 2015.

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152.22 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 152.22 to 152.37, the terms defined in this section have the meanings given them.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 3. **Disqualifying felony offense.** "Disqualifying felony offense" means a violation of a state or federal controlled substance law that is a felony under Minnesota law, or would be a felony if committed in Minnesota, regardless of the sentence imposed, unless the commissioner determines that the person's conviction was for the medical use of cannabis or assisting with the medical use of cannabis.

Subd. 4. **Health care practitioner.** "Health care practitioner" means a Minnesota licensed doctor of medicine, a Minnesota licensed physician assistant acting within the scope of authorized practice, or a Minnesota licensed advanced practice registered nurse who has the primary responsibility for the care and treatment of the qualifying medical condition of a person diagnosed with a qualifying medical condition.

Subd. 5. **Health records.** "Health records" means health records as defined in section 144.291, subdivision 2, paragraph (c).

Subd. 6. **Medical cannabis.** (a) "Medical cannabis" means any species of the genus cannabis plant, or any mixture or preparation of them, including whole plant extracts and resins, and is delivered in the form of:

(1) liquid, including, but not limited to, oil;

(2) pill;

(3) vaporized delivery method with use of liquid or oil but which does not require the use of dried leaves or plant form; or

(4) any other method, excluding smoking, approved by the commissioner.

(b) This definition includes any part of the genus cannabis plant prior to being processed into a form allowed under paragraph (a), that is possessed by a person while that person is engaged in employment duties necessary to carry out a requirement under sections 152.22 to 152.37 for a registered manufacturer or a laboratory under contract with a registered manufacturer.

Subd. 7. **Medical cannabis manufacturer.** "Medical cannabis manufacturer" or "manufacturer" means an entity registered by the commissioner to cultivate, acquire, manufacture, possess, prepare, transfer, transport, supply, or dispense medical cannabis, delivery devices, or related supplies and educational materials.

Subd. 8. **Medical cannabis product.** "Medical cannabis product" means any delivery device or related supplies and educational materials used in the administration of medical cannabis for a patient with a qualifying medical condition enrolled in the registry program.

Subd. 9. **Patient.** "Patient" means a Minnesota resident who has been diagnosed with a qualifying medical condition by a health care practitioner and who has otherwise met any other requirements for patients under sections 152.22 to 152.37 to participate in the registry program under sections 152.22 to 152.37.

Subd. 10. **Patient registry number.** "Patient registry number" means a unique identification number assigned by the commissioner to a patient enrolled in the registry program.

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Subd. 11. **Registered designated caregiver.** "Registered designated caregiver" means a person who:

(1) is at least 21 years old;

(2) does not have a conviction for a disqualifying felony offense;

(3) has been approved by the commissioner to assist a patient who has been identified by a health care practitioner as developmentally or physically disabled and therefore unable to self-administer medication or acquire medical cannabis from a distribution facility due to the disability; and

(4) is authorized by the commissioner to assist the patient with the use of medical cannabis.

Subd. 12. **Registry program.** "Registry program" means the patient registry established in sections 152.22 to 152.37.

Subd. 13. **Registry verification.** "Registry verification" means the verification provided by the commissioner that a patient is enrolled in the registry program and that includes the patient's name, registry number, and qualifying medical condition and, if applicable, the name of the patient's registered designated caregiver or parent or legal guardian.

Subd. 14. **Qualifying medical condition.** "Qualifying medical condition" means a diagnosis of any of the following conditions:

(1) cancer, if the underlying condition or treatment produces one or more of the following:

(i) severe or chronic pain;

(ii) nausea or severe vomiting; or

(iii) cachexia or severe wasting;

(2) glaucoma;

(3) human immunodeficiency virus or acquired immune deficiency syndrome;

(4) Tourette's syndrome;

(5) amyotrophic lateral sclerosis;

(6) seizures, including those characteristic of epilepsy;

(7) severe and persistent muscle spasms, including those characteristic of multiple sclerosis;

(8) Crohn's disease;

(9) terminal illness, with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:

(i) severe or chronic pain;

(ii) nausea or severe vomiting; or

(iii) cachexia or severe wasting; or

(10) any other medical condition or its treatment approved by the commissioner.

History: *2014 c 311 s 2; 2015 c 74 s 2*

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152.32 PROTECTIONS FOR REGISTRY PROGRAM PARTICIPATION.

Subdivision 1. **Presumption.** (a) There is a presumption that a patient enrolled in the registry program under sections 152.22 to 152.37 is engaged in the authorized use of medical cannabis.

(b) The presumption may be rebutted by evidence that conduct related to use of medical cannabis was not for the purpose of treating or alleviating the patient's qualifying medical condition or symptoms associated with the patient's qualifying medical condition.

Subd. 2. **Criminal and civil protections.** (a) Subject to section 152.23, the following are not violations under this chapter:

(1) use or possession of medical cannabis or medical cannabis products by a patient enrolled in the registry program, or possession by a registered designated caregiver or the parent or legal guardian of a patient if the parent or legal guardian is listed on the registry verification;

(2) possession, dosage determination, or sale of medical cannabis or medical cannabis products by a medical cannabis manufacturer, employees of a manufacturer, a laboratory conducting testing on medical cannabis, or employees of the laboratory; and

(3) possession of medical cannabis or medical cannabis products by any person while carrying out the duties required under sections 152.22 to 152.37.

(b) Medical cannabis obtained and distributed pursuant to sections 152.22 to 152.37 and associated property is not subject to forfeiture under sections 609.531 to 609.5316.

(c) The commissioner, the commissioner's staff, the commissioner's agents or contractors, and any health care practitioner are not subject to any civil or disciplinary penalties by the Board of Medical Practice, the Board of Nursing, or by any business, occupational, or professional licensing board or entity, solely for the participation in the registry program under sections 152.22 to 152.37. A pharmacist licensed under chapter 151 is not subject to any civil or disciplinary penalties by the Board of Pharmacy when acting in accordance with the provisions of sections 152.22 to 152.37. Nothing in this section affects a professional licensing board from taking action in response to violations of any other section of law.

(d) Notwithstanding any law to the contrary, the commissioner, the governor of Minnesota, or an employee of any state agency may not be held civilly or criminally liable for any injury, loss of property, personal injury, or death caused by any act or omission while acting within the scope of office or employment under sections 152.22 to 152.37.

(e) Federal, state, and local law enforcement authorities are prohibited from accessing the patient registry under sections 152.22 to 152.37 except when acting pursuant to a valid search warrant.

(f) Notwithstanding any law to the contrary, neither the commissioner nor a public employee may release data or information about an individual contained in any report, document, or registry created under sections 152.22 to 152.37 or any information obtained about a patient participating in the program, except as provided in sections 152.22 to 152.37.

(g) No information contained in a report, document, or registry or obtained from a patient under sections 152.22 to 152.37 may be admitted as evidence in a criminal proceeding unless independently obtained or in connection with a proceeding involving a violation of sections 152.22 to 152.37.

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(h) Notwithstanding section 13.09, any person who violates paragraph (e) or (f) is guilty of a gross misdemeanor.

(i) An attorney may not be subject to disciplinary action by the Minnesota Supreme Court or professional responsibility board for providing legal assistance to prospective or registered manufacturers or others related to activity that is no longer subject to criminal penalties under state law pursuant to sections 152.22 to 152.37.

(j) Possession of a registry verification or application for enrollment in the program by a person entitled to possess or apply for enrollment in the registry program does not constitute probable cause or reasonable suspicion, nor shall it be used to support a search of the person or property of the person possessing or applying for the registry verification, or otherwise subject the person or property of the person to inspection by any governmental agency.

Subd. 3. **Discrimination prohibited.** (a) No school or landlord may refuse to enroll or lease to and may not otherwise penalize a person solely for the person's status as a patient enrolled in the registry program under sections 152.22 to 152.37, unless failing to do so would violate federal law or regulations or cause the school or landlord to lose a monetary or licensing-related benefit under federal law or regulations.

(b) For the purposes of medical care, including organ transplants, a registry program enrollee's use of medical cannabis under sections 152.22 to 152.37 is considered the equivalent of the authorized use of any other medication used at the discretion of a physician and does not constitute the use of an illicit substance or otherwise disqualify a patient from needed medical care.

(c) Unless a failure to do so would violate federal law or regulations or 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 any term or condition of employment, or otherwise penalize a person, if the discrimination is based upon either of the following:

(1) the person's status as a patient enrolled in the registry program under sections 152.22 to 152.37; or

(2) a patient's positive drug test for cannabis components or metabolites, unless the patient used, possessed, or was impaired by medical cannabis on the premises of the place of employment or during the hours of employment.

(d) An employee who is required to undergo employer drug testing pursuant to section 181.953 may present verification of enrollment in the patient registry as part of the employee's explanation under section 181.953, subdivision 6.

(e) A person shall not be denied custody of a minor child or visitation rights or parenting time with a minor child solely based on the person's status as a patient enrolled in the registry program under sections 152.22 to 152.37. There shall be no presumption of neglect or child endangerment for conduct allowed under sections 152.22 to 152.37, unless the person's behavior is such that it creates an unreasonable danger to the safety of the minor as established by clear and convincing evidence.

History: *2014 c 311 s 12*

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152.125 INTRACTABLE PAIN.

Subdivision 1. **Definition.** For purposes of this section, "intractable pain" means a pain state in which the cause of the pain cannot be removed or otherwise treated with the consent of the patient and in which, in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts. Reasonable efforts for relieving or curing the cause of the pain may be determined on the basis of, but are not limited to, the following:

(1) when treating a nonterminally ill patient for intractable pain, evaluation by the attending physician and one or more physicians specializing in pain medicine or the treatment of the area, system, or organ of the body perceived as the source of the pain; or

(2) when treating a terminally ill patient, evaluation by the attending physician who does so in accordance with the level of care, skill, and treatment that would be recognized by a reasonably prudent physician under similar conditions and circumstances.

Subd. 2. **Prescription and administration of controlled substances for intractable pain.** Notwithstanding any other provision of this chapter, a physician may prescribe or administer a controlled substance in Schedules II to V of section 152.02 to an individual in the course of the physician's treatment of the individual for a diagnosed condition causing intractable pain. No physician shall be subject to disciplinary action by the Board of Medical Practice for appropriately prescribing or administering a controlled substance in Schedules II to V of section 152.02 in the course of treatment of an individual for intractable pain, provided the physician keeps accurate records of the purpose, use, prescription, and disposal of controlled substances, writes accurate prescriptions, and prescribes medications in conformance with chapter 147.

Subd. 3. **Limits on applicability.** This section does not apply to:

(1) a physician's treatment of an individual for chemical dependency resulting from the use of controlled substances in Schedules II to V of section 152.02;

(2) the prescription or administration of controlled substances in Schedules II to V of section 152.02 to an individual whom the physician knows to be using the controlled substances for nontherapeutic purposes;

(3) the prescription or administration of controlled substances in Schedules II to V of section 152.02 for the purpose of terminating the life of an individual having intractable pain; or

(4) the prescription or administration of a controlled substance in Schedules II to V of section 152.02 that is not a controlled substance approved by the United States Food and Drug Administration for pain relief.

Subd. 4. **Notice of risks.** Prior to treating an individual for intractable pain in accordance with subdivision 2, a physician shall discuss with the individual the risks associated with the controlled substances in Schedules II to V of section 152.02 to be prescribed or administered in the course of the physician's treatment of an individual, and document the discussion in the individual's record.

History: *1997 c 124 s 1*

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181.951 AUTHORIZED DRUG AND ALCOHOL TESTING.

Subdivision 1. **Limitations on testing.** (a) An employer may not request or require an employee or job applicant to undergo drug and alcohol testing except as authorized in this section.

(b) An employer may not request or require an employee or job applicant to undergo drug or alcohol testing unless the testing is done pursuant to a written drug and alcohol testing policy that contains the minimum information required in section 181.952; and, is conducted by a testing laboratory which participates in one of the programs listed in section 181.953, subdivision 1.

(c) An employer may not request or require an employee or job applicant to undergo drug and alcohol testing on an arbitrary and capricious basis.

Subd. 2. **Job applicant testing.** An employer may request or require a job applicant to undergo drug and alcohol testing provided a job offer has been made to the applicant and the same test is requested or required of all job applicants conditionally offered employment for that position. If the job offer is withdrawn, as provided in section 181.953, subdivision 11, the employer shall inform the job applicant of the reason for its action.

Subd. 3. **Routine physical examination testing.** An employer may request or require an employee to undergo drug and alcohol testing as part of a routine physical examination provided the drug or alcohol test is requested or required no more than once annually and the employee has been given at least two weeks' written notice that a drug or alcohol test may be requested or required as part of the physical examination.

Subd. 4. **Random testing.** An employer may request or require employees to undergo drug and alcohol testing on a random selection basis only if (1) they are employed in safety-sensitive positions, or (2) they are employed as professional athletes if the professional athlete is subject to a collective bargaining agreement permitting random testing but only to the extent consistent with the collective bargaining agreement.

Subd. 5. **Reasonable suspicion testing.** An employer may request or require an employee to undergo drug and alcohol testing if the employer has a reasonable suspicion that the employee:

(1) is under the influence of drugs or alcohol;

(2) has violated the employer's written work rules prohibiting the use, possession, sale, or transfer of drugs or alcohol while the employee is working or while the employee is on the employer's premises or operating the employer's vehicle, machinery, or equipment, provided the work rules are in writing and contained in the employer's written drug and alcohol testing policy;

(3) has sustained a personal injury, as that term is defined in section 176.011, subdivision 16, or has caused another employee to sustain a personal injury; or

(4) has caused a work-related accident or was operating or helping to operate machinery, equipment, or vehicles involved in a work-related accident.

Subd. 6. **Treatment program testing.** An employer may request or require an employee to undergo drug and alcohol testing if the employee has been referred by the employer for chemical dependency treatment or evaluation or is participating in a chemical dependency treatment program under an employee benefit plan, in which case the employee may be requested or required to undergo drug or alcohol testing without prior notice during the evaluation or treatment period and for a period of up to two years following completion of any prescribed chemical dependency treatment program.

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Subd. 7. **No legal duty to test.** Employers do not have a legal duty to request or require an employee or job applicant to undergo drug or alcohol testing as authorized in this section.

History: *1987 c 388 s 2; 1988 c 536 s 1; 1991 c 60 s 5; 2005 c 133 s 1*

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181.956 REMEDIES.

Subdivision 1. **Exhaustion.** An employee or collective bargaining agent may bring an action under this section only after first exhausting all applicable grievance procedures and arbitration proceeding requirements under a collective bargaining agreement; provided that, an employee's right to bring an action under this section is not affected by a decision of a collective bargaining agent not to pursue a grievance.

Subd. 2. **Damages.** In addition to any other remedies provided by law, an employer or laboratory that violates sections 181.950 to 181.954 is liable to an employee or job applicant injured by the violation in a civil action for any damages allowable at law. If a violation is found and damages awarded, the court may also award reasonable attorney fees for a cause of action based on a violation of sections 181.950 to 181.954 if the court finds that the employer knowingly or recklessly violated sections 181.950 to 181.954.

Subd. 3. **Injunctive relief.** An employee or job applicant, a state, county, or city attorney, or a collective bargaining agent who fairly and adequately represents the interests of the protected class has standing to bring an action for injunctive relief requesting the district court to enjoin an employer or laboratory that commits or proposes to commit an act in violation of sections 181.950 to 181.954.

Subd. 4. **Other equitable relief.** Upon finding a violation of sections 181.950 to 181.954, or as part of injunctive relief granted under subdivision 3, a court may, in its discretion, grant any other equitable relief it considers appropriate, including ordering the injured employee or job applicant reinstated with back pay.

Subd. 5. **Retaliation prohibited.** An employer may not retaliate against an employee for asserting rights and remedies provided in sections 181.950 to 181.954.

History: *1987 c 388 s 7*

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181.938 NONWORK ACTIVITIES; PROHIBITED EMPLOYER CONDUCT.

Subdivision 1. **Definition.** For the purpose of this section, "employer" has the meaning given it in section 179.01, subdivision 3.

Subd. 2. **Prohibited practice.** An employer may not refuse to hire a job applicant or discipline or discharge an employee because the applicant or employee engages in or has engaged in the use or enjoyment of lawful consumable products, if the use or enjoyment takes place off the premises of the employer during nonworking hours. For purposes of this section, "lawful consumable products" means products whose use or enjoyment is lawful and which are consumed during use or enjoyment, and includes food, alcoholic or nonalcoholic beverages, and tobacco.

Subd. 3. **Exceptions.** (a) It is not a violation of subdivision 2 for an employer to restrict the use of lawful consumable products by employees during nonworking hours if the employer's restriction:

(1) relates to a bona fide occupational requirement and is reasonably related to employment activities or responsibilities of a particular employee or group of employees; or

(2) is necessary to avoid a conflict of interest or the appearance of a conflict of interest with any responsibilities owed by the employee to the employer.

(b) It is not a violation of subdivision 2 for an employer to refuse to hire an applicant or discipline or discharge an employee who refuses or fails to comply with the conditions established by a chemical dependency treatment or aftercare program.

(c) It is not a violation of subdivision 2 for an employer to offer, impose, or have in effect a health or life insurance plan that makes distinctions between employees for the type of coverage or the cost of coverage based upon the employee's use of lawful consumable products, provided that, to the extent that different premium rates are charged to the employees, those rates must reflect the actual differential cost to the employer.

(d) It is not a violation of subdivision 2 for an employer to refuse to hire an applicant or discipline or discharge an employee on the basis of the applicant's or employee's past or present job performance.

Subd. 4. **Remedy.** The sole remedy for a violation of subdivision 2 is a civil action for damages. Damages are limited to wages and benefits lost by the individual because of the violation. A court shall award the prevailing party in the action, whether plaintiff or defendant, court costs and a reasonable attorney fee.

History: *1992 c 538 s 1*

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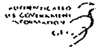

3768, which enacted sections 801a, 830, and 852 of this title, amended sections 352, 802, 811, 812, 823, 827, 841 to 843, 872, 881, 952, 953, and 965 of this title and section 242a of Title 42, The Public Health and Welfare, repealed section 830 of this title effective Jan. 1, 1981, and enacted provisions set out as notes under sections 801, 801a, 812, and 830 of this title. For complete classification of this Act to the Code, see Short Title of 1978 Amendment note set out under section 801 of this title and Tables.

This subchapter and subchapter II of this chapter, referred to in subsec. (g)(1), was in the original "titles II and III of the Comprehensive Drug Abuse Prevention and Control Act", which was translated as meaning titles II and III of the Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. 91–513, Oct. 27, 1970, 84 Stat. 1242, 1285, as amended, to reflect the probable intent of Congress. Title II is classified principally to this subchapter and part A of title III comprises subchapter II of this chapter. For complete classification of this Act to the Code, see Short Title notes set out under section 801 of this title and Tables.

AMENDMENTS

2004—Subsec. (g)(1). Pub. L. 108–358, §2(b)(1), substituted "drug which contains a controlled substance from the application of this subchapter and subchapter II of this chapter if such drug" for "substance from a schedule if such substance".

Subsec. (g)(3)(C). Pub. L. 108–358, §2(b)(2), added subpar. (C).

1984—Subsec. (g)(3). Pub. L. 98–473, §509(a), added par. (3).

Subsec. (h). Pub. L. 98–473, §508, added subsec. (h).

1978—Subsec. (d). Pub. L. 95–633 designated existing provisions as par. (1) and added pars. (2) to (5).

CHANGE OF NAME

"Secretary of Health and Human Services" substituted for "Secretary of Health, Education, and Welfare" in subsec. (d)(2), (3), (4)(A), (B), (5) pursuant to section 509(b) of Pub. L. 96–88 which is classified to section 3508(b) of Title 20, Education.

EFFECTIVE DATE OF 2004 AMENDMENT

Amendment by Pub. L. 108–358 effective 90 days after Oct. 22, 2004, see section 2(d) of Pub. L. 108–358, set out as a note under section 802 of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–633 effective on date the Convention on Psychotropic Substances enters into force in the United States [July 15, 1980], see section 112 of Pub. L. 95–633, set out as an Effective Date note under section 801a of this title.

§812. Schedules of controlled substances

(a) Establishment

There are established five schedules of controlled substances, to be known as schedules I, II, III, IV, and V. Such schedules shall initially consist of the substances listed in this section. The schedules established by this section shall be updated and republished on a semiannual basis during the two-year period beginning one year after October 27, 1970, and shall be updated and republished on an annual basis thereafter.

(b) Placement on schedules; findings required

Except where control is required by United States obligations under an international treaty, convention, or protocol, in effect on October 27, 1970, and except in the case of an immediate precursor, a drug or other substance may not be placed in any schedule unless the findings required for such schedule are made with respect to such drug or other substance. The findings required for each of the schedules are as follows:

(1) SCHEDULE I.—

(A) The drug or other substance has a high potential for abuse.

(B) The drug or other substance has no currently accepted medical use in treatment in the United States.

(C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.

(2) SCHEDULE II.—

(A) The drug or other substance has a high potential for abuse.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.

(C) Abuse of the drug or other substances may lead to severe psychological or physical dependence.

(3) SCHEDULE III.—

(A) The drug or other substance has a potential for abuse less than the drugs or other substances in schedules I and II.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States.

(C) Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

(4) SCHEDULE IV.—

(A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule III.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States.

(C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule III.

(5) SCHEDULE V.—

(A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule IV.

(B) The drug or other substance has a currently accepted medical use in treatment in the United States.

(C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule IV.

(c) Initial schedules of controlled substances

Schedules I, II, III, IV, and V shall, unless and until amended[1] pursuant to section 811 of this title, consist of the following drugs or other substances, by whatever official name, common or usual name, chemical name, or brand name designated:

SCHEDULE I

(a) Unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers,

[1] Revised schedules are published in the Code of Federal Regulations, Part 1308 of Title 21, Food and Drugs.

salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

(1) Acetylmethadol.
(2) Allylprodine.
(3) Alphacetylmathadol.[2]
(4) Alphameprodine.
(5) Alphamethadol.
(6) Benzethidine.
(7) Betacetylmethadol.
(8) Betameprodine.
(9) Betamethadol.
(10) Betaprodine.
(11) Clonitazene.
(12) Dextromoramide.
(13) Dextrorphan.
(14) Diampromide.
(15) Diethylthiambutene.
(16) Dimenoxadol.
(17) Dimepheptanol.
(18) Dimethylthiambutene.
(19) Dioxaphetyl butyrate.
(20) Dipipanone.
(21) Ethylmethylthiambutene.
(22) Etonitazene.
(23) Etoxeridine.
(24) Furethidine.
(25) Hydroxypethidine.
(26) Ketobemidone.
(27) Levomoramide.
(28) Levophenacylmorphan.
(29) Morpheridine.
(30) Noracymethadol.
(31) Norlevorphanol.
(32) Normethadone.
(33) Norpipanone.
(34) Phenadoxone.
(35) Phenampromide.
(36) Phenomorphan.
(37) Phenoperidine.
(38) Piritramide.
(39) Propheptazine.
(40) Properidine.
(41) Racemoramide.
(42) Trimeperidine.

(b) Unless specifically excepted or unless listed in another schedule, any of the following opium derivatives, their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Acetorphine.
(2) Acetyldihydrocodeine.
(3) Benzylmorphine.
(4) Codeine methylbromide.
(5) Codeine-N-Oxide.
(6) Cyprenorphine.
(7) Desomorphine.
(8) Dihydromorphine.
(9) Etorphine.
(10) Heroin.
(11) Hydromorphinol.
(12) Methyldesorphine.
(13) Methylhydromorphine.
(14) Morphine methylbromide.
(15) Morphine methylsulfonate.
(16) Morphine-N-Oxide.
(17) Myrophine.
(18) Nicocodeine.
(19) Nicomorphine.
(20) Normorphine.
(21) Pholcodine.
(22) Thebacon.

(c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation, which contains any quantity of the following hallucinogenic substances, or which contains any of their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) 3,4-methylenedioxy amphetamine.
(2) 5-methoxy-3,4-methylenedioxy amphetamine.
(3) 3,4,5-trimethoxy amphetamine.
(4) Bufotenine.
(5) Diethyltryptamine.
(6) Dimethyltryptamine.
(7) 4-methyl-2,5-diamethoxyamphetamine.
(8) Ibogaine.
(9) Lysergic acid diethylamide.
(10) Marihuana.
(11) Mescaline.
(12) Peyote.
(13) N-ethyl-3-piperidyl benzilate.
(14) N-methyl-3-piperidyl benzilate.
(15) Psilocybin.
(16) Psilocyn.
(17) Tetrahydrocannabinols.

SCHEDULE II

(a) Unless specifically excepted or unless listed in another schedule, any of the following substances whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate.

(2) Any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of the substances referred to in clause (1), except that these substances shall not include the isoquinoline alkaloids of opium.

(3) Opium poppy and poppy straw.

(4) coca[3] leaves, except coca leaves and extracts of coca leaves from which cocaine, ecgonine, and derivatives of ecgonine or their salts have been removed; cocaine, its salts, optical and geometric isomers, and salts of isomers; ecgonine, its derivatives, their salts, isomers, and salts of isomers; or any compound, mixture, or preparation which contains any quantity of any of the substances referred to in this paragraph.

(b) Unless specifically excepted or unless listed in another schedule, any of the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

[2] So in original. Probably should be "Alphacetylmethadol."

[3] So in original. Probably should be capitalized.

(1) Alphaprodine.
(2) Anileridine.
(3) Bezitramide.
(4) Dihydrocodeine.
(5) Diphenoxylate.
(6) Fentanyl.
(7) Isomethadone.
(8) Levomethorphan.
(9) Levorphanol.
(10) Metazocine.
(11) Methadone.
(12) Methadone-Intermediate, 4-cyano-2-dimethylamino-4,4-diphenyl butane.
(13) Moramide-Intermediate, 2-methyl-3-morpholino-1, 1-diphenylpropane-carboxylic acid.
(14) Pethidine.
(15) Pethidine-Intermediate-A, 4-cyano-1-methyl-4-phenylpiperidine.
(16) Pethidine-Intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate.
(17) Pethidine-Intermediate-C, 1-methyl-4-phenylpiperidine-4-carboxylic acid.
(18) Phenazocine.
(19) Piminodine.
(20) Racemethorphan.
(21) Racemorphan.

(c) Unless specifically excepted or unless listed in another schedule, any injectable liquid which contains any quantity of methamphetamine, including its salts, isomers, and salts of isomers.

SCHEDULE III

(a) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system:

(1) Amphetamine, its salts, optical isomers, and salts of its optical isomers.
(2) Phenmetrazine and its salts.
(3) Any substance (except an injectable liquid) which contains any quantity of methamphetamine, including its salts, isomers, and salts of isomers.
(4) Methylphenidate.

(b) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant effect on the central nervous system:

(1) Any substance which contains any quantity of a derivative of barbituric acid, or any salt of a derivative of barbituric acid.
(2) Chorhexadol.
(3) Glutethimide.
(4) Lysergic acid.
(5) Lysergic acid amide.
(6) Methyprylon.
(7) Phencyclidine.
(8) Sulfondiethylmethane.
(9) Sulfonethylmethane.
(10) Sulfonmethane.

(c) Nalorphine.

(d) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any salts thereof:

(1) Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium.
(2) Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
(3) Not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium.
(4) Not more than 300 milligrams of dihydrocodeinone per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
(5) Not more than 1.8 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
(6) Not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
(7) Not more than 500 milligrams of opium per 100 milliliters or per 100 grams, or not more than 25 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.
(8) Not more than 50 milligrams of morphine per 100 milliliters or per 100 grams with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

(e) Anabolic steroids.

SCHEDULE IV

(1) Barbital.
(2) Chloral betaine.
(3) Chloral hydrate.
(4) Ethchlorvynol.
(5) Ethinamate.
(6) Methohexital.
(7) Meprobamate.
(8) Methylphenobarbital.
(9) Paraldehyde.
(10) Petrichloral.
(11) Phenobarbital.

SCHEDULE V

Any compound, mixture, or preparation containing any of the following limited quantities of narcotic drugs, which shall include one or more nonnarcotic active medicinal ingredients in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by the narcotic drug alone:

(1) Not more than 200 milligrams of codeine per 100 milliliters or per 100 grams.
(2) Not more than 100 milligrams of dihydrocodeine per 100 milliliters or per 100 grams.
(3) Not more than 100 milligrams of ethylmorphine per 100 milliliters or per 100 grams.
(4) Not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit.

(5) Not more than 100 milligrams of opium per 100 milliliters or per 100 grams.

(Pub. L. 91–513, title II, §202, Oct. 27, 1970, 84 Stat. 1247; Pub. L. 95–633, title I, §103, Nov. 10, 1978, 92 Stat. 3772; Pub. L. 98–473, title II, §§507(c), 509(b), Oct. 12, 1984, 98 Stat. 2071, 2072; Pub. L. 99–570, title I, §1867, Oct. 27, 1986, 100 Stat. 3207–55; Pub. L. 99–646, §84, Nov. 10, 1986, 100 Stat. 3619; Pub. L. 101–647, title XIX, §1902(a), Nov. 29, 1990, 104 Stat. 4851.)

AMENDMENTS

1990—Subsec. (c). Pub. L. 101–647 added item (e) at end of schedule III.

1986—Subsec. (c). Pub. L. 99–646 amended schedule II(a)(4) generally. Prior to amendment, schedule II(a)(4) read as follows: "Coca leaves (except coca leaves and extracts of coca leaves from which cocaine, ecgonine, and derivatives of ecgonine or their salts have been removed); cocaine, its salts, optical and geometric isomers, and salts of isomers; and ecgonine, its derivatives, their salts, isomers, and salts of isomers."

Pub. L. 99–570 amended schedule II(a)(4) generally. Prior to amendment, schedule II(a)(4) read as follows: "Coca leaves and any salt, compound, derivative, or preparation of coca leaves (including cocaine and ecgonine and their salts, isomers, derivatives, and salts of isomers and derivatives), and any salt, compound, derivative, or preparation thereof which is chemically equivalent or identical with any of these substances, except that the substances shall not include decocainized coca leaves or extraction of coca leaves, which extractions do not contain cocaine or ecgonine."

1984—Subsec. (c). Pub. L. 98–473, §507(c), in schedule II(a)(4) added applicability to cocaine and ecgonine and their salts, isomers, etc.

Subsec. (d). Pub. L. 98–473, §509(b), struck out subsec. (d) which related to authority of Attorney General to except stimulants or depressants containing active medicinal ingredients.

1978—Subsec. (d)(3). Pub. L. 95–633 added cl. (3).

EFFECTIVE DATE OF 1990 AMENDMENT

Amendment by Pub. L. 101–647 effective 90 days after Nov. 29, 1990, see section 1902(d) of Pub. L. 101–647, set out as a note under section 802 of this title.

EFFECTIVE DATE OF 1978 AMENDMENT

Amendment by Pub. L. 95–633 effective on date the Convention on Psychotropic Substances enters into force in the United States [July 15, 1980], see section 112 of Pub. L. 95–633, set out as an Effective Date note under section 801a of this title.

CONGRESSIONAL FINDING; EMERGENCY SCHEDULING OF GHB IN CONTROLLED SUBSTANCES ACT

Pub. L. 106–172, §§2, 3(a), Feb. 18, 2000, 114 Stat. 7, 8, provided that:

"SEC. 2. FINDINGS.

"Congress finds as follows:

"(1) Gamma hydroxybutyric acid (also called G, Liquid X, Liquid Ecstasy, Grievous Bodily Harm, Georgia Home Boy, Scoop) has become a significant and growing problem in law enforcement. At least 20 States have scheduled such drug in their drug laws and law enforcement officials have been experiencing an increased presence of the drug in driving under the influence, sexual assault, and overdose cases especially at night clubs and parties.

"(2) A behavioral depressant and a hypnotic, gamma hydroxybutyric acid ('GHB') is being used in conjunction with alcohol and other drugs with detrimental effects in an increasing number of cases. It is difficult to isolate the impact of such drug's ingestion since it is so typically taken with an ever-changing array of other drugs and especially alcohol which potentiates its impact.

"(3) GHB takes the same path as alcohol, processes via alcohol dehydrogenase, and its symptoms at high levels of intake and as impact builds are comparable to alcohol ingestion/intoxication. Thus, aggression and violence can be expected in some individuals who use such drug.

"(4) If taken for human consumption, common industrial chemicals such as gamma butyrolactone and 1.4-butanediol are swiftly converted by the body into GHB. Illicit use of these and other GHB analogues and precursor chemicals is a significant and growing law enforcement problem.

"(5) A human pharmaceutical formulation of gamma hydroxybutyric acid is being developed as a treatment for cataplexy, a serious and debilitating disease. Cataplexy, which causes sudden and total loss of muscle control, affects about 65 percent of the estimated 180,000 Americans with narcolepsy, a sleep disorder. People with cataplexy often are unable to work, drive a car, hold their children or live a normal life.

"(6) Abuse of illicit GHB is an imminent hazard to public safety that requires immediate regulatory action under the Controlled Substances Act (21 U.S.C. 801 et seq.).

"SEC. 3. EMERGENCY SCHEDULING OF GAMMA HYDROXYBUTYRIC ACID AND LISTING OF GAMMA BUTYROLACTONE AS LIST I CHEMICAL.

"(a) EMERGENCY SCHEDULING OF GHB.—

"(1) IN GENERAL.—The Congress finds that the abuse of illicit gamma hydroxybutyric acid is an imminent hazard to the public safety. Accordingly, the Attorney General, notwithstanding sections 201(a), 201(b), 201(c), and 202 of the Controlled Substances Act [21 U.S.C. 811(a)–(c), 812], shall issue, not later than 60 days after the date of the enactment of this Act [Feb. 18, 2000], a final order that schedules such drug (together with its salts, isomers, and salts of isomers) in the same schedule under section 202(c) of the Controlled Substances Act as would apply to a scheduling of a substance by the Attorney General under section 201(h)(1) of such Act (relating to imminent hazards to the public safety), except as follows:

"(A) For purposes of any requirements that relate to the physical security of registered manufacturers and registered distributors, the final order shall treat such drug, when the drug is manufactured, distributed, or possessed in accordance with an exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 355(i)] (whether the exemption involved is authorized before, on, or after the date of the enactment of this Act [Feb. 18, 2000]), as being in the same schedule as that recommended by the Secretary of Health and Human Services for the drug when the drug is the subject of an authorized investigational new drug application (relating to such section 505(i)). The recommendation referred to in the preceding sentence is contained in the first paragraph of the letter transmitted on May 19, 1999, by such Secretary (acting through the Assistant Secretary for Health) to the Attorney General (acting through the Deputy Administrator of the Drug Enforcement Administration), which letter was in response to the letter transmitted by the Attorney General (acting through such Deputy Administrator) on September 16, 1997. In publishing the final order in the Federal Register, the Attorney General shall publish a copy of the letter that was transmitted by the Secretary of Health and Human Services.

"(B) In the case of gamma hydroxybutyric acid that is contained in a drug product for which an application is approved under section 505 of the Federal Food, Drug, and Cosmetic Act [21 U.S.C. 355] (whether the application involved is approved before, on, or after the date of the enactment of this Act [Feb. 18, 2000]), the final order shall schedule such drug in the same schedule as that recommended by the Secretary of Health and Human

Services for authorized formulations of the drug. The recommendation referred to in the preceding sentence is contained in the last sentence of the fourth paragraph of the letter referred to in subparagraph (A) with respect to May 19, 1999.

"(2) FAILURE TO ISSUE ORDER.—If the final order is not issued within the period specified in paragraph (1), gamma hydroxybutyric acid (together with its salts, isomers, and salts of isomers) is deemed to be scheduled under section 202(c) of the Controlled Substances Act [21 U.S.C. 812(c)] in accordance with the policies described in paragraph (1), as if the Attorney General had issued a final order in accordance with such paragraph."

PLACEMENT OF PIPRADROL AND SPA IN SCHEDULE IV TO CARRY OUT OBLIGATION UNDER CONVENTION ON PSYCHOTROPIC SUBSTANCES

Section 102(c) of Pub. L. 95–633 provided that: "For the purpose of carrying out the minimum United States obligations under paragraph 7 of article 2 of the Convention on Psychotropic Substances, signed at Vienna, Austria, on February 21, 1971, with respect to pipradrol and SPA (also known as (-)-1-dimethylamino-1,2-diphenylethane), the Attorney General shall by order, made without regard to sections 201 and 202 of the Controlled Substances Act [this section and section 811 of this title], place such drugs in schedule IV of such Act [see subsec. (c) of this section]."

Provision of section 102(c) of Pub. L. 95–633, set out above, effective on the date the Convention on Psychotropic Substances enters into force in the United States [July 15, 1980], see section 112 of Pub. L. 95–633, set out as an Effective Date note under section 801a of this title.

§813. Treatment of controlled substance analogues

A controlled substance analogue shall, to the extent intended for human consumption, be treated, for the purposes of any Federal law as a controlled substance in schedule I.

(Pub. L. 91–513, title II, §203, as added Pub. L. 99–570, title I, §1202, Oct. 27, 1986, 100 Stat. 3207–13; amended Pub. L. 100–690, title VI, §6470(c), Nov. 18, 1988, 102 Stat. 4378.)

REFERENCES IN TEXT

Schedule I, referred to in text, is set out in section 812(c) of this title.

AMENDMENTS

1988—Pub. L. 100–690 substituted "any Federal law" for "this subchapter and subchapter II of this chapter".

§814. Removal of exemption of certain drugs

(a) Removal of exemption

The Attorney General shall by regulation remove from exemption under section 802(39)(A)(iv) of this title a drug or group of drugs that the Attorney General finds is being diverted to obtain a listed chemical for use in the illicit production of a controlled substance.

(b) Factors to be considered

In removing a drug or group of drugs from exemption under subsection (a) of this section, the Attorney General shall consider, with respect to a drug or group of drugs that is proposed to be removed from exemption—

(1) the scope, duration, and significance of the diversion;

(2) whether the drug or group of drugs is formulated in such a way that it cannot be easily used in the illicit production of a controlled substance; and

(3) whether the listed chemical can be readily recovered from the drug or group of drugs.

(c) Specificity of designation

The Attorney General shall limit the designation of a drug or a group of drugs removed from exemption under subsection (a) of this section to the most particularly identifiable type of drug or group of drugs for which evidence of diversion exists unless there is evidence, based on the pattern of diversion and other relevant factors, that the diversion will not be limited to that particular drug or group of drugs.

(d) Reinstatement of exemption with respect to particular drug products

(1) Reinstatement

On application by a manufacturer of a particular drug product that has been removed from exemption under subsection (a) of this section, the Attorney General shall by regulation reinstate the exemption with respect to that particular drug product if the Attorney General determines that the particular drug product is manufactured and distributed in a manner that prevents diversion.

(2) Factors to be considered

In deciding whether to reinstate the exemption with respect to a particular drug product under paragraph (1), the Attorney General shall consider—

(A) the package sizes and manner of packaging of the drug product;

(B) the manner of distribution and advertising of the drug product;

(C) evidence of diversion of the drug product;

(D) any actions taken by the manufacturer to prevent diversion of the drug product; and

(E) such other factors as are relevant to and consistent with the public health and safety, including the factors described in subsection (b) of this section as applied to the drug product.

(3) Status pending application for reinstatement

A transaction involving a particular drug product that is the subject of a bona fide pending application for reinstatement of exemption filed with the Attorney General not later than 60 days after a regulation removing the exemption is issued pursuant to subsection (a) of this section shall not be considered to be a regulated transaction if the transaction occurs during the pendency of the application and, if the Attorney General denies the application, during the period of 60 days following the date on which the Attorney General denies the application, unless—

(A) the Attorney General has evidence that, applying the factors described in subsection (b) of this section to the drug product, the drug product is being diverted; and

(B) the Attorney General so notifies the applicant.

(4) Amendment and modification

A regulation reinstating an exemption under paragraph (1) may be modified or revoked with

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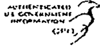

of the Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. 812).

(3) CONVICTION.—The term "conviction" means a finding of guilt (including a plea of nolo contendere), an imposition of sentence, or both, by a judicial body charged with the responsibility to determine violations of Federal or State criminal drug statutes.

(4) CRIMINAL DRUG STATUTE.—The term "criminal drug statute" means a criminal statute involving manufacture, distribution, dispensation, use, or possession of a controlled substance.

(5) DRUG-FREE WORKPLACE.—The term "drug-free workplace" means a site of an entity—

(A) for the performance of work done in connection with a specific contract or grant described in section 8102 or 8103 of this title; and

(B) at which employees of the entity are prohibited from engaging in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in accordance with the requirements of the Anti-Drug Abuse Act of 1988 (Public Law 100–690, 102 Stat. 4181).

(6) EMPLOYEE.—The term "employee" means the employee of a contractor or grantee directly engaged in the performance of work pursuant to the contract or grant described in section 8102 or 8103 of this title.

(7) FEDERAL AGENCY.—The term "Federal agency" means an agency as defined in section 552(f) of title 5.

(8) GRANTEE.—The term "grantee" means the department, division, or other unit of a person responsible for the performance under the grant.

(b) CONSTRUCTION.—This chapter does not require law enforcement agencies to comply with this chapter if the head of the agency determines it would be inappropriate in connection with the agency's undercover operations.

(Pub. L. 111–350, §3, Jan. 4, 2011, 124 Stat. 3826.)

HISTORICAL AND REVISION NOTES

Revised Section	*Source (U.S. Code)*	*Source (Statutes at Large)*
8101(a)(1)	41:706(7).	Pub. L. 100–690, title V, §§5157, 5158, Nov. 18, 1988, 102 Stat. 4308.
8101(a)(2)	41:706(3).	
8101(a)(3)	41:706(4).	
8101(a)(4)	41:706(5).	
8101(a)(5)	41:706(1).	
8101(a)(6)	41:706(2).	
8101(a)(7)	41:706(8).	
8101(a)(8)	41:706(6).	
8101(b)	41:707.	

§ 8102. Drug-free workplace requirements for Federal contractors

(a) IN GENERAL.—

(1) PERSONS OTHER THAN INDIVIDUALS.—A person other than an individual shall not be considered a responsible source (as defined in section 113 of this title) for the purposes of being awarded a contract for the procurement of any property or services of a value greater than the simplified acquisition threshold (as defined in section 134 of this title) by a Federal agency, other than a contract for the procurement of commercial items (as defined in section 103 of this title), unless the person agrees to provide a drug-free workplace by—

(A) publishing a statement notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the person's workplace and specifying the actions that will be taken against employees for violations of the prohibition;

(B) establishing a drug-free awareness program to inform employees about—

(i) the dangers of drug abuse in the workplace;

(ii) the person's policy of maintaining a drug-free workplace;

(iii) available drug counseling, rehabilitation, and employee assistance programs; and

(iv) the penalties that may be imposed on employees for drug abuse violations;

(C) making it a requirement that each employee to be engaged in the performance of the contract be given a copy of the statement required by subparagraph (A);

(D) notifying the employee in the statement required by subparagraph (A) that as a condition of employment on the contract the employee will—

(i) abide by the terms of the statement; and

(ii) notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than 5 days after the conviction;

(E) notifying the contracting agency within 10 days after receiving notice under subparagraph (D)(ii) from an employee or otherwise receiving actual notice of a conviction;

(F) imposing a sanction on, or requiring the satisfactory participation in a drug abuse assistance or rehabilitation program by, any employee who is convicted, as required by section 8104 of this title; and

(G) making a good faith effort to continue to maintain a drug-free workplace through implementation of subparagraphs (A) to (F).

(2) INDIVIDUALS.—A Federal agency shall not make a contract with an individual unless the individual agrees not to engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in the performance of the contract.

(b) SUSPENSION, TERMINATION, OR DEBARMENT OF CONTRACTOR.—

(1) GROUNDS FOR SUSPENSION, TERMINATION, OR DEBARMENT.—Payment under a contract awarded by a Federal agency may be suspended and the contract may be terminated, and the contractor or individual who made the contract with the agency may be suspended or debarred in accordance with the requirements of this section, if the head of the agency determines that—

(A) the contractor is violating, or has violated, the requirements of subparagraph (A), (B), (C), (D), (E), or (F) of subsection (a)(1); or

(B) the number of employees of the contractor who have been convicted of viola-

tions of criminal drug statutes for violations occurring in the workplace indicates that the contractor has failed to make a good faith effort to provide a drug-free workplace as required by subsection (a).

(2) CONDUCT OF SUSPENSION, TERMINATION, AND DEBARMENT PROCEEDINGS.—A contracting officer who determines in writing that cause for suspension of payments, termination, or suspension or debarment exists shall initiate an appropriate action, to be conducted by the agency concerned in accordance with the Federal Acquisition Regulation and applicable agency procedures. The Federal Acquisition Regulation shall be revised to include rules for conducting suspension and debarment proceedings under this subsection, including rules providing notice, opportunity to respond in writing or in person, and other procedures as may be necessary to provide a full and fair proceeding to a contractor or individual.

(3) EFFECT OF DEBARMENT.—A contractor or individual debarred by a final decision under this subsection is ineligible for award of a contract by a Federal agency, and for participation in a future procurement by a Federal agency, for a period specified in the decision, not to exceed 5 years.

(Pub. L. 111–350, §3, Jan. 4, 2011, 124 Stat. 3827.)

HISTORICAL AND REVISION NOTES

Revised Section	*Source (U.S. Code)*	*Source (Statutes at Large)*
8102	41:701.	Pub. L. 100–690, title V, §5152, Nov. 18, 1988, 102 Stat. 4304; Pub. L. 103–355, title IV, §4104(d), title VIII, §8301(f), Oct. 13, 1994, 108 Stat. 3342, 3397; Pub. L. 104–106, div. D, title XLIII, §§4301(a)(3), 4321(i)(13), Feb. 10, 1996, 110 Stat. 656, 677.

§8103. Drug-free workplace requirements for Federal grant recipients

(a) IN GENERAL.—

(1) PERSONS OTHER THAN INDIVIDUALS.—A person other than an individual shall not receive a grant from a Federal agency unless the person agrees to provide a drug-free workplace by—

(A) publishing a statement notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violations of the prohibition;

(B) establishing a drug-free awareness program to inform employees about—

(i) the dangers of drug abuse in the workplace;

(ii) the grantee's policy of maintaining a drug-free workplace;

(iii) available drug counseling, rehabilitation, and employee assistance programs; and

(iv) the penalties that may be imposed on employees for drug abuse violations;

(C) making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by subparagraph (A);

(D) notifying the employee in the statement required by subparagraph (A) that as a condition of employment in the grant the employee will—

(i) abide by the terms of the statement; and

(ii) notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than 5 days after the conviction;

(E) notifying the granting agency within 10 days after receiving notice under subparagraph (D)(ii) from an employee or otherwise receiving actual notice of a conviction;

(F) imposing a sanction on, or requiring the satisfactory participation in a drug abuse assistance or rehabilitation program by, any employee who is convicted, as required by section 8104 of this title; and

(G) making a good faith effort to continue to maintain a drug-free workplace through implementation of subparagraphs (A) to (F).

(2) INDIVIDUALS.—A Federal agency shall not make a grant to an individual unless the individual agrees not to engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance in conducting an activity with the grant.

(b) SUSPENSION, TERMINATION, OR DEBARMENT OF GRANTEE.—

(1) GROUNDS FOR SUSPENSION, TERMINATION, OR DEBARMENT.—Payment under a grant awarded by a Federal agency may be suspended and the grant may be terminated, and the grantee may be suspended or debarred, in accordance with the requirements of this section, if the head of the agency or the official designee of the head of the agency determines in writing that—

(A) the grantee is violating, or has violated, the requirements of subparagraph (A), (B), (C), (D), (E), (F), or (G) of subsection (a)(1); or

(B) the number of employees of the grantee who have been convicted of violations of criminal drug statutes for violations occurring in the workplace indicates that the grantee has failed to make a good faith effort to provide a drug-free workplace as required by subsection (a)(1).

(2) CONDUCT OF SUSPENSION, TERMINATION, AND DEBARMENT PROCEEDINGS.—A suspension of payments, termination, or suspension or debarment proceeding subject to this subsection shall be conducted in accordance with applicable law, including Executive Order 12549 or any superseding executive order and any regulations prescribed to implement the law or executive order.

(3) EFFECT OF DEBARMENT.—A grantee debarred by a final decision under this subsection is ineligible for award of a grant by a Federal agency, and for participation in a future grant by a Federal agency, for a period specified in the decision, not to exceed 5 years.

(Pub. L. 111–350, §3, Jan. 4, 2011, 124 Stat. 3828.)

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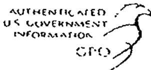

114TH CONGRESS
1ST SESSION

S. 683

To extend the principle of federalism to State drug policy, provide access to medical marijuana, and enable research into the medicinal properties of marijuana.

IN THE SENATE OF THE UNITED STATES

MARCH 10, 2015

Mr. BOOKER (for himself, Mrs. GILLIBRAND, and Mr. PAUL) introduced the following bill; which was read twice and referred to the Committee on the Judiciary

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A BILL

To extend the principle of federalism to State drug policy, provide access to medical marijuana, and enable research into the medicinal properties of marijuana.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Compassionate Access,
5 Research Expansion, and Respect States Act of 2015" or
6 the "CARERS Act of 2015".

7 **SEC. 2. FEDERALISM IN DRUG POLICY.**

8 Section 708 of the Controlled Substances Act (21
9 U.S.C. 903) is amended—

1 (1) by striking "No provision" and inserting
2 the following:
3 "(a) IN GENERAL.—Except as provided in subsection
4 (b), no provision"; and
5 (2) by adding at the end the following:
6 "(b) COMPLIANCE WITH STATE LAW.—Notwith-
7 standing any other provision of law, the provisions of this
8 title relating to marihuana shall not apply to any person
9 acting in compliance with State law relating to the produc-
10 tion, possession, distribution, dispensation, administra-
11 tion, laboratory testing, or delivery of medical mari-
12 huana.".

13 **SEC. 3. RESCHEDULING OF MARIHUANA.**

14 (a) REMOVAL FROM SCHEDULE I.—Schedule I, as
15 set forth in section 202(c) of the Controlled Substances
16 Act (21 U.S.C. 812(c)), is amended in subsection (c)—
17 (1) by striking paragraphs (10) and (17);
18 (2) by redesignating paragraphs (11) through
19 (16) as paragraphs (10) through (15), respectively;
20 and
21 (3) by redesignating paragraphs (18) through
22 (28) as paragraphs (16) through (26), respectively.
23 (b) LISTING IN SCHEDULE II.—Schedule II, as set
24 forth in section 202(c) of the Controlled Substances Act

1 (21 U.S.C. 812(c)), is amended by adding at the end the
2 following:
3 "(d) Unless specifically excepted or unless listed in
4 another schedule, any material, compound, mixture, or
5 preparation, which contains any quantity of marihuana,
6 including its salts, isomers, and salts of isomers.".
7 **SEC. 4. EXCLUSION OF CANNABIDIOL FROM DEFINITION OF**
8 **MARIHUANA.**
9 Section 102 of the Controlled Substances Act (21
10 U.S.C. 802) is amended—
11 (1) in paragraph (16)—
12 (A) by striking "or cake, or the sterilized"
13 and inserting "cake, the sterilized"; and
14 (B) by adding ", or cannabidiol" before
15 the period at the end; and
16 (2) by adding at the end the following:
17 "(57) The term 'cannabidiol' means the sub-
18 stance cannabidiol, as derived from marihuana or
19 the synthetic formulation, that contains not greater
20 than 0.3 percent delta-9-tetrahydrocannabinol on a
21 dry weight basis.".
22 **SEC. 5. CANNABIDIOL DETERMINATION BY STATES.**
23 Section 201 of the Controlled Substances Act (21
24 U.S.C. 811) is amended by adding at the end the fol-
25 lowing:

1 "(j) CANNABIDIOL DETERMINATION.—If a person
2 grows or processes marihuana for purposes of making
3 cannabidiol in accordance with State law, the marihuana
4 shall be deemed to meet the concentration limitation under
5 section 102(57), unless the Attorney General determines
6 that the State law is not reasonably calculated to comply
7 with section 102(57).".

8 **SEC. 6. BANKING.**

9 (a) DEFINITIONS.—In this section—
10 (1) the term "depository institution" means—
11 (A) a depository institution as defined in
12 section 3(c) of the Federal Deposit Insurance
13 Act (12 U.S.C. 1813(c));
14 (B) a Federal credit union as defined in
15 section 101 of the Federal Credit Union Act
16 (12 U.S.C. 1752); or
17 (C) a State credit union as defined in sec-
18 tion 101 of the Federal Credit Union Act (12
19 U.S.C. 1752);
20 (2) the term "Federal banking regulator"
21 means each of the Board of Governors of the Fed-
22 eral Reserve System, the Bureau of Consumer Fi-
23 nancial Protection, the Federal Deposit Insurance
24 Corporation, the Office of the Comptroller of the
25 Currency, the National Credit Union Administra-

1 tion, or any Federal agency or department that reg-
2 ulates banking or financial services, as determined
3 by the Secretary of the Treasury;
4 (3) the term "financial service" means a finan-
5 cial product or service as defined in section 1002 of
6 the Dodd-Frank Wall Street Reform and Consumer
7 Protection Act (12 U.S.C. 5481);
8 (4) the term "manufacturer" means a person
9 who manufactures, compounds, converts, processes,
10 prepares, or packages marijuana or marijuana prod-
11 ucts;
12 (5) the term "marijuana-related legitimate busi-
13 ness" means a manufacturer, producer, or any per-
14 son that—
15 (A) participates in any business or orga-
16 nized activity that involves handling marijuana
17 or marijuana products, including selling, trans-
18 porting, displaying, dispensing, or distributing
19 marijuana or marijuana products; and
20 (B) engages in such activity pursuant to a
21 law established by a State or a unite of local
22 government;
23 (6) the term "marijuana" has the meaning
24 given the term "marihuana" in section 102 of the

1 Controlled Substances Act (21 U.S.C. 802), as
2 amended by this Act;
3 (7) the term "marijuana product" means any
4 article that contains marijuana, including an article
5 that is a concentrate, an edible, a tincture, a mari-
6 juana-infused product, or a topical;
7 (8) the term "producer" means a person who
8 plants, cultivates, harvests, or in any way facilitates
9 the natural growth of marijuana; and
10 (9) the term "State" means each of the several
11 States, the District of Columbia, Puerto Rico, and
12 any territory or possession of the United States.
13 (b) SAFE HARBOR FOR DEPOSITORY INSTITU-
14 TIONS.—A Federal banking regulator may not—
15 (1) terminate or limit the deposit insurance of
16 a depository institution under the Federal Deposit
17 Insurance Act (12 U.S.C. 1811 et seq.) or the Fed-
18 eral Credit Union Act (12 U.S.C. 1751 et seq.) sole-
19 ly because the depository institution provides or has
20 provided financial services to a marijuana-related le-
21 gitimate business;
22 (2) prohibit, penalize, or otherwise discourage a
23 depository institution from providing financial serv-
24 ices to a marijuana-related legitimate business;

1 (3) recommend, incentivize, or encourage a de-
2 pository institution not to offer financial services to
3 an individual, or to downgrade or cancel the finan-
4 cial services offered to an individual solely because—
5 (A) the individual is a manufacturer or
6 producer of marijuana;
7 (B) the individual is the owner or operator
8 of a marijuana-related legitimate business;
9 (C) the individual later becomes an owner
10 or operator of a marijuana-related legitimate
11 business; or
12 (D) the depository institution was not
13 aware that the individual is the owner or oper-
14 ator of a marijuana-related legitimate business;
15 or
16 (4) take any adverse or corrective supervisory
17 action on a loan to an owner or operator of—
18 (A) a marijuana-related legitimate business
19 solely because the owner or operator is a mari-
20 juana-related business; or
21 (B) real estate or equipment that is leased
22 to a marijuana-related legitimate business solely
23 because the owner or operator of the real estate
24 or equipment leased the real estate or equip-
25 ment to a marijuana-related business.

1 (c) PROTECTIONS UNDER FEDERAL LAW.—
2 (1) INVESTIGATION AND PROSECUTION.—A de-
3 pository institution that provides financial services
4 to a marijuana-related legitimate business, or the of-
5 ficers, directors, and employees of that business,
6 shall be immune from Federal criminal prosecution
7 or investigation for providing those services.
8 (2) FEDERAL CRIMINAL LAW.—A depository in-
9 stitution that provides financial services to a mari-
10 juana-related legitimate business shall not be subject
11 to a criminal penalty under any Federal law solely
12 for providing those services or for further investing
13 any income derived from such services.
14 (3) FORFEITURE.—A depository institution
15 that has a legal interest in the collateral for a loan
16 made to an owner or operator of a marijuana-related
17 legitimate business, or to an owner or operator of
18 real estate or equipment that is leased to a mari-
19 juana-related legitimate business, shall not be sub-
20 ject to criminal, civil, or administrative forfeiture of
21 that legal interest pursuant to any Federal law for
22 providing such loan.
23 (d) EXEMPTION FROM FILING SUSPICIOUS ACTIVITY
24 REPORTS.—Section 5318(g) of title 31, United States
25 Code, is amended by adding at the end the following:

1 "(5) REQUIREMENTS FOR MARIJUANA-RELATED
2 LEGITIMATE BUSINESSES.—If a financial institution
3 or any director, officer, employee, or agent of a fi-
4 nancial institution reports a suspicious transaction
5 pursuant to this subsection, and the reason for the
6 report relates to a marijuana-related business, the
7 Secretary shall require that such report complies
8 with the requirements of the guidance issued by the
9 Financial Crimes Enforcement Network titled 'BSA
10 Expectations Regarding Marijuana-Related Busi-
11 nesses' (FIN–2014–G001; published on February
12 14, 2014).".

13 (e) RULE OF CONSTRUCTION.—Nothing in this sec-
14 tion requires a depository institution to provide financial
15 services to a marijuana-related legitimate business.

16 **SEC. 7. RESEARCH.**

17 (a) IN GENERAL.—Not later than 180 days after the
18 date of enactment of this Act, the Secretary for Health
19 and Human Services shall terminate the Public Health
20 Service interdisciplinary review process described in the
21 guidance entitled "Guidance on Procedures for the Provi-
22 sion of Marijuana for Medical Research" (issued on May
23 21, 1999).

24 (b) LICENSES FOR MARIJUANA RESEARCH .—Not
25 later than 1 year after the date of enactment of this Act,

1 the Attorney General, acting through the Drug Enforce-
2 ment Administration, shall issue not less than 3 licenses
3 under section 303 of the Controlled Substances Act (21
4 U.S.C. 823) to manufacture marijuana and marijuana-de-
5 rivatives for research approved by the Food and Drug Ad-
6 ministration.

7 **SEC. 8. PROVISION BY DEPARTMENT OF VETERANS AF-**
8 **FAIRS HEALTH CARE PROVIDERS OF REC-**
9 **OMMENDATIONS AND OPINIONS REGARDING**
10 **VETERAN PARTICIPATION IN STATE MARI-**
11 **JUANA PROGRAMS.**

12 Notwithstanding any other provision of law, the Sec-
13 retary of Veterans Affairs shall authorize physicians and
14 other health care providers employed by the Department
15 of Veterans Affairs to—

16 (1) provide recommendations and opinions to
17 veterans who are residents of States with State
18 marijuana programs regarding the participation of
19 veterans in such State marijuana programs; and

20 (2) complete forms reflecting such recommenda-
21 tions and opinions.

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10

Rohrabacher-Farr Amendment

This amendment is found in: Commerce, Justice, Science, and Related Agencies Appropriations Act, FY 2016.

SEC 542. None of the funds made available in this Act to the Department of Justice may be used, with respect to the States of Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampsjire, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming, or with respect to the District of Columbia, Guan, or Puerto Rico, to prevent any of them from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana.

11

2015 WL 6123062
Only the Westlaw citation is currently available.
United States District Court,
N.D. California.

United States of America, Plaintiff,
v.
Marin Alliance for Medical Marijuana,
and Lynette Shaw, Defendants.

No. C 98-00086 CRB | Signed 10/19/2015

Synopsis
Background: Medical marijuana dispensary brought action, seeking to dissolve a permanent injunction prohibiting it from dispensing marijuana.

[Holding:] The District Court, Charles R. Breyer, J., held that Department of Justice was precluded from enforcing permanent injunction prohibiting medical marijuana dispensary from distributing marijuana to extent dispensary complied with California law.

Motion denied.

West Headnotes (6)

[1] **Injunction**
Injunctions to enforce laws and regulations in general
When a court of equity exercises its discretion in determining whether an injunction should be means of enforcing a statute, it may not consider the advantages and disadvantages of nonenforcement of the statute, but only the advantages and disadvantages of employing the extraordinary remedy of injunction over the other available methods of enforcement.

Cases that cite this headnote

[2] **Injunction**
Injunctions to enforce laws and regulations in general
In determining whether an injunction should be the means of enforcing a statute instead of another permissible means of enforcement, to the extent a district court considers the public interest and the conveniences of the parties, the court is limited to evaluating how such interest and conveniences are affected by the selection of an injunction over other enforcement mechanisms.

Cases that cite this headnote

[3] **Injunction**
Grounds in general; multiple factors
At the initial stage, a plaintiff seeking a permanent injunction must satisfy a four-factor test before a court may grant such relief, by demonstrating: (1) that it has suffered an irreparable injury; (2) that remedies available at law, such as monetary damages, are inadequate to compensate for that injury; (3) that, considering the balance of hardships between the plaintiff and defendant, a remedy in equity is warranted; and (4) that the public interest would not be disserved by a permanent injunction.

Cases that cite this headnote

[4] **Injunction**
Specificity, vagueness, overbreadth, and narrowly-tailored relief
Injunction
Scope and duration of relief
Injunctive relief must be tailored to remedy the specific harm alleged, and an overbroad preliminary injunction is an abuse of discretion.

Cases that cite this headnote

[5] **Injunction**
Grounds in general
Injunction
Grounds or cause in general
Injunction
Evidence and affidavits

Typically, a party seeking modification or dissolution of an injunction bears the burden of establishing that a significant change in facts or law warrants revision or dissolution of the injunction; that requirement presumes that the moving party could have appealed the grant of the injunction but chose not to do so, and thus that a subsequent challenge to the injunctive relief must rest on grounds that could not have been raised before.

Cases that cite this headnote

[6] **Injunction**
Hospitals, pharmacies, and health care professionals

Provision of Appropriations Act prohibiting Department of Justice (DOJ) from using funds to prevent states from implementing their own state laws that authorize the use, distribution, possession, or cultivation of medical marijuana precluded Department of Justice (DOJ) from enforcing permanent inunction, prohibiting medical marijuana dispensary from distributing marijuana, to the extent that the dispensary complied with California law exempting from state criminal prosecution physicians, patients, and primary caregivers who possess or cultivate marijuana for medicinal purpose with a physician's recommendation. Pub. L. 114-53, § 103, 129 Stat. 502 (2015); West's Ann.Cal.Health & Safety Code § 11362.5.

Cases that cite this headnote

Attorneys and Law Firms

Kathryn L. Wyer, Washington, DC, for Plaintiff

Greg Anton, Lagunitas, CA, for Defendant

ORDER RE MOTION TO DISSOLVE PERMANENT INJUNCTION

CHARLES R. BREYER, UNITED STATES DISTRICT JUDGE

*1 The Marin Alliance for Medical Marijuana ("MAMM") asks this Court to dissolve a permanent injunction that this Court entered against it in 2002. See Mot. Dissolve Perm. Inj. (dkt. 262). Having reviewed the filings and accompanying papers, the Court DENIES the motion to dissolve the injunction. However, the enforcement of said injunction must be consistent with the new directive of Congress in Section 538 of the Consolidated and Further Continuing Appropriations Act of 2015, Pub. L. 113 235, 128 Stat. 2130 (2014) ("2015 Appropriations Act"),[1] which prohibits the Department of Justice from expending any funds in connection with the enforcement of any law that interferes with California's ability to "implement [its] own State law[ ] that authorize[s] the use, distribution, possession, or cultivation of medical marijuana." See 2015 Appropriations Act § 538. As long as Congress precludes the Department of Justice from expending funds in this manner, the permanent injunction will only be enforced against MAMM insofar as that organization is in violation of California "State laws that authorize the use, distribution, possession, or cultivation of medical marijuana." See id.; Fed. R. Civ. P. 60(b).

I. BACKGROUND

As a matter of federal law, marijuana is prohibited as a Schedule I drug under the Controlled Substances Act ("CSA"). 21 U.S.C. § 812(c). But under state law, California's Compassionate Use Act of 1996 exempted from state criminal prosecution physicians, patients, and primary caregivers who possess or cultivate marijuana for medicinal purpose with a physician's recommendation. See Cal. Health and Safety Code Ann. §§ 11362.5 ("Compassionate Use Act"). The Compassionate Use Act was passed in a state-wide November 1996 referendum with the support of 56% of voters. United States v. Cannabis Cultivators Club, 5 F.Supp.2d 1086, 1091 (N.D.Cal.1998) (dkt. 61).

This Court has a lengthy history with this defendant on these issues. In 1998, the Government filed an action seeking declaratory and injunctive relief against MAMM (and five other medical marijuana dispensaries, all of which were deemed related and reassigned to this Court) on the grounds that it was engaged in the distribution of marijuana in violation of the CSA. See 21 U.S.C. §§ 801 et seq. At that time, the City and County of San Francisco and other cities in which the related defendants are located, acting as amici curiae, "urge[d] the Court not to adopt the injunctive relief sought by the federal government because of the adverse consequences an injunction would have on the public health

of their citizens." Cannabis Cultivators Club, 5 F.Supp.2d at 1094. But this Court determined that the preliminary injunction "must be granted" on the grounds of there being "a strong likelihood that defendants' conduct violates the Controlled Substances Act, [and thus] the Supremacy Clause of the United States Constitution requires that the Court enjoin further violations of the Act." Cannabis Cultivators Club, 5 F.Supp.2d at 1091, 1105.

*2 [1] [2] Thereafter, defendants openly violated this Court's preliminary injunction, which prompted the Government to initiate contempt proceedings. In the litigation that ensued, defendants sought to modify the preliminary injunction to exclude distributions of marijuana that were medically necessary, which this Court denied on October 16, 1998. See Order (dkt. 174). The Ninth Circuit reversed this Court in an interlocutory appeal of that decision, United States v. Oakland Cannabis Buyers' Co-Op ("OCBC"), 190 F.3d 1109, 1115 (9th Cir.1999), and in turn were reversed by the Supreme Court, United States v. OCBC, 532 U.S. 483, 121 S.Ct. 1711, 149 L.Ed.2d 722 (2001). There, the Supreme Court held that there is no medical necessity exception to the CSA's prohibition on the manufacture and distribution of marijuana. OCBC, 532 U.S. at 486, 121 S.Ct. 1711. In so doing, the Supreme Court explained that even when a district court is exercising its equity jurisdiction in the course of fashioning an injunction, its usual discretion to "consider the necessities of the public interest" was "displaced" by the "judgment of Congress, deliberately expressed in legislation." Id. at 496–98, 121 S.Ct. 1711. As applied here, then, the district court may weigh whether an injunction should be the means of enforcing the statute instead of another permissible means of enforcement —"not whether enforcement is preferable to no enforcement at all." Id. at 497–98, 121 S.Ct. 1711. "Consequently, when a court of equity exercises its discretion, it may not consider the advantages and disadvantages of nonenforcement of the statute, but only the advantages and disadvantages of 'employing the extraordinary remedy of injunction' over the other available methods of enforcement." Id. at 498, 121 S.Ct. 1711 (quoting Weinberger v. Romero-Barcelo, 456 U.S. 305, 312, 102 S.Ct. 1798, 72 L.Ed.2d 91 (1982)). "To the extent the district court considers the public interest and the conveniences of the parties, the court is limited to evaluating how such interest and conveniences are affected by the selection of an injunction over other enforcement mechanisms." Id.

Following the Supreme Court's ruling, the OCBC defendants moved to dissolve their preliminary injunctions in this Court and the Government moved for summary judgment and for a permanent injunction. See Mem. and Order May 3, 2002 (dkt. 229). This Court granted the Government's motion for summary judgment and, after the defendants declined to reassure this Court that they would not resume their distribution activity, entered a permanent injunction on June 10, 2002. See United States v. Cannabis Cultivator's Club, No. 98–85 et al., 2002 WL 1310460 (June 10, 2002); Mem. and Order June 20, 2002 (dkt. 247); Permanent Injunction (dkt. 248).

For the next near-decade, defendant MAMM continued to operate a medical marijuana dispensary out of its same location. The United States Attorney's Office waited until September 2011 to send cease and desist letters to MAMM and other medical marijuana dispensaries in the area. The Mayor of the Town of Fairfax responded with a series of letters to United States Attorney Melinda Haag stating that MAMM was operating as a model business in careful compliance with its local Use Permit in a "cooperative and collaborative relationship" with the community. See Bragman Letter October 2011, Anton Aff. in Support of Defendant's Mot. to Dissolve Perm. Injunction (dkt. 262-3) at Ex. 2. The Mayor explained that Marin has "the highest documented rate of breast cancer in the United States," and Marin's breast cancer patients have especially benefitted from MAMM. Id. He asserted that "elimination of this vital community access facility would effectively prevent [patients] from obtaining medical marijuana," with the "paradoxical impact of increasing public safety concerns for local law enforcement" if the market were pushed underground. Id. According to the letter, the "record clearly establishes that [MAMM] has been in clear and unambiguous compliance with existing state and local laws providing for the medical use of marijuana." Id. To avoid "needlessly increas[ing] the suffering of hundreds of patients who have come to rely on [MAMM] as a safe access point for medical marijuana," he urged Haag "to exercise [her] discretion to reconsider [her] office's evaluation of the legal viability of [MAMM] in light of its documented record of lawful operation and benefit to the community." Id. [2]

*3 The U.S. Attorney's Office nevertheless pressed its forfeiture action. In response, MAMM and three other dispensaries filed suit seeking to enjoin the Government from taking any enforcement action against them. See Am. Compl. (dkt. 21), Marin Alliance For Med. Marijuana v. Holder, 866

F.Supp.2d 1142 (N.D.Cal.2011) (No. 11–5349 SBA). The court denied the Plaintiffs' motion for a temporary restraining order, denied their motion for a preliminary injunction, and granted the Government's motion to dismiss. See Marin Alliance, 866 F.Supp.2d 1142 (N.D.Cal.2011); Marin Alliance, No. 11–5349, 2012 WL 2862608 (N.D.Cal.July 11, 2012).

Seven days after the initial complaint in that litigation was filed, the Government initiated a forfeiture action against the property on which MAMM operated. See Compl., United States v. Real Property Located at 6 School Street, Fairfax, California, No. 11–cv–5596 (filed Nov. 18, 2011). The forfeiture complaint cited this Court's permanent injunction and MAMM's violation of the CSA given that it was operating a medical marijuana dispensary. See id. The litigation was resolved in a settlement with the property owner, who agreed no longer to rent the property to MAMM in exchange for the Government's agreement not to seize the property. See Stipulation and Order ¶ 4 (dkt. 18), No. 11–5596.

Then the legal and factual circumstances changed. Section 538 of the 2015 Appropriations Act—which governed Treasury Funds for the fiscal year ending September 30, 2015, and which has now been extended until December 11, 2015, by the 2016 Appropriations Act, Pub. L. 114–53, § 103, 129 Stat. 502 (2015)—states as follows:

> None of the funds made available in this Act to the Department of Justice may be used, with respect to the States of...California [and 32 other states], to prevent such States from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana.

2015 Appropriations Act § 538. MAMM argues that the injunction is now unenforceable under Section 538 and should therefore be dissolved.

II. LEGAL STANDARD

[3] [4] Federal Rule of Civil Procedure 60 provides for relief from a judgment or order under the following circumstances, as relevant here:

(b) Grounds for Relief from a Final Judgment, Order, or Proceeding. On motion and just terms, the court may relieve a party or its legal representative from a final judgment, order, or proceeding for the following reasons:

...

(5) the judgment has been satisfied, released or discharged; it is based on an earlier judgment that has been reversed or vacated; or applying it prospectively is no longer equitable; or

(6) any other reason that justifies relief.

[5] Fed. R. Civ. P. 60(b). Relief under Rule 60(b) is counterbalanced against "the strong public interest in the timeliness and finality of judgments." See Phelps v. Alameida, 569 F.3d 1120, 1135 (9th Cir.2009). Typically, "[a] party seeking modification or dissolution of an injunction bears the burden of establishing that a significant change in facts or law warrants revision or dissolution of the injunction." Alto v. Black, 738 F.3d 1111, 1120 (9th Cir.2013) (quoting Sharp v. Weston, 233 F.3d 1166, 1170 (9th Cir.2000)). "That requirement presumes that the moving party could have appealed the grant of the injunction but chose not to do so, and thus that a subsequent challenge to the injunctive relief must rest on grounds that could not have been raised before." Id. (citing Transgo, Inc. v. Ajac Transmission Parts Corp., 911 F.2d 363, 365 (9th Cir.1990)). In order to meet their burden under Rule 60(b), MAMM would have to establish that Section 538 represents a significant change in the law that "renders continued enforcement [of the injunction] detrimental to the public interest." Horne v. Flores, 557 U.S. 433, 447, 129 S.Ct. 2579, 174 L.Ed.2d 406 (2009) (as cited and characterized by the Government's supplemental brief (dkt. 272) at 12).[3]

III. DISCUSSION

*4 [6] The plain reading of the text of Section 538 forbids the Department of Justice from enforcing this injunction against MAMM to the extent that MAMM operates in compliance with California law. Although the parties argued at length whether equitable concerns—namely the harmful effects engendered by MAMM's closure and the demonstrable lack of harm that resulted from the 14 years in which it operated—support the dissolution or modification of the injunction, these arguments can be dismissed out of hand. MAMM's approach stems from Rule 60(b)(5)'s provision that the court may grant relief from a final judgment when "applying it prospectively is no longer equitable." See Fed. R. Civ. P. 60(b)(5). But this Court continues to be bound by

OCBC's prohibition on conducting public policy balancing in determining whether to enjoin behavior that violates the CSA. See OCBC, 532 U.S. at 496–98, 121 S.Ct. 1711. "To the extent the district court considers the public interest and the conveniences of the parties, the court is limited to evaluating how such interest and conveniences are affected by the selection of an injunction over other enforcement mechanisms." Id. at 498, 121 S.Ct. 1711.

In other words, this Court is not in a position to "override Congress' policy choice, articulated in a statute, as to what behavior should be prohibited." See id. at 497, 121 S.Ct. 1711. On the contrary: This Court's only task is to interpret and apply Congress's policy choices, as articulated in its legislation. And in this instance, Congress dictated in Section 538 that it intended to prohibit the Department of Justice from expending any funds in connection with the enforcement of any law that interferes with California's ability to "implement [its] own State law[ ] that authorize[s] the use, distribution, possession, or cultivation of medical marijuana." 2015 Appropriations Act § 538. The CSA remains in place, and this Court intends to enforce it to the full extent that Congress has allowed in Section 538, that is, with regard to any medical marijuana not in full compliance with "State law [ ] that authorize[s] the use, distribution, possession, or cultivation of medical marijuana." Id.

The Government's contrary reading so tortures the plain meaning of the statute that it must be quoted to ensure credible articulation. Specifically, the Government contends that Section 538 proscribes

> "the use of appropriated funds to 'prevent' states from 'implementing their own' medical marijuana laws. Such prohibited uses could include, for example, federal actions that interfered with a state's promulgation of regulations implementing its statutory provisions, or with its establishment of a state licensing scheme. However, such uses do not include CSA enforcement actions against individuals or private businesses because such actions do not prevent a State from implementing its own laws....[T]here is no evidence in the record that California has been impeded in any way in implementing its own State laws during the thirteen years the permanent injunction at issue has been in effect."

Gov't Supp. Brief (dkt. 272) at 6 & n.2. Where to start? An initial matter, perhaps, is the contradiction inherent in the Government's assertion that enjoining any one medical marijuana dispensary—here, MAMM—does not impede California's implementation of its medical marijuana laws. The Government appears to mean that, in the grand scheme of things, shutting down any given dispensary may be presumed to have such a minimal effect on California's medical marijuana regime that it does not "prevent" California from "implementing" its State law. But if anything, the Government's reliance on the operation of other medical marijuana dispensaries to justify enjoining this dispensary is an a fortiori reason why the injunction is inappropriate in its present form.

Moreover, this drop-in-the-bucket argument is at odds with fundamental notions of the rule of law. It has never been a legal principle than an otherwise impermissible government intrusion can be countenanced because any one defendant is a small piece of the legal landscape. Section 538 either allows the DOJ to shut down medical marijuana dispensaries for violating the CSA, or it does not. It contains no limitation that requires a State to implement its medical marijuana laws in one way or not another—via a centralized state dispensary, for example, or through highly regulated local private dispensaries—before Section 538's prohibition is triggered. Rather, Section 538 takes as a given that States implement their medical marijuana laws in the ways they see fit. California has chosen its way: allowing private dispensaries to operate under strict state and local regulation. California's Compassionate Use Act states that its purpose is "[t]o ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician..." Cal. Health & Safety Code § 11362.5(A). In the years following the passage of the Compassionate Use Act, the California Legislature enacted extensive legislation implementing and regulating the medical marijuana regime. The legislature established a detailed process through which patients receive permits from county health departments. See Cal. Health & Safety Code Ann. §§ 11362.7–11362.83 (West 2015). California law specifies that medical marijuana dispensaries must be located outside a 600-foot radius of any school and empowers local authorities to adopt additional restrictions. See id. at § 11362.768. It also requires the State Attorney General to "develop and adopt appropriate guidelines to

ensure the security and nondiversion of marijuana grown for medical use" by qualified patients. Id. at § 11362.81. These extensive Guidelines explain a detailed regime in which qualified, licensed patients may obtain medical marijuana from private dispensaries operating as nonprofit collectives or cooperatives under extensive licensing requirements for business incorporation, record keeping, taxation, verification, security, and the like. See Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use at Part IV (2008), http://ag.ca.gov/cms_attachments/press/pdfs/n1601_medicalmarijuanaguidelines.pdf. The Town of Fairfax, operating under its authority in Cal. Health & Safety Code § 11362.768, added its own extensive local permitting requirements, which mandate that a medical marijuana dispensary comply with 72 conditions regulating every conceivable aspect of the time, place, and manner of the dispensary's operation. See Amended Conditions of Approval for the Marin Alliance Medicinal Marijuana Dispensary Use Permit Number 97-UP-2, Approved on August 15, 2002, MAMM Supplemental Brief (dkt. 271) at Ex. 11.

*5 In sum, this intricate legal framework "implements" California's medical marijuana laws by allowing licensed patients to obtain medical marijuana from highly regulated non-profit cooperative dispensaries. Against this backdrop, Section 538 states that "None of the funds made available in this Act to the Department of Justice may be used, with respect to the States of...California [and 32 other states], to prevent such States from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana." 2015 Appropriations Act § 538. To "implement," of course, means to "carry out, accomplish, to give practical effect to and ensure of actual fulfillment by concrete measures." Merriam-Webster Dictionary (2015). It defies language and logic for the Government to argue that it does not "prevent" California from "implementing" its medical marijuana laws by shutting down these same heavily-regulated medical marijuana dispensaries; whether it shuts down one, some, or all, the difference is of degree, not of kind. And, contrary to the Government's representation, the record here does support a finding that Californians' access to legal medical marijuana has been substantively impeded by the closing of dispensaries, and the closing of MAMM in particular. See Bragman Letter December 2014, Anton Aff. in Support of Defendant's Mot. to Dissolve Perm. Injunction (dkt. 262-3) at Ex. 3 ("Since the departure of the Marin Alliance, the County of Marin, with a population of over 250,000, has not had a legal medical cannabis dispensary to serve the local patient population. Marin County has exceptionally high rates of breast and prostate cancer. Those patient groups both benefit from proven medical benefits of cannabis but now are unable to have safe access in their local community.").

Given that the statutory language of Section 538 is plain on its face, the Court "must enforce it according to its terms," see King v. Burwell, — U.S. — —, 135 S.Ct. 2480, 2489, 192 L.Ed.2d 483 (2015), and need not consider the legislative history. But it comes as no surprise to the Court that the legislative history of Section 538 points in only one direction: away from the counterintuitive and opportunistic meaning that the DOJ seeks to ascribe to it now. Without exception, it appears that both the supporters and opponents of Section 538 in Congress at least agreed that the words mean what they appear to mean. See, e.g., 60 Cong. Rec. 82, H4914, H4984 (daily ed. May 29, 2014) (statement of Cosponsor Rep. Dina Titus) ("[T]his commonsense amendment simply ensures that patients do not have to live in fear when following the laws of their States and the recommendations of their doctors. Physicians in those States will not be prosecuted for prescribing the substance, and local businesses will not be shut down for dispensing the same.") (emphasis added); 160 Cong. Rec. 82, H4914, H4984 (daily ed. May 29, 2014) (statement of Rep. Alcee Hastings) ("Specifically, the bill is a bipartisan appropriations measure that looks to prohibit the DEA from spending funds to arrest state-licensed medical marijuana patients and providers. Many of my colleagues and their constituencies agree that patients who are allowed to purchase and consume medical marijuana in their respective states should not be punished by the federal government.") (emphasis added); 160 Cong. Rec. 82, H4914, H4984 (daily ed. May 29, 2014) (statement of Lead Sponsor Rep. Sam Farr) ("This is essentially saying, look, if you are following State law, you are a legal resident doing your business under State law, the Feds just can't come in and bust you."); 160 Cong. Rec. 70, H4020, H4053–55 (daily ed. May 9, 2014) (statement of Lead Sponsor Dana Rohrabacher) ("The harassment from the [DEA] is something that should not be tolerated in the land of the free. Businesspeople who are licensed and certified to provide doctor recommended medicine within their own States have seen their businesses locked down, their assets seized, their customers driven away, and their financial lives ruined by very, very aggressive and energetic Federal law enforcers enforcing a law...Instead of continuing to finance this repressive and expensive approach, we should be willing to allow patients and small businesses to follow their doctors' advice under the watchful eye of State law enforcement and regulators...") (emphasis added); 160

Cong. Rec. 82, H4914, H4983–84 (daily ed. May 29, 2014) (statement of Rep. John Fleming in opposition) ("What this amendment would do is, it wouldn't change the law, it would just make it difficult, if not impossible, for the DEA and [DOJ] to enforce the law.").

In fact, the members of Congress who drafted Section 538 had the opportunity to respond to the very same argument that the DOJ advances here. In a letter to Attorney General Eric Holder on April 8, 2015, Congressmen Dana Rohrabacher and Sam Farr responded as follows to "recent statements indicating that the [DOJ] does not believe a spending restriction designed to protect [the medical marijuana laws of 35 states] applies to specific ongoing cases against individuals and businesses engaged in medical marijuana activity":

> *6 As the authors of the provision in question, we write to inform you that this interpretation of our amendment is emphatically wrong. Rest assured, the purpose of our amendment was to prevent the Department from wasting its limited law enforcement resources on prosecutions and asset forfeiture actions against medical marijuana patients and providers, including businesses that operate legally under state law. In fact, a close look at the Congressional Record of the floor debate of the amendment clearly illustrates the intent of those who sponsored and supported this measure. Even those who argued against the amendment agreed with the proponents' interpretation of their amendment.

Letter to Attorney General Holder, Anton Aff. in Support of Defendant's Mot. to Dissolve Perm. Injunction (dkt. 262-3) at Ex. 7. Having no substantive response or evidence, the Government simply asserts that it "need not delve into the legislative history here" because the meaning of the statute is clearly in its favor. The Court disagrees.

To the extent the Government cites a few cases addressing Section 538, none are analogous or even particularly favorable to the Government's position. In each one of the cases that the Government cites, the individual or organization at issue was not operating in compliance with State law—in which case this Court agrees that Section 538 does not apply by its own terms. See, e.g., United States v. Tote, No. 1:14–mj–212, 2015 WL 3732010 (E.D.Cal. June 12, 2015) (rejecting a criminal defendant's argument that his criminal prosecution for driving under the influence of marijuana on federal land should be dismissed under Section 538 because Section 538 did not repeal federal laws criminalizing the possession of marijuana and "Defendant was using marijuana in a manner that violates California law"); United States v. Firestack–Harvey, No. 13–cr–24, 2015 WL 3533222 (E.D.Wash. June 4, 2015) (rejecting the applicability of Section 538 to a criminal prosecution of three individuals because the conduct at issue involved operating a for-profit marijuana business that was not authorized by Washington state law); United States v. Silkeutsabay, No. 13–cr–140, 2015 WL 2376170 (E.D.Wash. May 18, 2015) (concluding that Section 538 was "inapplicable to prosecution of Defendants' case where over 1000 marijuana plants were seized—a number far in excess of that authorized under Washington's medical marijuana law"). A single Ninth Circuit case held that a prohibition on the deduction of expenses in connection with illegal drug trafficking applied to bar a medical marijuana dispensary from deducting its business expenses to eliminate a tax deficiency. See Olive v. Commissioner of Internal Revenue, 792 F.3d 1146 (9th Cir.2015). In that separate context, the Ninth Circuit explained that "Section 538 does not apply" because the government was "enforcing only a tax, which does not prevent people from using, distributing, possessing, or cultivating marijuana in California. Enforcing these laws might make it more costly to run a dispensary, but it does not change whether these activities are authorized in the state." See id. at 1150.

IV. CONCLUSION

For the foregoing reasons, as long as Congress precludes the Department of Justice from expending funds in the manner proscribed by Section 538, the permanent injunction will only be enforced against MAMM insofar as that organization is in violation of California "State laws that authorize the use, distribution, possession, or cultivation of medical marijuana."[4] See 2015 Appropriations Act § 538; Fed. R. Civ. P. 60(b).

***7 IT IS SO ORDERED.**

All Citations

--- F.Supp.3d ----, 2015 WL 6123062

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Footnotes

1 Congress extended the force of Section 538 by passing the Continuing Appropriations Act of 2016 ("2016 Appropriations Act"), Pub. L. 114–53, § 103, 129 Stat. 502 (2015).

2 A follow-up letter from the Mayor in December 2014 stated his belief that "changed circumstances justify reconsideration of the District Court's injunction," particularly the struggles of Marin patients who were left without a legal medical cannabis dispensary, the loss of tax revenues to the town, the uptick of drug-related arrests, and the change in the social and legal perception of medical marijuana. See Bragman Letter Dec. 2014, Anton Aff. in Support of Defendant's Mot. to Dissolve Perm. Injunction (dkt. 262-3) at Ex. 3.

3 At the initial stage, " 'a plaintiff seeking a permanent injunction must satisfy a four-factor test before a court may grant such relief. A plaintiff must demonstrate: (1) that it has suffered an irreparable injury; (2) that remedies available at law, such as monetary damages, are inadequate to compensate for that injury; (3) that, considering the balance of hardships between the plaintiff and defendant, a remedy in equity is warranted; and (4) that the public interest would not be disserved by a permanent injunction.' " Monsanto Co. v. Geertson Seed Farms, 561 U.S. 139, 156–57, 130 S.Ct. 2743, 177 L.Ed.2d 461 (2010) (quoting eBay Inc. v. MercExchange, L.L.C., 547 U.S. 388, 391, 126 S.Ct. 1837, 164 L.Ed.2d 641 (2006)). "An injunction should issue only if the traditional four-factor test is satisfied." Id. at 157, 130 S.Ct. 2743 (citing Winter v. Natural Resources Defense Council, Inc., 555 U.S. 7, 129 S.Ct. 365, 380–82, 172 L.Ed.2d 249 (2008)). "It is not enough for a court considering a request for injunctive relief to ask whether there is a good reason why an injunction should not issue; rather, a court must determine that an injunction should issue under the traditional four-factor test set out above." Id. at. 158, 130 S.Ct. 2743.

Even if a Plaintiff survives this inquiry, "[i]njunctive relief must be tailored to remedy the specific harm alleged, and an overbroad preliminary injunction is an abuse of discretion." Natural Resources Defense Coun cil, Inc. v. Winter, 508 F.3d 885, 886 (9th Cir.2007) (later litigation reversed on other grounds by Winter, 555 U.S. at 12, 129 S.Ct. 365).

4 To the Court's recollection, the Government has yet to allege or even suggest that MAMM was at any time operating in violation of state law. The only evidence in the record on this point is to the contrary: a letter from the Mayor of Fairfax to United States Attorney Melinda Haag states that "Based upon its satisfaction of the scores of conditions in the Use Permit issued by the Town of Fairfax, the record clearly establishes that the Marin Alliance has been in clear and unambiguous compliance with existing state and local laws providing for the medical use of marijuana." See Bragman Letter October 2011, Anton Aff. in Support of Defendant's Mot. to Dissolve Perm. Injunction (dkt. 262-3) at Ex. 2; see also Bragman Letter December 2014, id. at Ex. 3 (same). Rather, the Government has taken the position that the injunction is justified solely because MAMM operates in contravention of the CSA. Whether MAMM in fact operates in compliance with California state law is not before the Court at this time.

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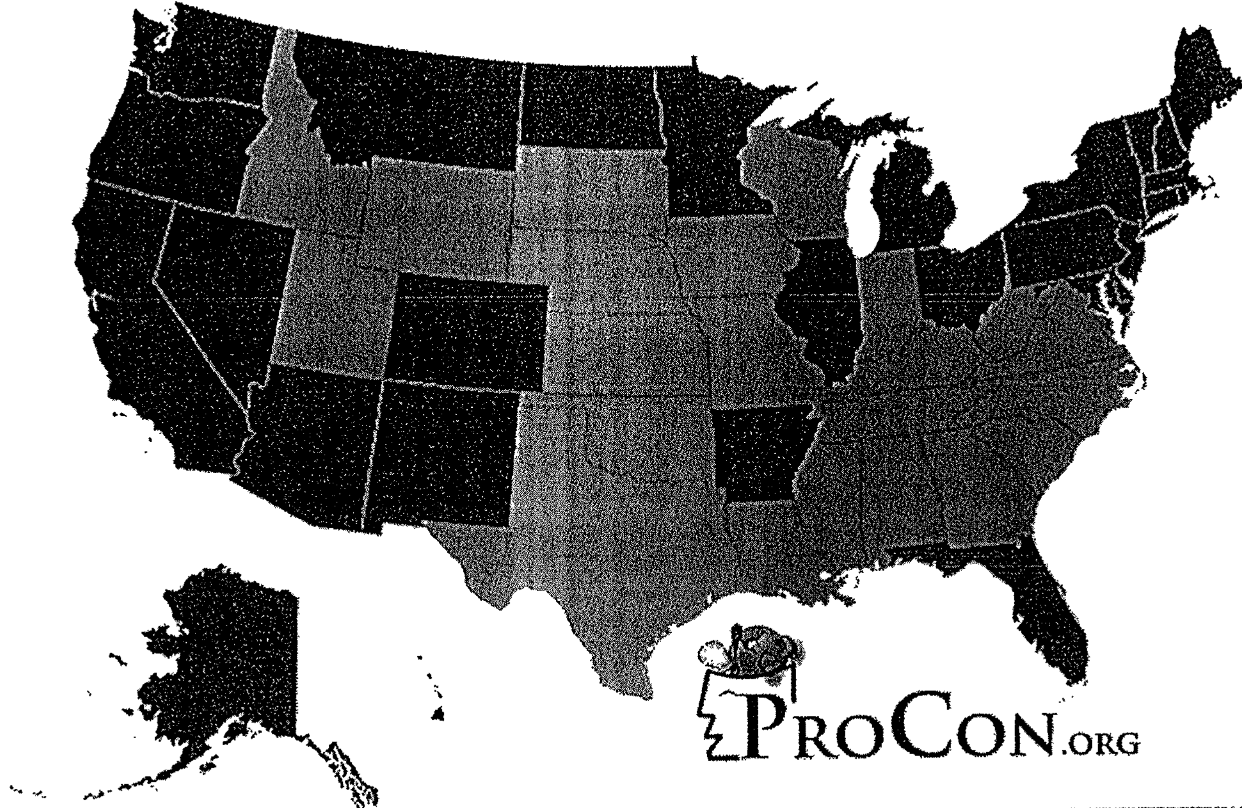
28 Legal Medical Marijuana States and DC

Laws, Fees, and Possession Limits



State	Year Passed / How Passed (Yes Vote) / Possession Limit
Marijuana State Laws – Summary Chart from ProCon.org	
1. Alaska	1998 Ballot Measure 8 (58%) 1 oz usable; 6 plants (3 mature, 3 immature)
2. Arizona	2010 Proposition 203 (50.13%) 2.5 oz usable; 12 plants
3. Arkansas	2016 Ballot Measure Issue 6 (53.2%) 3 oz usable per 14-day period
4. California	1996 Proposition 215 (56%) 8 oz usable; 6 mature or 12 immature plants

State	Details
5. Colorado	2000 Ballot Amendment 20 (54%) 2 oz usable; 6 plants (3 mature, 3 immature)
6. Connecticut	2012 House Bill 5389 (96-51 H, 21-13 S) 2.5 oz usable
7. Delaware	2011 Senate Bill 17 (27-14 H, 17-4 S) 6 oz usable
8. Florida	2016 Ballot Amendment 2 (71.3%) Amount to be determined
9. Hawaii	2000 Senate Bill 862 (32-18 H; 13-12 S) 4 oz usable; 7 plants
10. Illinois	2013 House Bill 1 (61-57 H; 35-21 S) 2.5 ounces of usable cannabis during a period of 14 days
11. Maine	1999 Ballot Question 2 (61%) 2.5 oz usable; 6 plants
12. Maryland	2014 House Bill 881 (125-11 H; 44-2 S) 30-day supply, amount to be determined
13. Massachusetts	2012 Ballot Question 3 (63%) 60-day supply for personal medical use (10 oz)
14. Michigan	2008 Proposal 1 (63%) 2.5 oz usable; 12 plants
15. Minnesota	2014 Senate Bill 2470 (46-16 S; 89-40 H) 30-day supply of non-smokable marijuana
16. Montana	2004 Initiative 148 (62%) 1 oz usable; 4 plants (mature); 12 seedlings
17. Nevada	2000 Ballot Question 9 (65%) 2.5 oz usable; 12 plants
18. New Hampshire	2013 House Bill 573 (284-66 H; 18-6 S) Two ounces of usable cannabis during a 10-day period
19. New Jersey	2010 Senate Bill 119 (48-14 H; 25-13 S) 2 oz usable
20. New Mexico	2007 Senate Bill 523 (36-31 H; 32-3 S) 6 oz usable; 16 plants (4 mature, 12 immature)
21. New York	2014 Assembly Bill 6357 (117-13 A; 49-10 S) 30-day supply non-smokable marijuana

22. North Dakota	2016 Ballot Measure 5 (63.7%) 3 oz per 14-day period
23. Ohio	2016 House Bill 523 (71-26 H; 18-15 S) Maximum of a 90-day supply, amount to be determined
24. Oregon	1998 Ballot Measure 67 (55%) 24 oz usable; 24 plants (6 mature, 18 immature)
25. Pennsylvania	2016 Senate Bill 3 (149-46 H; 42-7 S) 30-day supply
26. Rhode Island	2006 Senate Bill 0710 (52-10 H; 33-1 S) 2.5 oz usable; 12 plants
27. Vermont	2004 Senate Bill 76 (22-7) HB 645 (82-59) 2 oz usable; 9 plants (2 mature, 7 immature)
28. Washington	1998 Initiative 692 (59%) 8 oz usable; 6 plants
Washington, DC	2010 Amendment Act B18-622 (13-0 vote) 2 oz dried; limits on other forms to be determined
Marijuana State Laws – Summary Chart from ProCon.org	

We encourage people to link to this regularly updated page. However, reprinting this content, in part or in full, is not allowed without prior written permission from ProCon.org. Please see our reprinting policy for details. For a list of sources used to compile this information, please see our sources page. Why are some states not on this list? Our list includes states that have legalized use of the marijuana plant for medical purposes. States that limit use to the nonpsychoactive marijuana extract called cannabidiol (CBD) are not included on this list, although we do keep track of those legal CBD states in our resource States with Laws Specifically about Legal Cannabidiol (CBD). Also not included are states whose legalization laws require physicians to "prescribe" marijuana (an illegal act under federal law) vs. "recommend" marijuana (considered protected free speech between doctor and patient), as well as states that have passed "affirmative defense" laws in which arrested marijuana users are allowed to mention medical use in their defense.

Notes (click to expand)

1. Residency Requirement
2. Home Cultivation
3. Patient Registration: Mandatory vs. Voluntary
4. Louisiana's Medical Marijuana Legislation

5. United States Attorneys' Letters to Legal States, 2011-2013

6. Symbolic Medical Marijuana Laws, 1979-1991 and 2015

1. Alaska

State and Relevant Medical Marijuana Laws

Ballot Measure 8 – Approved Nov. 3, 1998 by 58% of voters
Effective: Mar. 4, 1999
Removed state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physician advising that they "might benefit from the medical use of marijuana."
Approved Conditions:
Cachexia, cancer, chronic pain, epilepsy and other disorders characterized by seizures, glaucoma, HIV or AIDS, multiple sclerosis and other disorders characterized by muscle spasticity, and nausea. Other conditions are subject to approval by the Alaska Department of Health and Social Services.
Possession/Cultivation:
Patients (or their primary caregivers) may legally possess no more than one ounce of usable marijuana, and may cultivate no more than six marijuana plants, of which no more than three may be mature. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients.
Amended:
Senate Bill 94
Effective: June 2, 1999
Mandates all patients seeking legal protection under this act to enroll in the state patient registry and possess a valid identification card. Patients not enrolled in the registry will no longer be able to argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges.
Update:
Alaska Statute Title 17 Chapter 37
Creates a confidential statewide registry of medical marijuana patients and caregivers and establishes identification card.

Contact and Program Details

Alaska Bureau of Vital Statistics
Marijuana Registry
P.O. Box 110699
Juneau, AK 99811-0699
Phone: 907-465-5423
BVSSpecialServices@health.state.ak.us
Website:
AK Marijuana Registry Online
Information provided by the state on sources for medical marijuana:
No information is provided
Patient Registry Fee:

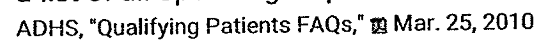
$25 new application/$20 renewal
Accepts other states' registry ID cards?
No
Registration:
Mandatory

2. Arizona

State and Relevant Medical Marijuana Laws
Ballot Proposition 203 "Arizona Medical Marijuana Act" -- Approved Nov. 2, 2010 by 50.13% of voters
Allows registered qualifying patients (who must have a physician's written certification that they have been diagnosed with a debilitating condition and that they would likely receive benefit from marijuana) to obtain marijuana from a registered nonprofit dispensary, and to possess and use medical marijuana to treat the condition.
Requires the Arizona Department of Health Services to establish a registration and renewal application system for patients and nonprofit dispensaries. Requires a web-based verification system for law enforcement and dispensaries to verify registry identification cards. Allows certification of a number of dispensaries not to exceed 10% of the number of pharmacies in the state (which would cap the number of dispensaries around 124).
Specifies that a registered patient's use of medical marijuana is to be considered equivalent to the use of any other medication under the direction of a physician and does not disqualify a patient from medical care, including organ transplants.
Specifies that employers may not discriminate against registered patients unless that employer would lose money or licensing under federal law. Employers also may not penalize registered patients solely for testing positive for marijuana in drug tests, although the law does not authorize patients to use, possess, or be impaired by marijuana on the employment premises or during the hours of employment.
Approved Conditions:Cancer, glaucoma, HIV/AIDS, Hepatitis C, ALS, Crohn's disease, Alzheimer's disease, cachexia or wasting syndrome, severe and chronic pain, severe nausea, seizures (including epilepsy), severe or persistent muscle spasms (including multiple sclerosis). Starting Jan.1, 2015, PTSD was added to the list.
Possession/Cultivation: Qualified patients or their registered designated caregivers may obtain up to 2.5 ounces of marijuana in a 14-day period from a registered nonprofit medical marijuana dispensary. If the patient lives more than 25 miles from the nearest dispensary, the patient or caregiver may cultivate up to 12 marijuana plants in an enclosed, locked facility.
Amended:Senate Bill 1443
Effective: Signed by Governor Jan Brewer on May 7, 2013
"Specifies the prohibition to possess or use marijuana on a postsecondary educational institution campus does not apply to medical research projects involving marijuana that are conducted on the campus, as authorized by applicable federal approvals and on approval of the applicable university institutional review board."
[Editor's Note: On Apr. 11, 2012, the Arizona Department of Health Services (ADHS) announced the revised rules for regulating medical marijuana and set the application dates for May 14 through May

25.
On Nov. 15, 2012, the first dispensary was awarded "approval to operate." ADHS Director Will Humble stated on his blog that, "[W]e'll be declining new 'requests to cultivate' among new cardholders in most of the metro area... because self-grow (12 plants) is only allowed when the patient lives more than 25 miles from the nearest dispensary. The vast majority of the Valley is within 25 miles of this new dispensary."
On Dec. 6, 2012, the state's first dispensary, Arizona Organix, opened in Glendale.]

Contact and Program Details

Arizona Department of Health Services (ADHS)
Medical Marijuana Program
150 North 18th Avenue
Phoenix, Arizona 85007
Phone: 602-542-1025
Website:
Arizona Medical Marijuana Program
Information provided by the state on sources for medical marijuana:
"Qualifying patients can obtain medical marijuana from a dispensary, the qualifying patient's designated caregiver, another qualifying patient, or, if authorized to cultivate, from home cultivation. When a qualifying patient obtains or renews a registry identification card, the Department will provide a list of all operating dispensaries to the qualifying patient."

ADHS, "Qualifying Patients FAQs," Mar. 25, 2010
Patient Registry Fee:
$150 / $75 for Supplemental Nutrition Assistance Program participants
Accepts other states' registry ID cards?
Yes, but does not permit visiting patients to obtain marijuana from an Arizona dispensary
Registration:
Mandatory

3. Arkansas

State and Relevant Medical Marijuana Laws

Medical Marijuana Amendment (Issue 6) – Approved Nov. 8, 2016 by 53.2% of voters
Effective: Nov. 9, 2016
Constitutional amendment making medical marijuana legal in Arkansas and establishing a system for cultivation, acquisition, and distribution of marijuana.
Approved Conditions: Cancer, glaucoma, HIV/AIDS, hepatitis C, ALS, Tourette's syndrome, Crohn's disease, ulcerative colitis, PTSD, severe arthritis, fibromyalgia, Alzheimer's disease; A chronic or debilitating disease or medical condition or its treatment that produces one (1) or more of the following: cachexia or wasting syndrome; peripheral neuropathy; intractable pain, which is pain that has not responded to ordinary medications, treatment, or surgical measures for more than six months; severe nausea; seizures, including without limitation those characteristic of epilepsy; or severe and persistent muscle spasms, including without limitation those characteristic of multiple sclerosis; Any other medical condition or its treatment approved by the Department of Health

Possession/Cultivation: 2.5 ounces of usable marijuana per 14-day period

Contact and Program Details

Arkansas Department of Health
1-800-462-0599
Website:www.healthy.arkansas.gov
Patient Registry Fee:
To be determined
The new law gives the Department of Health 120 days to adopt rules and regulations for the medical marijuana program. A Medical Marijuana Commission will be created to determine licensing requirements for dispensaries and cultivation facilities.
Accepts other states' registry ID cards?
Yes
Registration:
Mandatory

4. California

State and Relevant Medical Marijuana Laws

Ballot Proposition 215 -- Approved Nov. 5, 1996 by 56% of voters
Effective: Nov. 6, 1996
Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a "written or oral recommendation" from their physician that he or she "would benefit from medical marijuana." Patients diagnosed with any debilitating illness where the medical use of marijuana has been "deemed appropriate and has been recommended by a physician" are afforded legal protection under this act.
Approved Conditions: AIDS, anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, persistent muscle spasms, including spasms associated with multiple sclerosis, seizures, including seizures associated with epilepsy, severe nausea; Other chronic or persistent medical symptoms.

Amended:Senate Bill 420
Effective: Jan. 1, 2004
Imposes statewide guidelines outlining how much medicinal marijuana patients may grow and possess.
Possession/Cultivation: Qualified patients and their primary caregivers may possess no more than eight ounces of dried marijuana and/or six mature (or 12 immature) marijuana plants. However, S.B. 420 allows patients to possess larger amounts of marijuana when recommended by a physician. The legislation also allows counties and municipalities to approve and/or maintain local ordinances permitting patients to possess larger quantities of medicinal pot than allowed under the new state guidelines.
S.B. 420 also grants implied legal protection to the state's medicinal marijuana dispensaries, stating, "Qualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients ... who associate within the state of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions."

Challenge to Possession Limits: On Jan. 21, 2010, the California Supreme Court affirmed (S164830) the May 22, 2008 Second District Court of Appeals ruling in the Kelly Case that the possession limits set by SB 420 violate the California constitution because the voter-approved Prop. 215 can only be amended by the voters.

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

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

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

On Oct. 9, 2015, Gov. Jerry Brown signed three bills to regulate California's medical marijuana industry: AB 243, AB 266, and SB 643. The bills cover licensing requirements for cultivation, transportation, distribution, and more.

Contact and Program Details

California Department of Public Health
Public Health Policy and Research Branch
Attention: Medical Marijuana Program Unit
MS 5202
P.O. Box 997377
Sacramento, CA 95899-7377
Phone: 916-552-8600
Fax: 916-440-5591
mmpinfo@cdph.ca.gov
Website:
CA Medical Marijuana Program
Guidelines for the Security and Non-diversion of Marijuana Grown for Medical Use

Information provided by the state on sources for medical marijuana:

"The MMP is not authorized to provide information on acquiring marijuana or other related products."
"Medical Marijuana Program Frequently Asked Questions," cdph.ca.gov (accessed Mar. 1, 2016)

"The California Department of Public Health's MMP does not have jurisdiction over medical marijuana cooperatives, dispensaries, or collectives. For questions related to these areas, please contact your local city or county business licensing office."
"Medical Marijuana Identification Card Program," cdph.ca.gov (accessed Mar 1, 2016)

Patient Registry Fee:
$66 non Medi-Cal / $33 Medi-Cal, plus additional county fees (varies by location)
Accepts other states' registry ID cards?
No
Registration:
Voluntary

5. Colorado

State and Relevant Medical Marijuana Laws

Ballot Amendment 20 – Approved Nov. 7, 2000 by 54% of voters
Effective: June 1, 2001 Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physician affirming that he or she suffers from a debilitating condition and advising that they "might benefit from the medical use of marijuana." (Patients must possess this documentation prior to an arrest.)
Approved Conditions: Cancer, glaucoma, HIV/AIDS positive, cachexia; severe pain; severe nausea; seizures, including those that are characteristic of epilepsy; or persistent muscle spasms, including those that are characteristic of multiple sclerosis. Other conditions are subject to approval by the Colorado Board of Health.
Possession/Cultivation: A patient or a primary caregiver who has been issued a Medical Marijuana Registry identification card may possess no more than two ounces of a usable form of marijuana and not more than six marijuana plants, with three or fewer being mature, flowering plants that are producing a usable form of marijuana.
Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges.
Amended:House Bill 1284 and Senate Bill 109
Effective:
June 7, 2010Colorado Governor Bill Ritter signed the bills into law and stated the following in a June 7, 2010 press release:
"House Bill 1284 provides a regulatory framework for dispensaries, including giving local communities the ability to ban or place sensible and much-needed controls on the operation, location and ownership of these establishments.
Senate Bill 109 will help prevent fraud and abuse, ensuring that physicians who authorize medical marijuana for their patients actually perform a physical exam, do not have a DEA flag on their medical license and do not have a financial relationship with a dispensary."

Contact and Program Details

Medical Marijuana Registry
Colorado Department of Public Health and Environment
HSV-8608
4300 Cherry Creek Drive South
Denver, CO 80246-1530
Phone: 303-692-2184
medical.marijuana@state.co.us

Website:
CO Medical Marijuana Registry
Information provided by the state on sources for medical marijuana:
The Marijuana Enforcement Division (MED) website provides a list of licensed Medical Marijuana Centers, which are retail operations "from which Medical Marijuana Registry patients purchase Medical Marijuana and Medical Marijuana infused products." MED "is responsible for the regulation of both the Medical and Retail Marijuana industries, each of which have separate and distinct statute and rules under which they operate."
"Medical Marijuana Licensing Information," colorado.gov/revenue/med (accessed Feb. 26, 2014)
"Licensing Information," colorado.gov/revenue/med (accessed Feb. 26, 2014)
Patient Registry Fee:
$15
Accepts other states' registry ID cards?
No Registration:
Mandatory

6. ## Connecticut

State and Relevant Medical Marijuana Laws

HB 5389 – Signed into law by Gov. Dannel P. Malloy (D) on May 31, 2012
Approved: By House 96-51, by Senate 21-13
Effective: Some sections from passage (May 4, 2012), other sections on Oct. 1, 2012
"A qualifying patient shall register with the Department of Consumer Protection... prior to engaging in the palliative use of marijuana. A qualifying patient who has a valid registration certificate... shall not be subject to arrest or prosecution, penalized in any manner,... or denied any right or privilege."
Patients must be Connecticut residents at least 18 years of age. "Prison inmates, or others under the supervision of the Department of Corrections, would not qualify, regardless of their medical condition."
Approved Conditions: "Cancer, glaucoma, positive status for human immunodeficiency virus or acquired immune deficiency syndrome [HIV/AIDS], Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, posttraumatic stress disorder, or... any medical condition, medical treatment or disease approved by the Department of Consumer Protection..."
On Mar. 14, 2016, the Connecticut Department of Consumer Protection announced six new qualifying conditions: sickle cell disease, post laminectomy syndrome with chronic radiculopathy, severe psoriasis and psoriatic arthritis, amyotrophic lateral sclerosis, ulcerative colitis, and complex regional pain syndrome.
Possession/Cultivation: "The maximum allowable monthly amount is 2.5 ounces unless your physician indicates a lesser amount is appropriate."
Updates: The Connecticut Medical Marijuana Program website posted an update on Sep. 23, 2012 with instructions on how to register for the program starting on Oct. 1, 2012. "Patients who are currently receiving medical treatment for a debilitating medical conditions set out in the law may qualify for a temporary registration certificate beginning October 1, 2012. To qualify, a patient must

also be at least 18 years of age and a Connecticut resident."
Draft Regulations on Medical Marijuana were posted on Jan. 16, 2013.
On Apr. 3, 2014, the Connecticut Department of Consumer Protection announced the names and locations of the first six dispensary facilities that will be authorized by the state. The first dispensary opened on Aug. 20, 2014.

Contact and Program Details

Medical Marijuana Program
Department of Consumer Protection (DCP)
165 Capitol Avenue, Room 145
Hartford, CT 06106
Phone: 860-713-6066
Toll-Free: 800-842-2649
dcp.mmp@ct.gov
Website:
CT Medical Marijuana Program
Information provided by the state on sources for medical marijuana:
Connecticut's Medical Marijuana Program website has a list of six dispensary facilities.
Patient Registry Fee:
$100
|
Accepts other states' registry ID cards?
No
Registration:
Mandatory

7. Delaware

State and Relevant Medical Marijuana Laws

Senate Bill 17 – Signed into law by Gov. Jack Markell (D) on May 13, 2011
Approved: By House 27-14, by Senate 17-4
Effective: July 1, 2011
Under this law, a patient is only protected from arrest if his or her physician certifies, in writing, that the patient has a specified debilitating medical condition and that the patient would receive therapeutic benefit from medical marijuana. The patient must send a copy of the written certification to the state Department of Health and Social Services, and the Department will issue an ID card after verifying the information. As long as the patient is in compliance with the law, there will be no arrest. The law does not allow patients or caregivers to grow marijuana at home, but it does allow for the state-regulated, non-profit distribution of medical marijuana by compassion centers.
Approved Conditions:
Approved for treatment of debilitating medical conditions, defined as cancer, HIV/AIDS, decompensated cirrhosis (Hepatitis C), ALS, Alzheimer's disease. Also approved for "a chronic or debilitating disease or medical condition or its treatment that produces 1 or more of the following: cachexia or wasting syndrome; severe, debilitating pain that has not responded to previously

prescribed medication or surgical measures for more than 3 months or for which other treatment options produced serious side effects; intractable nausea; seizures; or severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis."
"Post-traumatic stress disorder (PTSD) can qualify as a debilitating medical condition when it manifests itself in severe physical suffering, such as severe or chronic pain or severe nausea and vomiting, or otherwise severely impairs the patient's physical ability to carry on the activities of daily living."
("Medical Marijuana Questions & Answers," dhss.delaware.gov (accessed Mar. 1, 2016))
Possession/Cultivation: Patients 18 and older with certain debilitating conditions may possess up to six ounces of marijuana with a doctor's written recommendation. A registered compassion center may not dispense more than 3 ounces of marijuana to a registered qualifying patient in any fourteen-day period, and a patient may register with only one compassion center. Home cultivation is not allowed. Senate Bill 17 contains a provision that allows for an affirmative defense for individuals "in possession of no more than six ounces of usable marijuana."
Updates: On Feb. 12, 2012, Gov. Markell released the following statement (presented in its entirety), available on delaware.gov, in response to a letter from US District Attorney Charles Oberly:
"I am very disappointed by the change in policy at the federal department of justice, as it requires us to stop implementation of the compassion centers. To do otherwise would put our state employees in legal jeopardy and I will not do that. Unfortunately, this shift in the federal position will stand in the way of people in pain receiving help. Our law sought to provide that in a manner that was both highly regulated and safe."
On Aug. 15, 2013, Gov. Markell announced in a letter to Delaware lawmakers his intention to relaunch the state's medical marijuana program, despite his previous decision to stop implementation. Markell wrote that the Department of Health and Social Services "will proceed to issue a request for proposal for a pilot compassion center to open in Delaware next year."
On June 23, 2015, Gov. Markell signed Rylie's Law, SB 90, which allows the use of non-smoked cannabis oil that is no more than 7% THC for minors with intractable epilepsy or dystonia.
On June 26, 2015, the state's first medical marijuana dispensary opened near Wilmington, Delaware.

Contact and Program Details

Delaware Department of Health and Social Services
Division of Public Health
Phone: 302-744-4749
Fax: 302-739-3071
MedicalMarijuanaDPH@state.de.us
Website:
DE Medical Marijuana Program
Information provided by the state on sources for medical marijuana:
"The State currently recognizes properly permitted compassion centers as the only legal way to obtain marijuana."
"Medical Marijuana Questions & Answers," dhss.delaware.gov (accessed Mar. 1, 2016)
Patient Registry Fee:
$125 (a sliding scale fee is available based on income)
Accepts other states' registry ID cards?
No

Registration:
Mandatory

8. Florida

State and Relevant Medical Marijuana Laws

Medical Marijuana Legalization Initiative (Amendment 2) – Approved Nov. 8, 2016 by 71.3% of voters. Amends the Florida Constitution.
"Allows medical use of marijuana for individuals with debilitating medical conditions as determined by a licensed Florida physician. Allows caregivers to assist patients' medical use of marijuana. The Department of Health shall register and regulate centers that produce and distribute marijuana for medical purposes and shall issue identification cards to patients and caregivers. Applies only to Florida law. Does not immunize violations of federal law or any non-medical use, possession or production of marijuana." Allows for Medical Marijuana Treatment Centers to be registered by the Department of Health.
Approved Conditions: Cancer, epilepsy, glaucoma, HIV/AIDS, PTSD, ALS, Crohn's disease, Parkinson's disease, multiple sclerosis, or other debilitating medical conditions of the same kind or class as or comparable to those enumerated, and for which a physician believes that the medical use of marijuana would likely outweigh the potential health risks for a patient.
Possession/Cultivation: To be determined during the rulemaking process

Contact and Program Details

Florida Department of Health
850-245-4444
Website:
www.floridahealth.gov
The law gives the Florida Department of Health six months to establish regulations and set a possession limit, and nine months to begin issuing identification cards. After nine months, a valid physician certification will serve as a qualifying patient identification card until the Department begins issuing cards.
Patient Registry Fee:
To be determined
Accepts other states' registry ID cards?
Unclear

9. Hawaii

State and Relevant Medical Marijuana Laws

Senate Bill 862 -- Signed into law by Gov. Ben Cayetano on June 14, 2000
Approved: By House 32-18, by Senate 13-12
Effective: Dec. 28, 2000
Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a signed statement from their physician affirming that he or she suffers from a debilitating condition and that the "potential benefits of medical use of marijuana would likely

outweigh the health risks." The law establishes a mandatory, confidential state-run patient registry that issues identification cards to qualifying patients.
Approved conditions: Cancer, glaucoma, positive status for HIV/AIDS; A chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome, severe pain, severe nausea, seizures, including those characteristic of epilepsy, or severe and persistent muscle spasms, including those characteristic of multiple sclerosis or Crohn's disease. PTSD added July 2015. Other conditions are subject to approval by the Hawaii Department of Health.
Possession/Cultivation: The amount of marijuana that may be possessed jointly between the qualifying patient and the primary caregiver is an "adequate supply," not to exceed seven plants and no more than four ounces of usable marijuana jointly between a registered patient and caregiver.
Amended:HB 668
Effective: June 25, 2013
Establishes a medical marijuana registry special fund to pay for the program and transfers the medical marijuana program from the Department of Public Safety to the Department of Public Health by no later than Jan. 1, 2015.
Amended:SB 642
Effective: Jan. 2, 2015
Redefines "adequate supply" as seven marijuana plants, whether immature or mature, and four ounces of usable marijuana at any given time; stipulates that physician recommendations will have to be made by the qualifying patient's primary care physician.
Amended:Act 241
Signed: July 14, 2015
Created "a regulated statewide dispensary system for medical marijuana" and added PTSD to list of conditions.
"The department shall issue eight dispensary licenses statewide... A dispensary licensee may establish up to two retail dispensing locations...
A qualifying patient or primary caregiver... shall be allowed to purchase no more than four ounces of marijuana within a consecutive period of fifteen days."

Contact and Program Details

Department of Health
Medical Marijuana Program
4348 Waialae Avenue #648
Honolulu, Hawaii 96816
Phone: 808-733-2177
medicalmarijuana@doh.hawaii.gov
Website:
HI Medical Marijuana Registry Program
Information provided by the state on sources for medical marijuana:
"[A]s a registered program participant, and assuming that you indicated your intent to grow your own supply of medical marijuana on your application, you are allowed to grow an 'adequate supply' of medical marijuana, not to exceed seven (7) plants and posses no more than 4oz of usable marijuana jointly between a registered patient and caregiver...
Act 241 was signed into law on July 14, 2015... [tentatively on] July 15, 2016 – and not sooner,

licensed dispensaries may begin dispensing from 8 AM – 8 PM and closed Sunday and state/federal holidays."

"Growing Medical Marijuana," health.hawaii.gov (accessed Mar. 1, 2016)

Patient Registry Fee:

$35

Accepts other states' registry ID cards?

No

(According to Act 241, beginning January 1, 2018: "qualifying patients from other states [will be accepted] provided that the patient is verified as a patient in their home state and registers with the department.")

Registration:

Mandatory

10. Illinois

State and Relevant Medical Marijuana Laws

House Bill 1

Approved: Apr. 17, 2013 by House, 61-57 and May 17, 2013 by Senate, 35-21

Signed into law by Gov. Pat Quinn on Aug. 1, 2013

Effective: Jan. 1, 2014

The Compassionate Use of Medical Cannabis Pilot Program Act establishes a patient registry program, protects registered qualifying patients and registered designated caregivers from "arrest, prosecution, or denial of any right or privilege," and allows for the registration of cultivation centers and dispensing organizations. Once the act goes into effect, "a tax is imposed upon the privilege of cultivating medical cannabis at a rate of 7% of the sales price per ounce."

Approved Conditions: "Debilitating medical conditions include 40 chronic diseases and conditions: cancer, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease, cachexia/wasting syndrome, muscular dystrophy, severe fibromyalgia, spinal cord disease (including but not limited to arachnoiditis), Tarlov cysts, hydromyelia syringomyelia, Rheumatoid arthritis, fibrous dysplasia, spinal cord injury, traumatic brain injury and post concussion syndrome, Multiple Sclerosis, Arnold-Chiari malformation and Syringomelia, Spinocerebellar Ataxia (SCA), Parkinson's Disease, Tourette Syndrome, Myoclonus, Dystonia, Reflex Sympathetic Dystrophy, RSD (Complex Regional Pain Syndromes Type I), Causalgia, CRPS (Complex Regional Pain Syndrome Type II), Neurofibromatosis, Chronic inflammatory Demyelinating Polyneuropathy, Chronic Inflammatory Demyelinating Polyneuropathy, Sjogren's Syndrome, Lupus, Interstitial Cystitis, Myasthenia Gravis, Hydrocephalus, nail-patella syndrome or residual limb pain; or the treatment of these conditions."

"Frequently Asked Questions," idph.state.il.us (accessed Apr. 23, 2014)

PTSD and terminal illness with a diagnosis of less than six months were added on July 1, 2016.

On July 20, 2014, Gov. Quinn signed Senate Bill 2636, which amended the Compassionate Use of Medical Cannabis Act to allow children under 18 to be treated with non-smokable forms of medical marijuana for the same conditions orginially approved for adults. An underage patient's parent or guardian must serve as caregiver, and signatures from two doctors are required. The bill, which

becomes effective Jan. 1, 2015, also added seizures, including those related to epilepsy, to the list of approved conditions.

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

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

On Jan. 21, 2014, the Department of Public Health released a draft of the proposed rules for public comments. The proposal included a fingerprint-based criminal history background check and an annual $150 application fee for qualifying patients. The rules also state that qualifying patients and caregivers "are not eligible for a Firearm Owners Identification Card or a Firearm Concealed Carry License."

On Apr. 18, 2014, the Department of Health released revised preliminary rules that removed from the previous versions the restrictions on gun owners applying for medical marijuana cards. The application fees were dropped to $100 ($50 for veterans and eligible patients on Social Security Insurance and Social Security Disability Insurance, and $25 for caregivers).

On July 1, 2016, Gov. Bruce Rauner (R) signed SB 10 into law, which extends the state's medical marijuana program through July 2020 and adds PTSD and terminal illness to the list of approved conditions.

Contact and Program Details

Illinois Department of Public Health
Division of Medical Cannabis
Illinois Department of Public Health
535 W. Jefferson Street
Springfield, IL 62761-0001
Attn: Rulemaking
DPH.MedicalCannabis@illinois.gov

Website:
Medical Cannabis Program

Information provided by the state on sources for medical marijuana:
"The first medical cannabis dispensary opened for business in Illinois on November 9, 2015. A total of twenty dispensaries were licensed in Illinois by December 31, 2015."
"Illinois Medical Cannabis Registry Pilot Program Mid-Year Report – January 2016," dph.illinois.gov (accessed Mar. 1, 2016)

Patient Registry Fee:
$100 / $50 for veterans or persons enrolled in federal Social Security Disability Income (SSDI) or Supplemental Security Income (SSI) disability programs

Accepts other states' registry ID cards?
No

Registration:
Mandatory

11. Maine

State and Relevant Medical Marijuana Laws

Ballot Question 2 -- Approved Nov. 2, 1999 by 61% of voters
Effective: Dec. 22, 1999
Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess an oral or written "professional opinion" from their physician that he or she "might benefit from the medical use of marijuana." The law does not establish a state-run patient registry.
Approved diagnosis: Epilepsy and other disorders characterized by seizures; glaucoma; multiple sclerosis and other disorders characterized by muscle spasticity; nausea or vomiting as a result of AIDS or cancer chemotherapy; ant PTSD.
Possession/Cultivation: Patients (or their primary caregivers) may legally possess no more than one and one-quarter (1.25) ounces of usable marijuana, and may cultivate no more than six marijuana plants, of which no more than three may be mature. Those patients who possess greater amounts of marijuana than allowed by law are afforded a "simple defense" to a charge of marijuana possession.
Amended:Senate Bill 611
Effective: Signed into law on Apr. 2, 2002
Increases the amount of useable marijuana a person may possess from one and one-quarter (1.25) ounces to two and one-half (2.5) ounces.
Amended:Question 5 -- Approved Nov. 3, 2009 by 59% of voters
List of approved conditions changed to include cancer, glaucoma, HIV, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, Alzheimer's, nail-patella syndrome, chronic intractable pain, cachexia or wasting syndrome, severe nausea, seizures (epilepsy), severe and persistent muscle spasms, and multiple sclerosis.
Instructs the Department of Health and Human Services (DHHS) to establish a registry identification program for patients and caregivers. Stipulates provisions for the operation of nonprofit dispensaries.
[Editor's Note: An Aug. 19, 2010 email to ProCon.org from Catherine M. Cobb, Director of Maine's Division of Licensing and Regulatory Services, stated:
"We have just set up our interface to do background checks on caregivers and those who are associated with dispensaries. They may not have a disqualifying drug offense."]
Amended:LD 1062
Effective: Enacted without the governor's signature on June 26, 2013
Adds post-traumatic stress disorder (PTSD) to the list of approved conditions for medical marijuana use.

Contact and Program Details

Maine Medical Use of Marijuana Program (MMMP)
Division of Licensing and Regulatory Services
Department of Health and Human Services
11 State House Station
Augusta, ME 04333
Phone: 207-287-4325
dhhs@maine.gov
Website:
Maine Medical Marijuana Program

Information provided by the state on sources for medical marijuana:
A list of dispensaries is available on the MMMP website. "The patient may either cultivate or designate a caregiver or dispensary to cultivate marijuana." ("Program Bulletin," Maine.gov, Sep. 28, 2011)
Patient Registry Fee:
$0
Caregivers pay $300/patient (limit of 5 patients; if not growing marijuana, there is no fee)
Accepts other states' registry ID cards?
Yes
"Law enforcement will accept appropriate authorization from a participating state, but that patient cannot purchase marijuana in Maine without registering here. That requires a Maine physician and a Maine driver license or other picture ID issued by the state of Maine. The letter from a physician in another state is only good for 30 days." (Aug. 19, 2010 email from Maine's Division of Licensing and Regulatory Services)
Registration:
Voluntary
"In addition to either a registry ID card or a physician certification form, all patients, including both non-registered and voluntarily registered patients, must also present their Maine driver license or other Maine-issued photo identification card to law enforcement, upon request." ("Program Bulletin," Maine.gov, Sep. 28, 2011)

12. Maryland

State and Relevant Medical Marijuana Laws

House Bill 881
Approved: Apr. 8, 2014 by House, 125-11 and by Senate, 44-2
Signed by Gov. Martin O'Malley on Apr. 14, 2014
Effective: June 1, 2014
The Natalie M. LaPrade Medical Marijuana Commission and the Maryland Department of Health and Mental Hygiene are tasked with developing regulations for patient registry and identification cards, dispensary licensing, setting fees and possession limits, and more. The Commission will issue yearly request for applications from academic medical centers to operate medical marijuana compassionate use programs.
Approved diagnosis: Cachexia, anorexia, or wasting syndrome, severe or chronic pain, severe nausea, seizures, severe or persistent muscle spasms, or other conditions approved by the Commission.
Possession/Cultivation: Patients are allowed to possess a 30-day supply (amount to be determined by the Commission). "Beginning June 1, 2016, the Commission may issue the number of [dispensary] licenses necessary to meet the demand for medical marijuana by qualifying patients and caregivers issued identification cards."
Learn more about medical marijuana laws in Maryland prior to legalization.

Contact and Program Details

Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201

dhmh.medicalcannabis@maryland.gov
Website:
Natalie M. LaPrade Medical Marijuana Commission
Information provided by the state on sources for medical marijuana:
"A Maryland patient can only obtain legal medical cannabis from Maryland-licensed dispensaries. The dispensaries can only obtain their cannabis from Maryland-licensed growers, and their extracts from Maryland-licensed processors... The Commission anticipates that medical cannabis may first be available to patients in the second half of 2016."
"Frequently Asked Questions (FAQ's)," mmcc.maryland.gov, June 26, 2015
Patient Registry Fee:
To be determined by the Commission during the rulemaking process
Accepts other states' registry ID cards?
No
Registration:
Mandatory

13. ## Massachusetts

State and Relevant Medical Marijuana Laws

Ballot Question 3 -- Approved Nov. 6, 2012 by 63% of voters
Effective: Jan. 1, 2013
"The citizens of Massachusetts intend that there should be no punishment under state law for qualifying patients, physicians and health care professionals, personal caregivers for patients, or medical marijuana treatment center agents for the medical use of marijuana...
In the first year after the effective date, the Department shall issue registrations for up to thirty-five non-profit medical marijuana treatment centers, provided that at least one treatment center shall be located in each county, and not more than five shall be located in any one county."
Approved diagnosis: "Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, multiple sclerosis and other conditions as determined in writing by a qualifying patient's physician."
Possession/Cultivation: Patients may posses a sixty-day supply, defined as 10 ounces.
"The Department shall issue a cultivation registration to a qualifying patient whose access to a medical treatment center is limited by verified financial hardship, a physical incapacity to access reasonable transportation, or the lack of a treatment center within a reasonable distance of the patient's residence. The Department may deny a registration based on the provision of false information by the applicant. Such registration shall allow the patient or the patient's personal caregiver to cultivate a limited number of plants, sufficient to maintain a 60-day supply of marijuana, and shall require cultivation and storage only in an enclosed, locked facility."
Updates: The DPH website wrote on Oct. 8, 2014 that "the Medical Use of Marijuana Online System (MMJ Online System) is now available for qualifying patients to register to possess marijuana for medical purposes. You will need to register with the MMJ Online System by January 1, 2015 in order to possess marijuana for medical purposes, even if you already have a paper written certification from your physician. Paper written certifications will no longer be valid as of February 1st, 2015."

Contact and Program Details

Department of Public Health of the Commonwealth of Massachusetts
One Ashburton Place
11th Floor
Boston, MA 02108
Phone: 617-624-5062
medicalmarijuana@state.ma.us
Website:
www.mass.gov/medicalmarijuana
Information provided by the state on sources for medical marijuana:
On February 12, 2016, Gov. Charlie Baker's Administration approved Patriot Care Corp. to begin retail sales of marijuana to registered qualifying patients and personal caregivers.
Patient Registry Fee:
$50
Accepts other states' registry ID cards?
Unknown
Registration:
Mandatory

14. Michigan

State and Relevant Medical Marijuana Laws

Proposal 1 "Michigan Medical Marihuana Act" – Approved by 63% of voters on Nov. 4, 2008
Approved: Nov. 4, 2008
Effective: Dec. 4, 2008
Approved Conditions: Approved for treatment of debilitating medical conditions, defined as cancer, glaucoma, HIV, AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease, nail patella, cachexia or wasting syndrome, severe and chronic pain, severe nausea, seizures, epilepsy, muscle spasms, multiple sclerosis, and PTSD.
Possession/Cultivation: Patients may possess up to two and one-half (2.5) ounces of usable marijuana and twelve marijuana plants kept in an enclosed, locked facility. The twelve plants may be kept by the patient only if he or she has not specified a primary caregiver to cultivate the marijuana for him or her.
Amended:HB 4856
Effective: Dec. 31, 2012
Makes it illegal to "transport or possess" usable marijuana by car unless the marijuana is "enclosed in a case that is carried in the trunk of the vehicle." Violation of the law is a misdemeanor "punishable by imprisonment for not more than 93 days or a fine of not more than $500.00, or both."
Amended:HB 4834
Effective: Apr. 1, 2013
Requires proof of Michigan residency when applying for a registry ID card (driver license, official state ID, or valid voter registration) and makes cards valid for two years instead of one.
Amended:HB 4851

Effective: Apr. 1, 2013
Requires a "bona fide physician-patient relationship," defined in part as one in which the physician "has created and maintained records of the patient's condition in accord with medically accepted standards" and "will provide follow-up care;" protects patient from arrest only with registry identification card and valid photo ID.
Amended:State of Michigan vs. McQueen
Decided: Feb. 8, 2013
The Michigan Supreme Court ruled 4-1 that dispensaries are illegal. As a result, medical marijuana patients in Michigan will have to grow their own marijuana or get it from a designated caregiver who is limited to five patients.

Contact and Program Details

Michigan Medical Marihuana Program
Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Michigan Medical Marihuana Program
PO Box 30083
Lansing, MI 48909
Phone: 517-284-6400
BHP-MMMPINFO@michigan.gov
Website:
MI Medical Marihuana Program
Information provided by the state on sources for medical marijuana:
"This is not addressed in the MMMA, therefore; the MMP is not authorized to provide information regarding this issue... The MMMA provides for a system of designated caregivers... The MMP is not authorized to associate patients and caregivers nor release the names of registered caregivers."
"Frequently Asked Questions," Michigan.gov (accessed Apr. 24, 2014)
Patient Registry Fee:
$60 new or renewal application
Accepts other states' registry ID cards?
Yes
The Office of Communications in the Department of Licensing and Regulatory Affairs told ProCon.org in an Oct.30, 2014 email: "The law says that cards from other states are recognized. However, the Michigan Medical Marihuana Program does not have any control over enforcement of that section of the statute."
Registration:
Mandatory

15. Minnesota

State and Relevant Medical Marijuana Laws

SF 2470 -- Signed into law by Gov. Mark Dayton on May 29, 2014
Approved: By Senate 46-16, by House 89-40
Effective: May 30, 2014

Approved Conditions: cancer (if the underlying condition or treatment produces severe or chronic pain, nausea or severe vomiting, or cachexia or severe wasting), glaucoma, HIV/AIDS, Tourette's syndorme, ALS, seizures/epilepsy, severe and persistent muscle spasms/MS, Crohn's disease, terminal illness with a life expectancy of under one year.
Patients certified as having intractable pain become eligible to receive medical marijuana starting Aug. 2016.
Possession/Cultivation: The Commissioner of Health will register two in-state manufacturers for the production of all medical cannabis within the state. Manufacturers are required to ensure that the medical cannabis distributed contains a maximum of a 30-day supply of the dosage determined for that patient.
"Medical cannabis" is defined as any species of the genus cannabis plant delivered in the form of (1) liquid, including, but not limited to, oil; (2) pill; (3) vaporized delivery method that does not require the use of dried leaves or plant form.
Smoking is not a method approved by the bill.

Contact and Program Details

Minnesota Department of Health
Office of Medical Cannabis
651-201-5598
844-879-3381 (toll-free)
health.cannabis@state.mn.us
Website:
Medical Cannabis Program
Information provided by the state on sources for medical marijuana:
The cannabis program website has a list of three operating dispensaries and five more scheduled to open in Spring 2016.
Patient Registry Fee:
$200 annual fee / $50 for patients on Social Security disability, Supplemental Security Insurance, or enrolled in MinnesotaCare
Accepts other states' registry ID cards?
No
Registration:
Mandatory

16. Montana

State and Relevant Medical Marijuana Laws

Initiative 148 -- Approved by 62% of voters on Nov. 2, 2004
Effective: Nov. 2, 2004
Approved Conditions: Cancer, glaucoma, or positive status for HIV/AIDS, or the treatment of these conditions; a chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome, severe or chronic pain, severe nausea, seizures, including seizures caused by epilepsy, or severe or persistent muscle spasms, including spasms caused by multiple sclerosis or Crohn's disease; admittance to hospice care; or any other medical condition or treatment

for a medical condition adopted by the department by rule. Pain and PTSD added with the Nov. 8, 2016 passage of Initiative 182.
Possession/Cultivation: "Registered cardholders are limited to 12 seedlings (<12"), 4 mature flowering plants, and 1 ounce of usable marijuana. If a registered cardholder assigns a provider, they cannot grow for themselves."
Amended:SB 423 -- Passed on Apr. 28, 2011 and transmitted to the Governor on May 3, 2011
Effective: July 1, 2011
SB 423 changes the application process to require a Montana driver's license or state issued ID card. A second physician is required to confirm a chronic pain diagnosis.
"A provider or marijuana-infused products provider may assist a maximum of three registered cardholders..." and "may not accept anything of value, including monetary remuneration, for any services or products provided to a registered cardholder."
Approved Conditions: Cancer, glaucoma, or positive status for HIV/AIDS when the condition or disease results in symptoms that seriously and adversely affect the patient's health status; Cachexia or wasting syndrome; Severe, chronic pain that is persistent pain of severe intensity that significantly interferes with daily activities as documented by the patient's treating physician; Intractable nausea or vomiting; Epilepsy or intractable seizure disorder; Multiple sclerosis; Chron's Disease; Painful peripheral neuropathy; A central nervous system disorder resulting in chronic, painful spasticity or muscle spasms; Admittance into hospice care.
Possession/Cultivation: Amended to 12 seedlings (less than 12"), four mature flowering plants, and one ounce of usable marijuana.
Updates: On Nov. 6, 2012, Montana voters approved initiative referendum No. 124 by a vote of 56.5% to 43.5%, upholding SB 423.
On Nov. 8, 2016, Montana voters approved the Montana Medical Marijuana Initiative (I-182). The initiative repeals the requirement of SB 143 that limited medical marijuana providers to three patients; adds pain and PTSD to the list of approved conditions; and revokes the requirement that physicians who provide certifications for 25 or more patients annually be referred to the board of medical examiners.

Contact and Program Details

Medical Marijuana Program
Montana Department of Health and Human Services
Licensure Bureau
2401 Colonial Drive, 2nd Floor
P.O. Box 202953
Helena, MT 59620-2953
Phone: 406-444-0596
jbuska@mt.gov
Website:
MT Medical Marijuana Program
Medical Marijuana Program FAQs
Information provided by the state on sources for medical marijuana:
"The department has no advice on obtaining marijuana."
"MMP FAQ," dphhs.mt.gov (accessed Mar. 1, 2016)

Patient Registry Fee:
$75 new application / $75 renewal
Accepts other states' registry ID cards?
No (reciprocity ended when SB 423 took effect)
Registration:
Mandatory

17. Nevada

State and Relevant Medical Marijuana Laws
Ballot Question 9 -- Approved Nov. 7, 2000 by 65% of voters
Effective: Oct. 1, 2001
Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who have "written documentation" from their physician that marijuana may alleviate his or her condition.
Approved Conditions: AIDS; cancer; glaucoma; and any medical condition or treatment to a medical condition that produces cachexia, persistent muscle spasms or seizures, severe nausea or pain, and PTSD. Other conditions are subject to approval by the health division of the state Department of Human Resources.
Possession/Cultivation: Patients (or their primary caregivers) may legally possess no more than two and a half ounces of usable marijuana in a 14-day period and 12 plants.
Registry: The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges. Legislators added a preamble to the legislation stating, "[T]he state of Nevada as a sovereign state has the duty to carry out the will of the people of this state and regulate the health, medical practices and well-being of those people in a manner that respects their personal decisions concerning the relief of suffering through the medical use of marijuana." A separate provision requires the Nevada School of Medicine to "aggressively" seek federal permission to establish a state-run medical marijuana distribution program.
Amended:Assembly Bill 453
Effective: Oct. 1, 2001
Created a state registry for patients whose physicians recommend medical marijuana and tasked the Department of Motor Vehicles with issuing identification cards. No state money will be used for the program, which will be funded entirely by donations.
Amended:Senate Bill 374
Signed into law by Gov. Brian Sandoval on June 12, 2013
"Provides for the registration of medical marijuana establishments authorized to cultivate or dispense marijuana or manufacture edible marijuana products or marijuana-infused products for sale to persons authorized to engage in the medical use of marijuana...
From Apr. 1, 2014, through Mar. 31, 2016, a nonresident purchaser must sign an affidavit attesting to the fact that he or she is entitled to engage in the medical use of marijuana in his or her state or jurisdiction of residency. On and after Apr. 1, 2016, the requirement for such an affidavit is replaced by computer cross-checking between the State of Nevada and other jurisdictions." Patients who were

growing before July 1, 2013 are allowed to continue home cultivation until Mar. 31, 2016.
Updates: The Department of Health and Human Services adopted regulations based on the previous amendment on Apr. 1, 2014.

Contact and Program Details

Nevada State Health Division
4150 Technology Way, Suite 106
Carson City, NV, 89706
Phone: 775-684-3487
Fax: 775-684-4156
medicalmarijuana@health.nv.gov
Website:
NV Medical Marijuana Program
Information provided by the state on sources for medical marijuana:
The medical marijuana program website has a list of 15 open dispensaries. Nevada law allows patients to home cultivate only in specific circumstances. "The Nevada MM Program is not a resource for the growing process and does not have information to give to patients. It is recommended that you talk to an attorney to learn about your rights and protections." "Medical Marijuana Patient Cardholder Registry - FAQs," health.nv.gov, Jan. 19, 2016
Patient Registry Fee:
$25 application fee, plus $75 for the card
Accepts other states' registry ID cards?
Yes, starting Apr. 1, 2014 with an affidavit
Registration:
Mandatory

18. New Hampshire

State and Relevant Medical Marijuana Laws

House Bill 573
Approved: May 23, 2013 by Senate, 18-6 and June 26, 2013 by House, 284-66
Signed into law by Gov. Maggie Hassan on July 23, 2013
Effective: Upon passage
The bill authorizes the use of therapeutic cannabis in New Hampshire, establishes a registry identification card system, allows for the registration of up to four non-profit alternative treatment centers in the state, and establishes an affirmative defense for qualified patients and designated caregivers with valid registry ID cards.
HB 573 also calls for the creation of a Therapeutic Use of Cannabis Advisory Council, which in five years will be required to "issue a formal opinion on whether the program should be continued or repealed."
A valid ID card from another medical marijuana state will be recognized as allowing the visiting patient to possess cannabis for therapeutic purposes, but the "visiting qualifying patient shall not cultivate or purchase cannabis in New Hampshire or obtain cannabis from alternative treatment centers..."

Approved Conditions: "(1) Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C currently receiving antiviral treatment, amyotrophic lateral sclerosis, muscular dystrophy, Crohn's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, epilepsy, lupus, Parkinson's disease, Alzheimer's disease, or one or more injuries that significantly interferes with daily activities as documented by the patient's provider; AND
(2) A severely debilitating or terminal medical condition or its treatment that has produced at least one of the following: elevated intraocular pressure, cachexia, chemotherapy-induced anorexia, wasting syndrome, agitation of Alzheimer's disease, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms."
Possession/Cultivation: "A qualifying patient shall not obtain more than 2 ounces of usable cannabis directly or through the qualifying patient's designated caregiver during a 10-day period." A patient may possess two ounces of usable cannabis at any one time.
Updates: On Apr. 3, 2014, the Department of Health and Human Services (DHHS) posted proposed Therapeutic Cannabis Program Registry Rules and began the formal rulemaking process.
DHHS began issuing Registry Identification Cards on Dec. 28, 2015 by mail to qualifying patients and designated caregivers whose applications had been approved. The cards cannot be used in New Hampshire until the Alternative Treatment Center (ATC) dispensaries open.
The state's first dispensary opened in Plymouth, New Hampshire, on May 1, 2016.

Contact and Program Details

New Hampshire Department of Health and Human Services
Therapeutic Cannabis Program
129 Pleasant Street, Brown Building
Concord, NH 03301-3857
Phone: 603-271-9234
Email Contact Form
Website:
Therapeutic Use of Cannabis Program
Information provided by the state on sources for medical marijuana:
"There will be four Alternative Treatment Centers (ATCs) operating in New Hampshire. The ATCs will be located in Dover, Merrimack, Lebanon, and Plymouth. A Qualifying Patient may select any of the ATCs but may select only one at any given time. A Qualifying Patient will be allowed to purchase cannabis only from the ATC he or she has selected. No Alternative Treatment Center in New Hampshire is open for business at this time. It is expected that they will become operational in Spring 2016."
"Alternative Treatment Centers" dhhs.nh.gov (accessed Feb. 29, 2016)
Patient Registry Fee:
$50
Accepts other states' registry ID cards?
Yes

Registration:
Mandatory

19. New Jersey

State and Relevant Medical Marijuana Laws

Senate Bill 119
Approved: Jan. 11, 2010 by House, 48-14; by Senate, 25-13
Signed into law by Gov. Jon Corzine on Jan. 18, 2010
Effective: Six months from enactment
Protects "patients who use marijuana to alleviate suffering from debilitating medical conditions, as well as their physicians, primary caregivers, and those who are authorized to produce marijuana for medical purposes" from "arrest, prosecution, property forfeiture, and criminal and other penalties." Also provides for the creation of alternative treatment centers, "at least two each in the northern, central, and southern regions of the state. The first two centers issued a permit in each region shall be nonprofit entities, and centers subsequently issued permits may be nonprofit or for-profit entities."
Approved Conditions: Amyotrophic lateral sclerosis (Lou Gehrig's disease); multiple sclerosis; terminal cancer; muscular dystrophy; inflammatory bowel disease, including Crohn's disease; terminal illness, if the physician has determined a prognosis of less than 12 months of life.
The following conditions apply if conventional therapy is unsuccessful: Seizure disorder, including epilepsy; intractable skeletal muscular spasticity; glaucoma.
The following conditions, if severe or chronic pain, severe nausea or vomiting, cachexia, or wasting syndrome results from the condition or treatment: Positive status for HIV/AIDS; cancer.
Possession/Cultivation: Physicians determine how much marijuana a patient needs and give written instructions to be presented to an alternative treatment center. The maximum amount for a 30-day period is two ounces.
Amended:SB 2842
Signed into law by Gov. Chris Christie on Sep. 10, 2013 following legislative adoption of his conditional veto
Allows edible forms of marijuana only for qualifying minors, who must receive approval from a pediatrician and a psychiatrist.
Updates:
S119 was supposed to become effective six months after it was enacted on Jan. 18, 2010, but the legislature, DHHS, and New Jersey Governor Chris Christie had difficulty coming to agreement on the details of how the program would be run.
The New Jersey Department of Health and Senior Services released draft rules outlining the registration and application process on Oct. 6, 2010. A public hearing to discuss the proposed rules was held on Dec. 6, 2010 at the New Jersey Department of Health and Senior Services, according to the *New Jersey Register*.
On Dec. 20, 2011, Senator Nicholas Scutari (D), lead sponsor of the medical marijuana bill, submitted Senate Concurrent Resolution (SCR) 140 declaring that the "Board of Medical Examiners proposed medicinal marijuana program rules are inconsistent with legislative intent." The New Jersey Senate Health, Human Services and Senior Citizens committee held a public hearing to discuss SCR 140 and a similar bill, SCR 130, on Jan. 20, 2010.

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

On Aug. 9, 2012, the New Jersey Medical Marijuana Program opened the patient registration system on its website. Patients must have a physician's recommendation, a government-issued ID, and proof of New Jersey residency to register. The first dispensary is expected to be licensed to open in September.

On Oct. 16, 2012, the Department of Health issued the first dispensary permit to Greenleaf Compassion Center, allowing it to operate as an Alternative Treatment Center and dispense marijuana. The center opened on Dec. 6, 2012, becoming New Jersey's first dispensary.

Contact and Program Details

Department of Health (DOH)
P. O. Box 360
Trenton, NJ 08625-0360
Phone: 609-292-0424
Contact form

Website:
Medicinal Marijuana Program

Information provided by the state on sources for medical marijuana:
Patients are not allowed to grow their own marijuana. On Mar. 21, 2011, the New Jersey DOH announced the locations of six nonprofit alternative treatment centers (ATCs) from which medical marijuana may be obtained, five of which were operational as of Mar. 1, 2016.
Medical marijuana is not covered by Medicaid.

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

Accepts other states' registry ID cards?
No

Registration:
Mandatory

20. New Mexico

State and Relevant Medical Marijuana Laws

Senate Bill 523 "The Lynn and Erin Compassionate Use Act"
Approved: Mar. 13, 2007 by House, 36-31; by Senate, 32-3
Effective: July 1, 2007
Removes state-level criminal penalties on the use and possession of marijuana by patients "in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments." The New Mexico Department of Health is designated to administer the program and register patients, caregivers, and providers.
Approved Conditions: Amyotrophic Lateral Sclerosis (Lou Gehrig's disease); cancer; Crohn's disease;

epilepsy; glaucoma; hepatitis C infection currently receiving antiviral treatment; HIV/AIDS; Huntington's Disease; hospice care; inclusion body myositis; inflammatory autoimmune?mediated arthritis; intractable nausea/vomiting; multiple sclerosis; damage to the nervous tissue of the spinal cord; painful peripheral neuropathy; Parkinson's disease; PTSD; severe chronic pain; severe anorexia/cachexia; spasmodic torticollis; ulcerative colitis
Possession/Cultivation: Patients have the right to possess up to six ounces of usable cannabis, four mature plants and 12 seedlings. Usable cannabis is defined as dried leaves and flowers; it does not include seeds, stalks or roots. A primary caregiver may provide services to a maximum of four qualified patients under the Medical Cannabis Program.

Contact and Program Details

New Mexico Department of Health
Medical Cannabis Program
1190 Saint Francis Drive Suite S-3400
Santa Fe, NM 87505
Phone: 505-827-2321
medical.cannabis@state.nm.us
Website:
NM Medical Cannabis Program
Information provided by the state on sources for medical marijuana:
"Currently, there are 23 independent Licensed Nonprofit Producers (LNPP). These are the agencies where those actively enrolled in the program purchase product. The NM Department of Health does not provide medical cannabis or set the prices. Patients must contact each LNPP directly to initiate the registration process. Questions regarding the LNPP should be directed to each LNPP separately, and not to the NMDOH Medical Cannabis Program."
"Medical Cannabis List of Licensed Non-Profit Producers," nmhealth.org, Feb. 29, 2016
Patient Registry Fee:
No fee
Accepts other states' registry ID cards?
No
Registration:
Mandatory

21. New York

State and Relevant Medical Marijuana Laws

Assembly Bill 6357
Approved: June 19, 2014 by Assembly, 117-13; June 20, 2014 by Senate, 49-10
Signed into law by Governor Andrew Cuomo on July 5, 2014
Effective: Upon Governor's signature
The Department of Health had 18 months to establish regulations and register dispensing organizations. Marijuana will be taxed at 7%, to be paid by the dispensary. The law automatically expires after seven years.
Approved Conditions: "You are potentially eligible for medical marijuana if you have been diagnosed

with a specific severe, debilitating or life threatening condition that is accompanied by an associated or complicating condition. By law, those conditions are: cancer, HIV infection or AIDS, amyotrophic lateral sclerosis (ALS), Parkinson's disease, multiple sclerosis, spinal cord injury with spasticity, epilepsy, inflammatory bowel disease, neuropathy, and Huntington's disease. The associated or complicating conditions are cachexia or wasting syndrome, severe or chronic pain, severe nausea, seizures, or severe or persistent muscle spasms."

Physicians must complete a four-hour New York State Department of Health (Department)-approved course and register with the Department to certify patients.

Possession/Cultivation: 30-day supply

Smoking is not a method approved by the bill.

Update:

On Nov. 11, 2015 Gov. Cuomo signed a bill to allow emergency access to medical marijuana, requiring state health officials to establish an expedited certification process for seriously ill patients and to register marijuana producers "as expeditiously as practicable."

On Jan. 7, 2016, the medical marijuana program officially launched with eight dispensaries statewide.

Contact and Program Details

New York Department of Health

866-811-7957

Email Contact Form

Website:

New York State Medical Marijuana Program

Information provided by the state on sources for medical marijuana:

The medical marijuana program website lists five registered organizations, each with four dispensing sites.

"A certified patient may receive medical marijuana products from any dispensing facility of any Registered Organization in New York State."

"Frequently Asked Questions," health.ny.gov (accessed Mar. 1, 2016)

Patient Registry Fee:

$50

Accepts other states' registry ID cards?

No

Registration:

Mandatory

22. North Dakota

State and Relevant Medical Marijuana Laws

Initiated Statutory Measure 5 "North Dakota Compassionate Care Act" – Approved Nov. 8, 2016 by 63.7% of the voters

"This initiated measure would add a new chapter to Title 19 of the North Dakota Century Code creating an Act providing for the medical use of marijuana... To participate in the program, the Act would create identification cards with specific criteria before they can be issued by the Department of Health for patients, caregivers, compassion centers and other facilities. The Act would create

procedures for monitoring, inventorying, dispensing, and cultivation and growing of marijuana to be regulated and enforced by the Department of Health."
Approved Conditions: Cancer, HIV/AIDS, hepatitis C, ALS, PTSD, Alzheimer's disease, dementia, Crohn's disease, fibromyalgia, spinal stenosis or chronic back pain including neuropathy or damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, glaucoma, epilepsy; A chronic or debilitating disease medical condition or its treatment that produces one or more of the following: cachexia or wasting syndrome, severe debilitating pain that has not responded to previously prescribed medication or surgical measures for more than three months or for which other treatment options produced serious side effects, intractable nausea, seizures, or severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis; Any other medical condition or its treatment added by the North Dakota Department of Health.
Possession/Cultivation: 3 ounces of usable marijuana per 14-day period

Contact and Program Details

North Dakota Department of Health
701-328-2372
Website:
www.ndhealth.gov
"If the qualifying patient's home is located more than forty miles from the nearest compassionate care center, the qualified patient or designated caregiver may cultivate up to eight marijuana plants in an enclosed, locked facility." Source: North Dakota Compassionate Care Act
Patient Registry Fee:
To be determined
Accepts other states' registry ID cards?
Unclear

23. Ohio

State and Relevant Medical Marijuana Laws

House Bill 523
Approved: May 10, 2016 by House, 71-26; May 25, 2016 by Senate, 18-15
Signed into law by Governor John Kasich on June 8, 2016
Effective: Sep. 8, 2016
Authorizes the use of marijuana for medical purposes and establishes the Medical Marijuana Control Program.
"Only the following forms of medical marijuana may be dispensed under this chapter: oils, tinctures, plant material, edibles, patches." The smoking or combustion of medical marijuana is prohibited while vaporization is permitted.
Approved Conditions: AIDS/HIV, Alzheimer's disease, ALS, cancer, chronic traumatic encephalopathy, Crohn's disease, epilepsy, fibromyalgia, glaucoma, hepatitis C, inflammatory bowel disease, multiple sclerosis, chronic, severe, or intractable pain, Parkinson's disease, PTSD, sickle cell anemia, spinal cord disease or injury, Tourette's syndrome, traumatic brain injury, ulcerative colitis
Possession/Cultivation: The law allows for a maximum of a 90-day supply, to be determined during

the rulemaking process.
Smoking is not a method approved by the bill.
"The Ohio Department of Commerce and the State of Ohio Board of Pharmacy are required by law to take all actions necessary to ensure that Ohio's Medical Marijuana Control Program is fully operational no later than September 2018. At that time, there will be an established structure for Ohioans with a qualifying medical condition to obtain a recommendation for medical marijuana, purchase medical marijuana from a licensed dispensary, and consume medical marijuana."
"Frequently Asked Questions, medicalmarijuana.ohio.gov (accessed Aug. 9, 2016)

Contact and Program Details

Ohio Medical Marijuana Control Program
Website:
medicalmarijuana.ohio.gov
Contact Form
Information provided by the state on sources for medical marijuana:
"Medical marijuana will be available from retail dispensaries licensed by the Board of Pharmacy. The Board of Pharmacy is currently developing rules on the licensing of medical marijuana dispensaries. The law prohibits the cultivation of medical marijuana for personal, family, or household use."
"Frequently Asked Questions, medicalmarijuana.ohio.gov (accessed Aug. 9, 2016)
Patient Registry Fee:
To be determined
Accepts other states' registry ID cards?
"The state board of pharmacy shall attempt in good faith to negotiate and enter into a reciprocity agreement with any other state under which a medical marijuana registry identification card or equivalent authorization that is issued by the other state is recognized in this state."
Registration:
Mandatory

24. Oregon

State and Relevant Medical Marijuana Laws

Ballot Measure 67 – Approved by 55% of voters on Nov. 3, 1998
Effective: Dec. 3, 1998
Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a signed recommendation from their physician stating that marijuana "may mitigate" his or her debilitating symptoms.
Approved Conditions: Cancer, glaucoma, degenerative or pervasive neurological condition; positive status for HIV/AIDS, or treatment for these conditions; A medical condition or treatment for a medical condition that produces cachexia, severe pain, severe nausea, seizures, including seizures caused by epilepsy, or persistent muscle spasms, including spasms caused by multiple sclerosis. Other conditions are subject to approval by the Health Division of the Oregon Department of Human Resources.
Possession/Cultivation: A registry identification cardholder or the designated primary caregiver of the cardholder may possess up to six mature marijuana plants and 24 ounces of usable marijuana. A

registry identification cardholder and the designated primary caregiver of the cardholder may possess a combined total of up to 18 marijuana seedlings. (per Oregon Revised Statutes ORS 475.300 -- ORS 475.346)

Amended:Senate Bill 1085
Effective: Jan. 1, 2006
State-qualified patients who possess cannabis in amounts exceeding the new state guidelines will no longer retain the ability to argue an "affirmative defense" of medical necessity at trial. Patients who fail to register with the state, but who possess medical cannabis in amounts compliant with state law, still retain the ability to raise an "affirmative defense" at trial.
The law also redefines "mature plants" to include only those cannabis plants that are more than 12 inches in height and diameter, and establish a state-registry for those authorized to produce medical cannabis to qualified patients.
Amended:House Bill 3052
Effective: July 21, 1999
Mandates that patients (or their caregivers) may only cultivate marijuana in one location, and requires that patients must be diagnosed by their physicians at least 12 months prior to an arrest in order to present an "affirmative defense." This bill also states that law enforcement officials who seize marijuana from a patient pending trial do not have to keep those plants alive. Last year the Oregon Board of Health approved agitation due to Alzheimer's disease to the list of debilitating conditions qualifying for legal protection.
In August 2001, program administrators filed established temporary procedures further defining the relationship between physicians and patients. The new rule defines attending physician as "a physician who has established a physician/patient relationship with the patient;... is primarily responsible for the care and treatment of the patients... has reviewed a patient's medical records at the patient's request, has conducted a thorough physical examination of the patient, has provided a treatment plan and/or follow-up care, and has documented these activities in a patient file."
Amended:SB 281
Signed by Gov. John Kitzhaber on June 6, 2013
Adds post-traumatic stress disorder (PTSD) to the list of approved conditions for medical marijuana use.
Amended: HB 3460
Signed by Gov. John Kitzhaber on Aug. 14, 2013
Creates a dispensary program by allowing the state licensing and regulation of medical marijuana facilities to transfer marijuana to registry identification cardholders or their designated primary caregivers.
Updates: On Mar. 3, 2014, the program began accepting applications from people seeking a license to operate a medical marijuana dispensary.
On Mar. 19, 2014, Senate Bill 1531 was signed into law. The bill allows local governments to restrict the operation of medical marijuana dispensaries, including the moratoriums up through May 1, 2015.
On Apr.18, 2014, the Medical Marijuana Dispensary Program approved 15 dispensary applications, bringing the total number of approved applications to 58.
HB 3400, signed into law on July 1, 2015 by Gov. Kate Brown, added a provision requiring patients to be state residents, but there is no minimum length of residency required before getting a card.

Contact and Program Details

Oregon Department of Human Services
Medical Marijuana Program
PO Box 14116
Portland, OR 97293
Phone: 855-244-9580 (toll-free)
medmj.dispensaries@state.or.us
Website:
healthoregon.org/ommp
Information provided by the state on sources for medical marijuana:
The Oregon Medical Marijuana Dispensary Program publishes a directory of approved dispensaries on its website.
"As of October 1, 2015, registered medical marijuana dispensaries may sell limited amounts of recreational marijuana to adults age 21 and older."
Patient Registry Fee:
$200 for new applications and renewals; Reduced fees: $60 for persons receiving SNAP (food stamp); $50 for Oregon Health Plan cardholders; $20 for persons receiving SSI benefits; $20 for individuals who have served in the Armed Forces of the United States
Accepts other states' registry ID cards?
No
Registration:
Mandatory

25. Pennsylvania

State and Relevant Medical Marijuana Laws

Senate Bill 3 -- Apr. 12, 2016 by Senate, 42-7, and Apr. 13 by House, 149-46
Signed into law by Gov. Tom Wolf (D) on Apr. 17, 2016
Effective: 30 days after passage
Approved Conditions: Cancer, HIV/AIDS, ALS, Parkinson's, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, inflammatory bowel disease, neuropathies, Huntington's disease, Crohn's disease, PTSD, intractable seizures, glaucoma, sickle cell anemia, severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain in which conventional therapeutic intervention and opiate therapy is contraindicated or ineffective, autism.
Possession/Cultivation: 30-day supply; According to SB 3, "Medical marijuana may only be dispensed to a patient or caregiver in the following forms: (i) pill; (ii) oil; (iii) topical forms, including gel, creams or ointments; (iv) a form medically appropriate for administration by vaporization or nebulization, excluding dry leaf or plant form... (v) tincture; or (vi) liquid. Unless otherwise provided in regulations adopted by the department under section 1202, medical marijuana may not be dispensed to a patient or a caregiver in dry leaf or plant form."
Smoking is not a method approved by the bill.
Update:
On June 24, 2016 , Pennsylvania Secretary of Health Karen Murphy announced new guidelines for a

Safe Harbor provision: "In July [2016], parents, legal guardians, caregivers, and spouses will be able to apply to the department for a Safe Harbor Letter that will allow them to administer medical marijuana obtained from outside of Pennsylvania to minors in their care. Once approved, the letter should be carried whenever medical marijuana is being transported outside of an individual's home."

Contact and Program Details

Pennsylvania Department of Health
1-877-PA-HEALTH

Website:
Medical Marijuana Program
Information provided by the state on sources for medical marijuana:
"The department may not initially issue permits to more than 50 dispensaries. Each dispensary may provide medical marijuana at no more than three separate locations."
"Senate Bill 3," Apr. 12, 2016
More details pending establishment of state program; a Dec. 21, 2016 update from the Department of Health stated that the program "is expected to be fully implemented by 2018."
Patient Registry Fee:
$50
Accepts other states' registry ID cards?
Unknown
Registration:
Mandatory

26. Rhode Island

State and Relevant Medical Marijuana Laws

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

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

Effective: Jan. 3, 2006
Approved Conditions: Cancer, glaucoma, positive status for HIV/AIDS, Hepatitis C, or the treatment of these conditions; A chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome; severe, debilitating, chronic pain; severe nausea; seizures, including but not limited to, those characteristic of epilepsy; or severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis or Crohn's disease; or agitation of Alzheimer's Disease; or any other medical condition or its treatment approved by the state

Department of Health.
Possession/Cultivation: Limits the amount of marijuana that can be possessed and grown to up to 12 marijuana plants or 2.5 ounces of cultivated marijuana. Primary caregivers may not possess an amount of marijuana in excess of 24 marijuana plants and five ounces of usable marijuana for qualifying patients to whom he or she is connected through the Department's registration process.
Amended:H5359 - The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act (substituted for the original bill)
Timeline:

1. May 20, 2009: passed the House 63-5
2. June 6, 2009: passed the State Senate 31-2
3. June 12, 2009: Gov. Carcieri vetoed the bill
4. June 16, 2009: Senate overrode the veto 35-3
5. June 16, 2009: House overrode the veto 67-0
   Effective June 16, 2009: Allows the creation of compassion centers, which may acquire, possess, cultivate, manufacture, deliver, transfer, transport, supply, or dispense marijuana, or related supplies and educational materials, to registered qualifying patients and their registered primary caregivers. Rules & Regulations last updated Dec. 2012.

The first dispensary, the Thomas C. Slater Compassion Center, opened on Apr. 19, 2013. Compassion centers must be operated on a not-for-profit basis.

Contact and Program Details

Rhode Island Department of Health
Office of Health Professions Regulation, Room 104
3 Capitol Hill
Providence, RI 02908-5097
Phone: 401-222-2828
doh.mmp@health.ri.gov
Website:
RI Medical Marijuana Program (MMP)
Information provided by the state on sources for medical marijuana:
"Compassion centers are places for patients who have qualifying conditions to obtain medical marijuana as allowed by Rhode Island law. Three compassion centers are licensed in Rhode Island: the Thomas C. Slater Compassion Center in Providence; Summit Medical Compassion Center in Warwick; and Greenleaf Compassionate Care Center in Portsmouth."
"Medical Marijuana Compassion Centers," health.ri.gov (accessed Mar. 1, 2016)
Patient Registry Fee:
$100 / $10 for applicants on Medicaid or Supplemental Security Income (SSI)
Accepts other states' registry ID cards?
Yes, but only for the conditions approved in Rhode Island
Registration:
Mandatory

27. Vermont

State and Relevant Medical Marijuana Laws

Senate Bill 76 -- Approved 22-7; House Bill 645 -- Approved 82-59
"Act Relating to Marijuana Use by Persons with Severe Illness" (Sec. 1. 18 V.S.A. chapter 86 passed by the General Assembly) Gov. James Douglas (R), allowed the act to pass into law unsigned on May 26, 2004
Effective: July 1, 2004
Amended:Senate Bill 00007
Effective: May 30, 2007
Approved Conditions: Cancer, AIDS, positive status for HIV, multiple sclerosis, or the treatment of these conditions if the disease or the treatment results in severe, persistent, and intractable symptoms; or a disease, medical condition, or its treatment that is chronic, debilitating and produces severe, persistent, and one or more of the following intractable symptoms: cachexia or wasting syndrome, severe pain or nausea or seizures.
Possession/Cultivation: No more than two mature marijuana plants, seven immature plants, and two ounces of usable marijuana may be collectively possessed between the registered patient and the patient's registered caregiver. A marijuana plant shall be considered mature when male or female flower buds are readily observed on the plant by unaided visual examination. Until this sexual differentiation has taken place, a marijuana plant will be considered immature.
Amended:Senate Bill 17 "An Act Relating To Registering Four Nonprofit Organizations To Dispense Marijuana For Symptom Relief"
Signed by Gov. Peter Shumlin on June 2, 2011
The bill "establishes a framework for registering up to four nonprofit marijuana dispensaries in the state... A dispensary will be permitted to cultivate and possess at any one time up to 28 mature marijuana plants, 98 immature marijuana plants, and 28 ounces of usable marijuana."
On Sep. 12, 2012, the State of Vermont Department of Public Safety announced conditional approval of two medical marijuana dispensaries. In June 2013, two dispensaries opened in Vermont.

Contact and Program Details

Marijuana Registry
Department of Public Safety
45 State Drive
Waterbury, VT 05671-1300
Phone: 802-241-5115
Fax: 802-241-5230
DPS.MJRegistry@vermont.gov
Website:
VT Marijuana Registry Program
Information provided by the state on sources for medical marijuana:
"The Marijuana Registry is neither a source for marijuana nor can the Registry provide information to patients on how to obtain marijuana." (accessed Mar. 1, 2016)
Patient Registry Fee:
$50
Accepts other states' registry ID cards?
No

Registration:
Mandatory

28. Washington

State and Relevant Medical Marijuana Laws

Chapter 69.51A RCW Ballot Initiative I-692 -- Approved by 59% of voters on Nov. 3, 1998
Effective: Nov. 3, 1998
"Qualifying patients with terminal or debilitating illnesses who, in the judgment of their physicians, may benefit from the medical use of marijuana, shall not be found guilty of a crime under state law for their possession and limited use of marijuana."
Approved Conditions: cachexia; cancer; HIV or AIDS; epilepsy; glaucoma; intractable pain (defined as pain unrelieved by standard treatment or medications); and multiple sclerosis. Other conditions are subject to approval by the Washington Board of Health.
Additional conditions as of Nov. 2, 2008: Crohn's disease, Hepatitis C with debilitating nausea or intractable pain, diseases, including anorexia, which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, or spasticity, when those conditions are unrelieved by standard treatments or medications.
Added as of Aug. 31, 2010: chronic renal failure
Amended:Senate Bill 6032
Effective: 2007 (rules being defined by Legislature with a July 1, 2008 due date)
Amended:Final Rule based on Significant Analysis
Effective: Nov. 2, 2008
Possession/Cultivation: "On July 1, 2016, the possession amounts will change and will depend on whether the patient or designated provider is entered into the marijuana database. Patients and designated providers who are entered into the database will be able to:

- Possess six plants and eight ounces of useable marijuana.
- Be authorized by their healthcare practitioner for up to fifteen plants and sixteen ounces of usable marijuana."

Amended:SB 5073
Effective: July 22, 2011
Gov. Christine Gregoire signed sections of the bill and partially vetoed others, as explained in the Apr. 29, 2011 veto notice. Gov. Gregoire struck down sections related to creating state-licensed medical marijuana dispensaries and a voluntary patient registry.
Updates: On Jan. 21, 2010, the Supreme Court of the State of Washington ruled that Ballot Initiative "I-692 did not legalize marijuana, but rather provided an authorized user with an affirmative defense if the user shows compliance with the requirements for medical marijuana possession." *State v. Fry*
ProCon.org contacted the Washington Department of Health to ask whether it had received any instructions in light of this ruling. Kristi Weeks, Director of Policy and Legislation, stated the following in a Jan. 25, 2010 email response to ProCon.org:

"The Department of Health has a limited role related to medical marijuana in the state of Washington. Specifically, we were directed by the Legislature to determine the amount of a 60 day supply and conduct a study of issues related to access to medical marijuana. Both of these tasks have been completed. We have maintained the medical marijuana webpage for the convenience of the public.
The department has not received 'any instructions' in light of *State v. Fry*. That case does not change the law or affect the 60 day supply. Chapter 69.51A RCW, as confirmed in Fry, provides an affirmative defense to prosecution for possession of marijuana for qualifying patients and caregivers."

On Nov. 6, 2012, Washington voters passed Initiative 502, which allows the state to "license and regulate marijuana production, distribution, and possession for persons over 21 and tax marijuana sales." The website for Washington's medical marijuana program states that the initiative "does not amend or repeal the medical marijuana laws (chapter 69.51A RCW) in any way. The laws relating to authorization of medical marijuana by healthcare providers are still valid and enforceable."
SB 5052 passed the House by a vote of 60-36 on Apr. 10, 2015 and the Senate by a vote of 41-8 on Apr. 14, 2015. Gov. Jay Inslee signed the bill into law with partial vetoes on Apr. 24, 2015.
Qualifying patients in Washington need a valid Medical Marijuana authorization form from their healthcare practitioners.
"Beginning July 1, 2016, patients and designated providers who are entered into the Medical Marijuana Authorization Database will receive a recognition card which will entitle the patient to additional rights and protections under SB 5052:
-Arrest protection
-Purchase products sales tax free
-Purchase three times the legal limit for recreational
Patients and designated providers who hold valid authorizations but aren't entered into the database will have an affirmative defense to criminal prosecution if they possess no more than four plants and six ounces of usable marijuana. They may purchase only in accordance with the laws and rules for non-patients."

Contact and Program Details

Department of Health
PO Box 47866
Olympia, WA 98504-7866
Phone: 360-236-4700
Fax: 360-236-4768
MedicalMarijuana@doh.wa.gov
Website:
Medical Marijuana (Cannabis)
Information provided by the state on sources for medical marijuana:
"The new medical marijuana cooperative law replaced the marijuana collectives law on July 1, 2016. Up to four medical marijuana patients or their designated provider may join together to grow marijuana for the patients' personal use.

Every member must be entered into the medical marijuana authorization database and have a medical marijuana recognition card."
"A Patient's Guide to Medical Marijuana Cooperatives," doh.wa.gov, June 2016
Patient Registry Fee:
$1
Accepts other states' registry ID cards?
No
Registration:
Voluntary - Patients who join the medical marijuana authorization database receive a medical marijuana recognition card

Washington, DC

State and Relevant Medical Marijuana Laws

Amendment Act B18-622 "Legalization of Marijuana for Medical Treatment Amendment Act of 2010" -- Approved 13-0 by the Council of the District of Columbia on May 4, 2010; signed by the Mayor on May 21, 2010|
Effective: July 27, 2010 [After being signed by the Mayor, the law underwent a 30-day Congessional review period. Neither the Senate nor the House acted to stop the law, so it became effective when the review period ended.]
Approved Conditions: HIV, AIDS, cancer, glaucoma, conditions characterized by severe and persistent muscle spasms, such as multiple sclerosis; patients undergoing chemotherapy or radiotherapy, or using azidothymidine or protease inhibitors.
Possession/Cultivation: "Patients are permitted to purchase up to two (2) ounces of dried medical marijuana per month or the equivalent of two ounces of dried medical marijuana when sold in any other form." ("Patient FAQ," doh.dc.gov, Mar. 1, 2016)
Updates: On Apr. 14, 2011, Mayor Vincent C. Gray announced the adoption of an emergency amendment to title 22 of the District of Columbia Municipal Regulations (DCMR), which added a new subtitle C entitled "Medical Marijuana." The emergency amendment "will set forth the process and procedure" for patients, caregivers, physicians, and dispensaries, and "implement the provisions of the Act that must be addressed at the onset to enable the Department to administer the program." The final rulemaking was posted online on Jan. 3, 2012.
On Feb. 14, 2012, the DC Department of Health's Health Regulation and Licensing Administration posted a revised timeline for the dispensary application process, which listed June 8, 2012 as the date by which the Department intends to announce dispensary applicants available for registration. The first dispensary, Capital City Care, was licensed in Apr. 2013.

Contact and Program Details

Health Regulation and Licensing Administration
899 N. Capitol Street, NE
2nd Floor
Washington, DC 20002
Phone: 202-442-5955
doh.mmp@dc.gov

Website:
Medical Marijuana Program
Information provided by the state on sources for medical marijuana:
"A dispensary is a facility operated by an organization or business registered with the Department of Health... Patients are required to choose a single dispensary to register with...
Dispensaries and cultivation centers may dispense or distribute medical marijuana in any form deemed safe which allows patients to eat, inhale, or otherwise use medical marijuana for medical purposes. Medical marijuana will be subject to testing for quality assurance and safety purposes."
"Medical Marijuana Program Frequently Asked Questions," doh.dc.gov (accessed Mar. 1, 2016)
Patient Registry Fee:
$100 initial or renewal fee / $25 for low income patients
Accepts other states' registry ID cards?
No
Registration:
Mandatory

****

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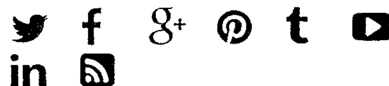

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Medical Marijuana and Pain

As of February 2017, 25 states allow the use of medical marijuana for some type of "pain," as follows:

- **Alaska:** "chronic pain"
- **Arizona:** "severe or chronic pain"
- **Arkansas:** "intractable pain, which is pain that has not responded to ordinary medications, treatment, or surgical measures for more than six months."
- **California:** "chronic pain"
- **Colorado:** "severe pain"
- **Connecticut:** "damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity," "post laminectomy syndrome with chronic radiculopathy," and "complex regional pain syndrome"
- **Delaware:** "severe, debilitating pain that has not responded to previously prescribed medication or surgical measures for more than 3 months or for which other treatment options produced serious side effects"
- **Hawaii:** "severe pain"
- **Illinois:** "severe fibromyalgia," "chronic regional pain syndrome"
- **Maine:** "chronic intractable pain"
- **Maryland:** "severe or chronic pain"
- **Michigan:** "severe and chronic pain"
- **Minnesota:** "intractable pain"
- **Montana:** "severe or chronic pain"
- **Nevada:** "severe nausea or pain"
- **New Hampshire:** "severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects."
- **New Jersey:** "severe or chronic pain"
- **New Mexico:** "severe chronic pain"
- **North Dakota:** "severe debilitating pain that has not responded to previously prescribed medication or surgical measures for more than three months or for which other treatment options produced serious side effects"
- **Ohio:** "chronic, severe, or intractable pain"
- **Oregon:** "severe pain"
- **Pennsylvania:** "severe chronic or intractable pain of neuropathic origin or severe chronic or intractable pain in which conventional therapeutic intervention and opiate therapy is contraindicated or ineffective"
- **Rhode Island:** "severe, debilitating, chronic pain"
- **Vermont:** "severe pain"
- **Washington:** "intractable pain"

Three states (Florida, New York, Massachusetts) and Washington, D.C., have legalized medical marijuana, but "pain" is not an approved condition. Note that one approved condition in Washington, D.C. is "severe and persistent muscle spasms" but not "pain."

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ARTHUR CHAPMAN
KETTERING SMETAK & PIKALA, P.A.
ATTORNEYS AT LAW

THC and "Impairment"

Six states have defined the level of impairment relative to THC in the blood.

Colorado

- "Colorado law specifies that drivers with five nanograms of active tetrahydrocannabinol (THC) in their whole blood can be prosecuted for driving under the influence (DUI). However, no matter the level of THC, law enforcement officers base arrests on observed impairment."

  https://www.codot.gov/safety/alcohol-and-impaired-driving/druggeddriving/marijuana-and-driving

Montana

- "With blood levels of 5 ng/ml of Delta-9-Tetrahydrocannabinol or more, a driver is presumed to be too impaired to drive safely."

  https://www.mdt.mt.gov/visionzero/docs/dui_penalties.pdf

Nevada

- Nevada's DUI per se levels by substance: marijuana (2ng/ml of blood), marijuana metabolite (5 ng/ml of blood).

  http://norml.org/legal/item/nevada-drugged-driving

Ohio

- Ohio's DUI per se levels by substance: marijuana (2 ng/ml of blood), marijuana metabolite (50 ng/ml of blood), marijuana metabolite in combination with alcohol or other drugs (5 ng/ml of blood).

  http://norml.org/legal/item/ohio-drugged-driving

Pennsylvania

- 1 ng/ml of THC in the blood is per se impairment.

  http://www.pabulletin.com/secure/data/vol41/41-18/738.html

Washington

- "Under Washington's law, motorists with detectable levels of THC in the blood above 5 ng/ml are guilty of DUID. Revised Code of Washington 46.61.502(1)(b)."

  http://norml.org/legal/item/washington-drugged-driving

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SEPTEMBER 8, 2016

Stanford engineers develop the 'potalyzer,' a roadside saliva test for marijuana intoxication

As the breathalyzer does for alcohol, this experimental 'potalyzer' could provide a practical field test for determining whether a driver might be impaired from smoking marijuana.

BY CARRIE KIRBY

This November, several states will vote whether to legalize marijuana use, joining more than 20 states that already allow some form of cannabis use. This has prompted a need for effective tools for police to determine on the spot whether people are driving under the influence.

Stanford researchers have devised a potential solution, applying magnetic nanotechnology, previously used as a cancer screen, to create what could be the first practical roadside test for marijuana intoxication.

Stanford engineers are developing a portable device that measures THC levels in saliva, a step toward creating a roadside test for driving under the influence of marijuana. *(Image credit: Reuters/Rick Wilking)*

While police are trying out potential tools, no device currently on the market has been shown to quickly provide a precise measurement of a driver's marijuana intoxication as effectively as a breathalyzer gauges alcohol intoxication. THC, the drug's most potent psychoactive agent, is commonly screened for in laboratory blood or urine tests – not very helpful for an officer in the field.

The Stanford device might function as a practical "potalyzer" because it can quickly detect not just the presence of THC in a person's saliva, but also measure its concentration.

Led by Shan Wang (https://profiles.stanford.edu/shan-wang), a professor of materials science and engineering and of electrical engineering, the Stanford team created a mobile device that uses magnetic biosensors to detect tiny THC molecules in saliva. Officers could collect a spit sample with a cotton swab and read the results on a smartphone or laptop in as little as three minutes.

Researchers tackling the "potalyzer" problem have zeroed in on saliva because testing it is less invasive and because THC in saliva may correlate with impairment better than THC in urine or blood. The big challenge is that these spit tests may be called upon to detect superlatively tiny concentrations of THC. Some states have no set limit of THC in the body for drivers, while others set a limit of 0 or 5 nanograms (a billionth of a gram) per milliliter of blood.

Wang’s device can detect concentrations of THC in the range of 0 to 50 nanograms per milliliter of saliva. While there’s still no consensus on how much THC in a driver’s system is too much, previous studies have suggested a cutoff between 2 and 25 ng/mL, well within the capability of Wang’s device.

Repurposing biomedical tools

The researchers achieved such precision by harnessing the behavior of magnetism in nanoparticles, which measure just a few tens of billionths of a meter.

The Wang Group has been exploring magnetic nanotechnology for years, using it to attack such diverse problems as *in vitro* cancer diagnostics and magnetic information storage. In this case, they’re combining magnetic nanotechnology with the time-tested biochemical technique of the immunoassay. Immunoassays detect a certain molecule in a solution by introducing an antibody that will bind only to that molecule.

In the test, saliva is mixed with THC antibodies, which bind to any THC molecules in the sample. Then the sample is placed on a disposable chip cartridge, which contains magnetoresistive (GMR) sensors pre-coated with THC, and inserted into the handheld reader.

This sets in motion a “competition” between the THC pre-coated on the sensor and THC in the saliva to bind with the antibodies; the more THC in the saliva, the fewer antibodies will be available to bind to the THC on the sensor surface.

The number of antibodies bound to THC molecules on the sensor tells the device how many antibodies the THC in the sample used up, and therefore how many THC molecules were present in the sample.

Next, magnetic nanoparticles, specially made to bind only to the antibodies, are introduced to the sample. Each nanoparticle binds onto a THC-antibody pair like a sticky beacon, but only the molecules on the sensor surface will be close enough to trip the GMR biosensors in the reader. The device then uses Bluetooth to communicate results to the screen of a smartphone or laptop.

“To the best of our knowledge, this is the first demonstration that GMR biosensors are capable of detecting small molecules,” Wang wrote in a paper describing the device, published in ***Analytical Chemistry*.** **(http://pubs.acs.org/doi/abs/10.1021/acs.analchem.6b01688)**

Beyond marijuana

The platform has potential usefulness beyond THC. Just as they do with THC, the GMR biosensors in the device could detect any small molecule, meaning that the platform could also test for morphine, heroin, cocaine or other drugs.

In fact, with 80 sensors built into it, the GMR biosensor chip could screen a single sample for multiple substances. The team has already tried screening for morphine with promising results.

Students are currently working on creating a user-friendly form factor for the device, which would need to go through field tests and be approved by regulators before it can be deployed by police.

Another thing that would have to happen before the device would be useful to law enforcement: State laws must set limits for the concentration of THC allowed in a driver’s saliva.

Here too, the Wang Group's device could be helpful. For example, the next generation of the device could screen both the blood and saliva of a subject to establish an understanding of the correlation between blood THC level and saliva THC level at the same degree of intoxication.

The co-authors of the *Analytical Chemistry* paper are Jung-Rok Lee (ME PhD'15), Joohong Choi (EE PhD'15), and Tyler O. Shultz (Biology BS'13).

Media Contacts

Tom Abate, Stanford Engineering: (650) 736-2245, **tabate@stanford.edu (mailto:tabate@stanford.edu)**

(mailto:?subject=An%20interesting%20article%20from%20Stanford%20News&body=I%20want%20to%20share%20this%20news%20story%20from%20Stanford%20University%20with%20you%3A%20http%3A%2F%2Fstanford.io%2F2c9xrwd)

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347 P.3d 732
Court of Appeals of New Mexico.

Miguel MAEZ, Worker–Appellant,
v.
RILEY INDUSTRIAL and Chartis,
Employer/Insurer–Appellees.

No. 33,154.
|
Jan. 13, 2015.

Synopsis
Background: Workers' compensation claimant was awarded benefits for two compensable injuries to his lumbar spine. The Workers' Compensation Administration, David L. Skinner, J., determined that medical marijuana was not reasonable and necessary medical care. Claimant appealed.

[Holding:] The Court of Appeals, Wechsler, J., held that evidence supported finding that medical marijuana constituted reasonable and necessary medical care.

Reversed.

West Headnotes (8)

[1] **Workers' Compensation**
Presumptions and burden of showing error
Workers' Compensation
Conclusiveness of administrative findings in general
The Court of Appeals gives deference to the workers' compensation judge (WCJ) as factfinder and views the evidence in the light most favorable to the decision without disregarding contravening evidence.

Cases that cite this headnote

[2] **Appeal and Error**
Extent of Review
While the Court of Appeals generally may not weigh the evidence, even under whole record review, such review allows the reviewing court greater latitude to determine whether a finding of fact was reasonable based on the evidence.

Cases that cite this headnote

[3] **Appeal and Error**
Where Evidence Was in Writing
Appellate review has even greater latitude when reviewing an issue for which the evidence is documentary in nature.

Cases that cite this headnote

[4] **Appeal and Error**
Where Evidence Was in Writing
Appeal and Error
Affidavits or depositions
When all or substantially all of the evidence on a material issue is documentary or by deposition, an appellate court may examine and weigh it.

Cases that cite this headnote

[5] **Workers' Compensation**
In general;questions of law or fact
The Court of Appeals applies a de novo standard to the workers' compensation judge's (WCJ) application of law to the facts.

Cases that cite this headnote

[6] **Workers' Compensation**
Treatment to relieve from effects of permanent injury
The fact that physician did not "prescribe" medical marijuana for workers' compensation claimant did not support the conclusion that medical marijuana was not reasonable and necessary medical care for claimant; the certification required under the Compassionate Use Act by a person licensed in New Mexico to prescribe and

administer controlled substances was the functional equivalent of a prescription. N.M.Admin.Code 11.4.7.7(OO); West's NMSA § 26–2B–3(E, H).

1 Cases that cite this headnote

[7] **Workers' Compensation**
Extent of right;amount

Evidence supported finding that medical marijuana constituted reasonable and necessary medical care, in workers' compensation case; physician's report indicated that claimant failed traditional pain management, and claimant still had unrelieved symptoms related to his back injuries. West's NMSA § 26–2B–3(E, H).

1 Cases that cite this headnote

[8] **Workers' Compensation**
Burden of proof

Workers' compensation claimant has the burden to establish that medical marijuana is a necessary medical treatment.

1 Cases that cite this headnote

Attorneys and Law Firms

***732** Titus & Murphy Law Firm, Victor A. Titus, Farmington, NM, for Appellant.

Hoffman Kelley Lopez LLP, Lori A. Martinez, Albuquerque, NM, for Appellees.

OPINION

WECHSLER, Judge.

{1} In *Vialpando v. Ben's Automotive Services,* 2014–NMCA–084, ¶ 1, 331 P.3d 975, *cert. denied,* 331 P.3d 924 (2014), this Court held that the Workers' Compensation Act, NMSA 1978, §§ 52–1–1 to –70 (1929, as amended through 2013), authorizes reimbursement for medical marijuana used pursuant to the Lynn and Erin Compassionate Use Act (Compassionate Use Act), NMSA 1978, §§ 26–2B–1 to –7 (2007). The workers' ***733** compensation judge in *Vialpando* had found that the worker was qualified to participate in the Department of Health Medical Cannabis Program authorized by the Compassionate Use Act and that such treatment would be reasonable and necessary medical care. 2014–NMCA–084, ¶ 1, 331 P.3d 975.

{2} In this appeal, the workers' compensation judge (WCJ) found that the worker's authorized treating health care provider (HCP) did not prescribe medical marijuana and concluded that medical marijuana was not reasonable and necessary medical care. Worker Miguel Maez argues that the WCJ erred in this conclusion because Worker had proven that medical marijuana was reasonable and necessary medical care, particularly based on the evidence that the HCP's treatment plan for Worker included medical marijuana, and the HCP and another doctor had certified Worker's use of medical marijuana as required by the Compassionate Use Act.

{3} Because there is not substantial evidence supporting the WCJ's conclusion that medical marijuana was not reasonable and necessary medical care for Worker, we reverse the WCJ's compensation order.

I. BACKGROUND

{4} Worker suffered two compensable injuries to his lumbar spine in the course and scope of his employment with Riley Industrial on February 14, 2011 and March 4, 2011. Riley Industrial was insured by Chartis (both referred to as Employer herein). Worker was entitled to payment of temporary disability until the date of maximum medical improvement and permanent partial disability thereafter based on a seven percent whole body impairment for the balance of the 500–week benefit period. He was also entitled to ongoing reasonable and necessary medical care. His authorized HCP was Dr. Anthony Reeve.

{5} The WCJ found that "Dr. Reeve did not prescribe medical marijuana to Worker" and concluded that "[m]edical marijuana is not reasonable and necessary medical care from an authorized HCP" that would require payment by Employer. Worker appeals from the WCJ's compensation order to the extent that the WCJ did not award medical benefits for Worker's use of medical marijuana for pain management.

II. REASONABLE AND NECESSARY MEDICAL CARE

A. Issue on Appeal

{6} On appeal, Worker initially makes arguments concerning the interrelationship of the Workers' Compensation Act and the Compassionate Use Act that are similar to those we decided in *Vialpando.* In *Vialpando,* filed after Worker filed his brief-in-chief in this case, we determined that medical marijuana treatment approved under the Compassionate Use Act that the WCJ found to be reasonable and necessary medical care qualifies for reimbursement under the Workers' Compensation Act. *Vialpando,* 2014–NMCA–084, ¶ 1, 331 P.3d 975.

{7} The WCJ in this case did not find Worker's medical marijuana treatment to be reasonable and necessary medical care. To the contrary, the WCJ specifically concluded that "[m]edical marijuana is not reasonable and necessary medical care from an authorized HCP." Worker argues that the WCJ erred in reaching this conclusion because the evidence indicated that medical marijuana is reasonable care for Worker's chronic low back pain and because the WCJ incorrectly found that medical marijuana was not "prescribed" by Dr. Reeve.

{8} The Workers' Compensation Act requires an employer to provide a worker "reasonable and necessary health care services from a health care provider." Section 52–1–49(A). Conversely, an employer need not provide a worker with health care that is not reasonable and necessary. *See Vargas v. City of Albuquerque,* 1993–NMCA–136, ¶ 8, 116 N.M. 664, 866 P.2d 392 ("[T]he employer's obligation is limited by Section 52–1–49(A) to paying for 'reasonable and necessary' health care services"). Thus, the pivotal question in Worker's appeal is whether the evidence supports the WCJ's conclusion that medical marijuana was not reasonable and necessary medical care.

*734 B. Standard of Review

[1] {9} We address this question under a whole record standard of review by determining whether substantial evidence in the record as a whole supports the WCJ's conclusion. *Dewitt v. Rent–A–Center, Inc.,* 2009–NMSC–032, ¶ 12, 146 N.M. 453, 212 P.3d 341. Substantial evidence is credible evidence in light of the whole record "that is sufficient for a reasonable mind to accept as adequate to support the conclusion[.]" *Id.* (internal quotation marks and citation omitted). We give deference to the WCJ as factfinder and view the evidence in the light most favorable to the decision without disregarding contravening evidence. *Id.*

[2] **[3]** **[4]** {10} While we generally may not weigh the evidence, even under whole record review, such review "allows the reviewing court greater latitude to determine whether a finding of fact was reasonable based on the evidence [.]" *Herman v. Miners' Hosp.,* 1991–NMSC–021, ¶ 10, 111 N.M. 550, 807 P.2d 734. Moreover, our review has even greater latitude when reviewing an issue for which the evidence is documentary in nature. As in this case, when "all or substantially all of the evidence on a material issue is documentary or by deposition," an appellate court may "examine and weigh it[.]" *United Nuclear Corp. v. Gen. Atomic Co.,* 1979–NMSC–036, ¶ 62, 93 N.M. 105, 597 P.2d 290 (internal quotation marks and citation omitted). In review for substantial evidence of such a record from a district court proceeding, the appellate court must then give "some weight to the findings of the trial judge on such issue" and not disturb such findings based on conflicting evidence "unless such findings are manifestly wrong or clearly opposed to the evidence." *Id.* (internal quotation marks and citation omitted). In this case, in which we are applying whole record review, we must similarly give weight to the WCJ's findings and consider contravening evidence. *Dewitt,* 2009–NMSC–032, ¶ 12, 146 N.M. 453, 212 P.3d 341. Following *United Nuclear,* we will not disturb the WCJ's findings unless they are manifestly wrong or clearly opposed to the evidence. 1979–NMSC–036, 93 N.M. 105, 597 P.2d 290, ¶ 69.

[5] {11} We apply a de novo standard to the WCJ's application of law to the facts. *Vialpando,* 2014–NMCA–084, ¶ 5, 331 P.3d 975.

C. Review of the Evidence

{12} Dr. Reeve provided the evidence concerning the issue of whether medical marijuana constituted reasonable and necessary medical care. He testified by deposition. He made detailed medical reports of each of Worker's visits, and the reports were included as exhibits to his deposition.

{13} Dr. Reeve began treating Worker on June 13, 2011. He testified that his diagnosis of Worker included chronic

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back pain and that he treated Worker with medication for pain management. Over the course of Worker's treatment, Dr. Reeve had injected Worker with Toradol and had prescribed Soma, Ultram, Sprix, Percocet, Lortab (oxycodone), and hydrocodone for Worker's pain. Dr. Reeve also referred Worker to another doctor for spinal injections. During one test required for pain management patients, Worker tested positive for marijuana. Dr. Reeve informed Worker that if Worker was going to take marijuana, he needed to have a license for Dr. Reeve to continue administering other narcotics, and further, even if Worker had a license, he would probably consider only additional nonnarcotic pain medication.

{14} On February 28, 2012, Dr. Reeve first saw Worker for a medical marijuana evaluation. In his medical report, Dr. Reeve states that Worker has had spinal injections and chronic pain management and that Worker "has failed traditional pain management and is a candidate for the cannabis program." At that time, Dr. Reeve was treating Worker with hydrocodone. His report concludes with the following:

> **IMPRESSION**
>
> 1. Lumbar radiculopathy.
>
> 2. Chronic low back pain.
>
> 3. Failed traditional management.
>
> **REHABILITATION MANAGEMENT AND SUGGESTIONS**
>
> I have reviewed the records and examined the patient. The history, radiographic and *735 physical findings are consistent at this time. I will recommend authorization of medical marijuana as a trial. Authorization is good for one year and the patient will need to show symptomatic progress upon reauthorization.
>
> **TREATMENT PLAN**
>
> Authorization for medical marijuana for one year.

{15} Dr. Reeve re-authorized Worker for the medical marijuana program after an evaluation on April 3, 2013. Similarly, Dr. Reeve again stated in his report that Worker had "failed traditional pain management and is a candidate for the cannabis program." He stated the same "IMPRESSION" and "REHABILITATION MANAGEMENT AND SUGGESTIONS" as he had on February 28, 2012. His "TREATMENT PLAN" stated "Reauthorization for medical marijuana for one year."

{16} The Compassionate Use Act requires for enrollment that "a person licensed in New Mexico to prescribe and administer drugs that are subject to the Controlled Substances Act" provide a "written certification" that "the patient has a debilitating medical condition" and that the person certifying "believes that the potential health benefits of the medical use of cannabis would likely outweigh the health risks for the patient." Section 26–2B–3(E), (H). Dr. Reeve signed the certification for Worker to 3 qualify for the Compassionate Use Act medical marijuana program. The original certification is not part of the record on appeal. Dr. Reeve also signed the certification re-enrolling Worker in the program. In that certification, in addition to the statutory requirements stated above, Dr. Reeve further certified that Worker "has current unrelieved symptoms that have failed other medical therapies."

{17} At his deposition, Dr. Reeve was asked: "And because you signed for [medical marijuana], do you believe that it is an appropriate medical treatment for [Worker's] herniated disk?" Dr. Reeve responded:

> Well, I think I need to be really clear on this issue. What happens is patients are going to use the cannabis [marijuana] either one way or the other. He already tested positive for it. And so I explain to patients, "If you're going to use cannabis, you should probably have a license for it because people will suspect you of using it ultimately, and you can always pass a preemployment screen or other tests if you have a license for it." And if patients request that I sign it, I will sign for them, but I'm not recommending or distributing or in any way advocating for the use of medical cannabis.

1. Necessity of a Prescription

[6] {18} Worker contends that the WCJ erred in his conclusion that medical marijuana does not constitute reasonable and necessary medical care because Dr. Reeve did not "prescribe" medical marijuana for Worker. The WCJ found that Dr. Reeve did not prescribe medical marijuana to Worker and further found that "Employer is not liable for the purchase of medical marijuana based on the fact that the medical marijuana is not

being prescribed by the authorized HCP, Dr. Reeve." The Workers' Compensation Administration regulations adopted pursuant to NMSA 1978, Section 52–4-5 (1993) and NMSA 1978, Section 52–5–4 (2003) applicable at the time Worker filed his application defined "prescription drug" as a drug requiring "a written order from an authorized HCP for dispensing by a licensed pharmacist or authorized HCP." 11.4.7.7(OO) NMAC (12/31/2011). But, as we stated in *Vialpando,* medical marijuana is not a prescription drug. 2014–NMCA–084, ¶ 11, 331 P.3d 975. Moreover, as we further stated in *Vialpando,* the certification required under the Compassionate Use Act by a person licensed in New Mexico to prescribe and administer controlled substances is the functional equivalent of a prescription. *Id.* ¶ 12; see § 26–2B–3(E), (H). We thus agree with Worker that the fact that Dr. Reeve did not provide Worker a prescription as defined in the regulations does not support the WCJ's conclusion that medical marijuana was not reasonable and necessary medical care for Worker.

2. Conclusion Regarding Reasonable Medical Care

[7] {19} As we have stated, to the extent that the WCJ based his conclusion that medical ***736** marijuana was not reasonable and necessary medical care on his finding that Dr. Reeve did not prescribe medical marijuana for Worker, the WCJ's conclusion is based on a faulty premise. Employer argues that the evidence in the record nevertheless supports the WCJ's conclusion. We therefore turn to the other evidence to determine whether it supports the conclusion that medical marijuana was not reasonable and necessary medical care for Worker.

{20} We discuss the two aspects of the WCJ's conclusion separately. With regard to whether medical marijuana was reasonable medical care for Worker, we have little difficulty concluding that the evidence as a whole does not support the WCJ's conclusion. Regardless of whether Worker requested treatment with medical marijuana, Dr. Reeve had treated Worker with traditional pain management that had failed. He adopted a treatment plan based on medical marijuana. He would not have done so if it were an unreasonable medical treatment. The evidence does not support a conclusion that Dr. Reeve did not believe medical marijuana to be a reasonable treatment for Worker.

3. Conclusion Regarding Necessary Medical Care

{21} The aspect concerning necessary medical care is more difficult. Dr. Reeve did not testify that the medical marijuana treatment was necessary for Worker's care. Rather, when asked in his deposition whether he believed it was appropriate medical treatment because he had signed for it, Dr. Reeve stated that Worker was using marijuana, that such patients need a license for such use, and that he will sign for them if he is requested. He specified that in doing so he was not recommending 2 marijuana use. He also considered the medical marijuana program to be a patient's decision "as it's private and voluntary and it's not overseen by a physician."

{22} The WCJ decided from this evidence that medical marijuana was not necessary medical care for Worker. The question before us is whether there was substantial evidence for the WCJ to reach this conclusion. Under our standard of review, we must defer to the finder of fact and view the evidence in the most favorable light to the decision without disregarding contravening evidence.

[8] {23} Worker had the burden to establish that medical marijuana was a necessary medical treatment. *See DiMatteo v. Doña Ana Cnty.,* 1985–NMCA–099, ¶ 26, 104 N.M. 599, 725 P.2d 575 (stating under previous version of Workers' Compensation Act that the worker had the burden of proving that his medical expenses were reasonably necessary). The evidence indicates that Dr. Reeve considered traditional pain management to have failed and planned to treat Worker with medical marijuana. Dr. Reeve also testified, however, that medical marijuana treatment is a patient's decision and that he will adopt it on a patient's request. The question before us distills to whether, considering all the evidence, the WCJ could reasonably have concluded that medical marijuana was not necessary medical care because Dr. Reeve merely acceded to Worker's choice and adopted medical marijuana as his treatment plan because Worker had begun to use it on his own.

{24} We begin with the contravening evidence. Dr. Reeve's medical reports clearly state that he had treated Worker with traditional pain management and that such treatment had failed. The medical reports further state that Dr. Reeve was adopting medical marijuana as his treatment plan and would recommend its use for Worker. Dr. Reeve did so, certifying in Worker's re-enrollment form that Worker had "unrelieved symptoms that have failed other medical therapies." We consider this

evidence to clearly establish that medical marijuana was necessary for Worker's treatment because (1) traditional pain management had failed and (2) it would not be possible for Dr. Reeve to institute or carry out his treatment plan without medical marijuana.

{25} To support the WCJ's conclusion and to consider the evidence in the light most favorable to the WCJ's conclusion, we must be able to infer from Dr. Reeve's deposition testimony, as argued by Employer, that medical marijuana treatment was entirely Worker's *737 choice and that Dr. Reeve certified Worker for the medical marijuana program only because Worker intended to use it regardless and asked Dr. Reeve for the certification. In this regard, Dr. Reeve testified that Worker had tested positive for marijuana, that patients use marijuana "either one way or the other[,]" and that he will sign for patients if requested. He further stated that he was "not recommending or distributing or in any way advocating for the use of medical cannabis."

{26} But, even reading this evidence in the light most favorable to the WCJ's decision, we do not consider this testimony to be inconsistent with Dr. Reeve's medical records. There is no conflict in the evidence that Dr. Reeve addressed medical marijuana as a treatment for Worker because Worker had used marijuana and tested positive for it. Nor do we question that Dr. Reeve pursued medical marijuana as a treatment plan because Worker requested it. Dr. Reeve's testimony also indicates that, in adopting his treatment plan, he did not recommend medical marijuana to Worker or advocate its use. Dr. Reeve did not distribute medical marijuana to Worker. *See* Section 26–2B–4(E) (stating that a practitioner may not be subject to arrest, prosecution, or penalty for distributing medical marijuana under the Compassionate Use Act).

{27} We must focus on the question at issue—whether medical marijuana was necessary medical care for Worker. The facts that Dr. Reeve did not initiate or recommend to Worker such care are not dispositive. Regardless of whether he took such action or was merely "passive," as Employer contends, Dr. Reeve adopted a treatment plan that called for medical marijuana. By the very nature of such treatment, medical marijuana was a necessary component. Dr. Reeve then recommended Worker for receipt of medical marijuana by his certification. He did so, even though at Worker's request, because traditional pain management was not successful for Worker.

{28} Perhaps most significantly, we cannot accept the contention, albeit implied, that Dr. Reeve would certify Worker for medical marijuana use solely on Worker's request regardless of whether it was appropriate for Worker's medical care. Marijuana is a controlled substance. The Compassionate Use Act makes an exception to the contraband use of marijuana only when necessary for medical treatment. *See* § 26–2B–2 ("The purpose of the [Compassionate Use Act] is to allow the beneficial use of medical cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments."). Of course, a patient must wish to participate in the Compassionate Use Act program, but that law does not contemplate that individuals who wish to receive marijuana may do so merely upon request; it requires the certification by a professional. Nor does it contemplate that this professional certification will be issued in an irresponsible fashion. Dr. Reeve was familiar with the Compassionate Use Act program and testified that he was "one of only two doctors that I know of in the state that will sign for the medical cannabis[.]" We cannot infer from Dr. Reeve's testimony that he would certify Worker for the Compassionate Use Act program without exercising his medical judgment. Indeed, to the contrary, his medical records describe in detail the basis for his exercise of his medical judgment.

{29} We additionally note that Dr. Reeve re-examined Worker on April 3, 2013 and re-authorized Worker for the Compassionate Use Act program. Dr. Reeve certified at that time that Worker continued to meet the eligibility requirements for the program and that Worker "has current unrelieved symptoms that have failed other medical therapies." This certification underscores Worker's need for medical marijuana therapy.

{30} We thus read the evidence in the record as a whole as failing to support and as clearly opposed to the WCJ's conclusion that medical marijuana was not reasonable and necessary medical care.

III. WORKER'S REFUSAL OF REASONABLE AND NECESSARY MEDICAL CARE

{31} Employer also argues that, if medical marijuana is reasonable and necessary medical care, Employer should

not be responsible ***738** to reimburse it because Worker refused the reasonable and necessary medical care that Dr. Reeve was providing to him. We address this argument because, if Employer is correct, we could affirm the WCJ's compensation order because it is right for a reason that it does not address. *See Davis v. Los Alamos Nat'l Lab.*, 1989–NMCA–023, ¶ 18, 108 N.M. 587, 775 P.2d 1304 (stating that we will affirm the decision of a workers' compensation order if it is right for any reason).

{32} However, we do not agree with Employer. Employer's argument is premised on its position that:

> It was Worker's own choice, and not Dr. Reeve's professional judgment of what constituted reasonable and necessary care, that first motivated the medical use of marijuana. Dr. Reeve's rationale for signing for the medical cannabis was not that he wasn't providing reasonable and necessary care, but rather that Worker was going to use marijuana regardless of whether Worker was taking narcotic pain medication.

{33} As we have discussed, however, the substantial evidence in the record as a whole does not support the proposition that Dr. Reeve certified Worker for medical marijuana treatment merely because Worker had made that choice. The record, which includes Dr. Reeve's medical reports, does not support a conclusion that traditional pain medication was the sole reasonable and necessary treatment, precluding any other.

IV. CONCLUSION

{34} Substantial evidence in the record as a whole does not support the WCJ's conclusion that medical marijuana was not reasonable and necessary medical care. We therefore reverse the WCJ's compensation order.

{35} **IT IS SO ORDERED.**

WE CONCUR: CYNTHIA A. FRY and MICHAEL E. VIGIL, Judges.

All Citations

347 P.3d 732, 2015 -NMCA- 049

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2015 WL 1577995 (Cal.W.C.A.B.)
Only the Westlaw citation is currently available.
WCAB PANEL DECISION
NOTICE: California Workers' Compensation Appeals Board panel decisions are not binding precedent
Workers' Compensation Appeals Board, State of California.

CHRISTOPHER COCKRELL, Applicant,

v.

FARMERS INSURANCE; LIBERTY MUTUAL INSURANCE COMPANY, Defendants.

Nos. ADJ504565 (SBR 0266567), ADJ2584271 (SBR 0297503).
March 13, 2015.

OPINION AND DECISION AFTER RECONSIDERATION

DEIDRA E. LOWE.

*1 In order to further study the factual and legal issues in this matter, on September 11, 2014, we granted defendant's Petition for Reconsideration of a workers' compensation administrative law judge's (WCJ) Findings & Award of June 24, 2014, wherein it was found that, "Reimbursement for self-procured medically recommended marijuana as opposed to providing or paying a supplier of this drug is awarded in a sum not to exceed the lower of the fee schedule for medications being replaced by the medical cannabis or the actual expense of the self-procured item. Reasonableness and necessity under L.C. Sect. 4600 is supported by the opinion of the Agreed Medical Examiner herein. The Workers' Compensation insurance carrier is not an entity included in the provisions of Health & Safety Code Sections 11362.785 and Section 1342.6 [*sic*]. Labor Code Section 4600.35 does not apply to the insurance carrier in this context."

Defendant contends that the WCJ erred in finding that applicant was entitled to reimbursement for self-procured medical marijuana. We have received an answer, and the WCJ has filed a Report and Recommendation on Petition for Reconsideration.

Previously in this matter, in a Findings & Award of June 20, 2012, the WCJ found the applicant entitled to reimbursement for medical marijuana. Defendant sought reconsideration of that decision and, on September 14, 2012, we granted reconsideration of the Findings & Award of June 20, 2012, rescinded the decision, and returned the matter to the trial level so that the parties could consider the application of Health and Safety Code section 11362.785(d), which the parties and the WCJ had not discussed in the trial level proceedings. Health and Safety Code section 11362.785(d) states that, "Nothing in this article [Medical Marijuana Program] shall require a governmental, private, or any other health insurance provider or health care service plan to be liable for any claim for reimbursement for the medical use of marijuana."

However, while the parties and the WCJ analyzed the issue of whether a workers' compensation insurer constitutes a "health care service plan," it appears that the parties and the WCJ did not analyze the issue of whether a workers' compensation insurer constitutes a "health insurance provider" for the purposes of Health and Safety Code section 11362.785(d). Since the parties should be heard on this issue (*Rucker v. Workers' Comp. Appeals Bd.* . (2000) 82 Cal.App.4th 151, 157–158 [65 Cal.Comp.Cases 805]; *Gangwish v. Workers' Comp. Appeals Bd.* (2001) 89 Cal.App.4th 1284, 1295 [66 Cal.Comp.Cases 584]) before a decision is rendered, we will return this matter to the trial level for further proceedings and decision on this issue.

Without purporting to decide the issue, we note that the "fundamental rule of statutory construction is that a court should ascertain the intent of the Legislature so as to effectuate the purpose of the law." (*DuBois v. Workers' Comp.*

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Appeals Bd. (1993) 5 Cal.4th 382, 387 [58 Cal.Comp.Cases 286].) The Medical Marijuana Program does not appear to specifically define the term "health insurance provider." "Health insurance" is not one of the classes of insurance in the Insurance Code. (Ins.Code, § 100.) It appears that non-occupational health insurance is a type of disability insurance. (See, e.g., Ins.Code, § 10785). Although for purposes of the Insurance Code the term "health insurance" does not include "insurance arising out of a workers' compensation or similar law" (Ins.Code, § 106), we note that Labor Code section 4600 refers to "health care coverage for nonoccupational injuries or illnesses" (Lab.Code, § 4600, subd. (d)(1)). The fact that the Legislature felt the need to qualify "health care coverage" with "for nonoccupational injuries or illnesses" may signify that coverage for occupational injuries or illnesses also constitutes "health care coverage." Similarly, the fact that the term "health insurance" specifically excludes workers' compensation in the Insurance Code may signify that "health insurance" includes workers' compensation insurance when there is no express statutory exclusion. We take no position on this issue.

***2** In considering whether the Legislature sought to include workers' compensation policies providing coverage for occupational injuries and illnesses in the definition of "health insurance provider" for the purposes of Health and Safety Code section 11362.785(d), the parties and the WCJ should analyze whether there is any rational basis for treating occupational and nonoccupational insurers differently with regard to reimbursement for medical marijuana. We take no position on this issue. The parties should brief the above issues, and the WCJ should decide these issues in the first instance. The foregoing is not intended to limit the areas of inquiry regarding the application of Health and Safety Code section 11362.785(d) to this case. After issuance of a final decision by the WCJ, any aggrieved party may file a petition for reconsideration.

In reaching this decision, we make no determination regarding the propriety of the WCJ's determination that a workers' compensation insurer does not constitute a "health care service plan" within the meaning of Health and Safety Code section 11362.785(d).

For the foregoing reasons,

IT IS ORDERED as the Decision after Reconsideration of the Workers' Compensation Appeals Board that the Findings & Award of June 24, 2014 is hereby **RESCINDED** and that this matter is **RETURNED** for further proceedings and decision consistent with the opinion herein.

I CONCUR, KATHERINE ZALEWSKI.

CONCURRING, BUT NOT SIGNING, MARGUERITE SWEENEY.

OPINION AND ORDER GRANTING PETITION FOR RECONSIDERATION

Reconsideration has been sought by defendant with regard to a decision filed on June 24, 2014.

Taking into account the statutory time constraints for acting on the petition, and based upon our initial review of the record, we believe reconsideration must be granted in order to allow sufficient opportunity to further study the factual and legal issues in this case. We believe that this action is necessary to give us a complete understanding of the record and to enable us to issue a just and reasoned decision. Reconsideration will be granted for this purpose and for such further proceedings as we may hereinafter determine to be appropriate.

For the foregoing reasons,

IT IS ORDERED that the Petition for Reconsideration is **GRANTED.**

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IT IS FURTHER ORDERED that pending the issuance of a Decision After Reconsideration in the above matter, all further correspondence, objections, motions, requests and communications shall be filed in writing only with the Office of the Commissioners of the Workers' Compensation Appeals Board at either its street address (455 Golden Gate Avenue, 9th Floor, San Francisco, CA 94102) or its Post Office Box address (PO Box 429459, San Francisco, CA 94142–9459), and shall *not* be submitted to any district office of the WCAB and shall *not* be e-filed in the Electronic Adjudication Management System.

WE CONCUR, MARGUERITE SWEENEY, and KATHERINE ZALEWSKI.

REPORT AND RECOMMENDATION OF W.C. JUDGE ON PETITION FOR RECONSIDERATION

Robert T. Pusey, W.C.Judge.

Introduction:

***3** Timely Petition for Reconsideration has been filed and apparently verified and served herein by defendant on 7/18/14 from the Findings & Award served 6/25/14. Proof of service by mail is on file showing service on applicant.

Summary:

The WCJ does not adopt the statement of facts given by the petitions but relies on the summary herein as well as that set forth in the record of proceedings on file. The Findings and Award served herein provides in material part as follows:

FINDINGS

1. Christopher Cockrell, applicant, born [redacted], while employed by Farmers Insurance Group; Helmsman Management Svcs/Liberty Mutual Ins. on 9/16/95 as an attorney within California, sustained injury arising out of and in the course of employment to his low back, right elbow and heart. Defendant maintained insurance coverage in accordance with the Labor Code administered by Helmsman Management Services.

2. The minutes of hearing for the hearings on 11/29/11, 2/9/12, 6/20/12, 5/13/14 and 6/24/14 are true and correct except as corrected herein and are incorporated by this reference. The latter date was set for receipt of briefs only.

3. Reimbursement for self-procured medically recommended marijuana as opposed to providing or paying a supplier of this drug is awarded in a sum not to exceed the lower of the fee schedule for medications being replaced by the medical cannabis or the actual expense of the self-procured item. Reasonableness and necessity under L.C.Sect. 4600 is supported by the opinion of the Agreed Medical Examiner herein. The Workers' Compensation insurance carrier is not an entity included in the provisions of Health & Safety Code Sections 11362.785 and Section 1342.6. Labor Code Section 4600.35 does not apply to the insurance carrier in this context. Jurisdiction is reserved as to further disputes concerning the rate of reimbursement.

4. Attorney's fees under L.C.Sect. 5814.5 are not payable herein but a reasonable fee at 15% on and from the reimbursement of medical expense to applicant is ordered payable to counsel for applicant."

RESPONSE TO CONTENTIONS

Contention I: Workers Compensation Insurance carriers are considered health care service plans per appropriate statutory interpretation principles.

Response: The WCJ notes that L.C. Sect. 3202 advises that liberal construction applies to the provision of benefits under the Workers' Compensation statutes. The argument by petitioner does not appear to take this into account. The definition of health care service plans has been considered by the WCJ as noted below and broader scope does not appear warranted.

Contention II and III: Employer control and Utilization review:

Response: These points do not appear to have been properly raised at trial. Defendant has declined to provide the medication on non-medical grounds. The parties agreed to submit the issue of reasonableness and necessity under L.C. Sect. 4600 to the Agreed Medical Examiner who concurred in the use of the medical marijuana given applicant's unique problems. The petitioner should be deemed to have waived these points and be barred from initiating argument on reconsideration.

***4** Contention IV: Legislative intent and public policy; Medical Treatment Utilization Schedule; Federal Law; Equal Protection.

Response: The same points made in the WCJ's response to II and III above apply here. There is expert medical opinion based on the physician's expertise including the points noted in his analysis per the reports by Dr. Levister and otherwise in the medical record relied on by the WCJ. As with any medication the primary treating physician must make regular reports per Reg. 9785 when he renews the prescription. The defense retains the right to revisit the ongoing use of the medication with the AME and to monitor the quantities used. The defense may take the deposition of the prescribing treating physician as well. The petitioner is concerned over "unfettered use" by the applicant but this appears to be unsupported by the testimony of applicant and the danger would appear no greater and perhaps less so than with opiate based medications which have compromised applicant's internal systems. Apparently the petitioner concedes that not all appropriate treatment has been set forth in the MTUS. The AME's opinion and his review of materials herein qualify as substantial unrebutted evidence under LC.Sect. 3202.5 and 4600.

The rate of reimbursement has been deferred and the defense retains their right to challenge the sums claimed as un reasonable even in the absence of an OMFS provision so no prejudice can be asserted on that basis. The defense has made no showing that the sum which applicant seeks are unreasonable or higher than the medications the defense had been providing in the past but that issue has been reserved.

As to Federal Law, the petitioner is not being ordered to engage in any of the prohibited acts cited by the petitioner. Reimbursement for out of pocket medical expense permissible under Labor Code Section 4600 has not been shown to violate the federal statutes.

As to Equal Protection, the WCJ may not rule on constitutionality of statutes but the WCJ does not see that the distinguishing between types of insurance by the Legislature would be a denial of equal protection. The Insurance Code for the State of California makes several distinctions amongst the various types of coverage provided by insurance companies which are designed for specific risks and are as varied as automobile insurance, home owners insurance, health care plan carriers, malpractice, etc.

FURTHER RESPONSE TO ALL CONTENTIONS:

The WCJ incorporates in material part his opinion as further response herein, to wit:

"OPINION ON DECISION/ C. COCKRELL/ADJ504565;ADJ2584271

REIMBURSEMENT FOR MEDICAL TREATMENT/L.C.SECT 4600/ORAL SETTLEMENT AGREEMENT

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The defense maintains that even if there was an oral agreement as part of a settlement herein to reimburse applicant for out of pocket expense in the purchase of medical marijuana/cannabis permissible under the laws of the State of California, that the contract is void ab initio because it is in violation of federal statutes and is unenforceable.

***5** It is further argued by the defendant, based on the defense witnesses assertions, that the defendant never agreed to be bound by the determination of the AME but only to return the matter to Dr. Levister for further comment pursuant to the WCJ's pre-award recommendation to develop the record. Applicant and his attorney formed a different impression of the contacts.

During trial the defense argued that an evidentiary privilege based on confidential communications with an attorney representing the carrier precluded him from being compelled to testify. The defense also argued that the carrier could not be required to produce the claims adjuster for the carrier involved with an alleged oral agreement to settle this case and that the applicant would have to subpoena that person. Applicant argued that neither position was valid and made an offer of proof as to the testimony which would have been given by these witnesses had they attended trial. The offer of proof made by applicant's counsel was in part through his sworn testimony as a participant in the discussions with the attorney for the defense involved in the alleged settlement agreement. If the attorney is engaged in negotiation regarding a contract his statements to the other party during said negotiations are not privileged and to the extent the attorney for the other party is relating terms of his client in that negotiation there is no confidential communication on the actual disclosures during the negotiation so testimony by the attorney confirming or denying those statements is not privileged. The defendant's attorney testified at trial regarding his material statements during the negotiations.

Having reviewed the testimony the WCJ is persuaded that the record does not establish a meeting of the minds so as to give rise to an agreement beyond obtaining further discovery to clarify the record in terms of reasonableness and necessity of the disputed treatment under L.C. Sect. 4600. Clearly the AME would not be able to resolve the defense position based on the federal statute or the applicant's assertion of an agreement relating to the issues in these proceedings.

The earlier decision of the Commissioners herein raising the additional statute in the Health and Safety Code was apparently not contemplated by the parties at the time of the first trial on this treatment issue so there was no question of the defendant's waiving that provision if it was applicable.

Applicant contends that the defense is not being required to violate the Federal statute in that the defense is not making a purchase of the controlled substance or supplying it to the applicant. Applicant also argues per citations to the other provisions of the law cited in Health & Safety Code Section 11362.785, that it does not apply to the Labor Code generally and specifically Workers' Compensation medical benefits under L.C.Sect. 4600. This argument appears to have merit.

As earlier noted the AME herein Dr. Levister has concurred in the medical use of Marijuana in this case in accord with L.C.Sect. 4600.

***6** The Commissioners directed that the provisions of Health & Safety Code Section 11362.785(d) be considered in the factual setting of this matter. The WCJ notes that a Workers Compensation insurer whether self-insured or as the insurance carrier arguably should not be classified as a medical insurance provider under the Health & Safety Code. In this regard it is noted that the Commissioners also referred the parties to L.C.Sect. 4600.35 which discusses reimbursement to certain providers with licensed status under Health & Safety Code Section 1340. This citation would appear to relate to an entity such as Blue CrossBlue Shield, etc. as being eligible to receive payments in connection with a Workers Compensation case. It does not appear that a Workers Compensation insurer is such an entity under the Knox–Keene Health Care Service Plan Act of 1976 rather the Workers' Compensation carrier is making the reimbursement under the Labor Code independent of the Knoex–Keene, etc. statutes.

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Labor Code Section 4600.35. Any entity seeking to reimburse health care providers for health care services rendered to injured workers on a capitated, or per person per month basis, shall be licensed pursuant to the Knox–Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

Health & Safety Code Section 1384, located in the Chapter 2.2, etc. specifies, in material part:

As used in this chapter ...

(e) "Group contract" means a contract which by its terms limits the eligibility of subscribers and enrollees to a specified group.

(f) "Health care service plan" or "specialized health care service plan" means either of the following:

(1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

Health & Safety Code Section 11362.785.

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

(b) Notwithstanding subdivision (a), a person shall not be prohibited or prevented from obtaining and submitting the written information and documentation necessary to apply for an identification card on the basis that the person is incarcerated in a jail, correctional facility, or other penal institution in which prisoners reside or persons under arrest are detained.

*7 (c) Nothing in this article shall prohibit a jail, correctional facility, or other penal institution in which prisoners reside or persons under arrest are detained, from permitting a prisoner or a person under arrest who has an identification card, to use marijuana for medical purposes under circumstances that will not endanger the health or safety of other prisoners or the security of the facility.

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

H & S Section 1342.6 reads as follows:

"1342.6. It is the intent of the Legislature to ensure that the citizens of this state receive high-quality health care coverage in the most efficient and cost-effective manner possible. In furtherance of this intent, the Legislature finds and declares that it is in the public interest to promote various types of contracts between public or private payers of health care coverage, and institutional or professional providers of health care services. This intent has been demonstrated by the recent enactment of Chapters 328, 329, and 1594 of the Statutes of 1982, authorizing various types of contracts to be entered into between public or private payers of health care coverage, and institutional or professional providers of health care services. The Legislature further finds and declares that individual providers, whether institutional or professional, and individual purchasers, have not proven to be efficient-sized bargaining units for these contracts, and that the formation of groups and combinations of institutional and professional providers and combinations of

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purchasing groups for the purpose of creating efficient-sized contracting units represents a meaningful addition to the health care marketplace. The Legislature further finds and declares that negotiations between purchasers or payers of health services, and health care service plans governed by the provisions of this chapter, or through a person or entity acting for, or on behalf of, a purchaser or payer of health services, or a health care service plan, are in furtherance of the public's interest in obtaining quality health care services in the most efficient and cost-effective manner possible. It is the intent of the Legislature, therefore, that the formation of groups and combinations of providers and purchasing groups for the purpose of creating efficient-sized contracting units be recognized as the creation of a new product within the health care marketplace, and be subject, therefore, only to those antitrust prohibitions applicable to the conduct of other presumptively legitimate enterprises.

This section does not change existing antitrust law as it relates to any agreement or arrangement to exclude from any of the above-described groups or combinations, any person who is lawfully qualified to perform the services to be performed by the members of the group or combination, where the ground for the exclusion is failure to possess the same license or certification as is possessed by the members of the group or combination.

***8** In conclusion it does not appear that the Health & Safety Code nor federal statute precludes reimbursement by a Workers Compensation Insurance carrier of self-procured expenses incurred by an applicant for medical marijuana prescribed by a licensed physician.

It is further argued by applicant that the Health and Safety Code does not operate to negate the provisions of L.C. Section 4600(a) and (b). Applicant cites the Medical Treatment Utilization Schedule as neutral with regard to the use of medical marijuana indicating that further study is needed. In this regard the opinion of the AME as substantial expert opinion is deemed controlling.

Applicant's argument on the application of the Knox, etc. statutes to the Labor Code is noted. The latter provisions do not apply medical treatment pursuant to Labor Code Sect. 4600 as this is not medical insurance but is compensation under the Labor Code for out of pocket self-procured L.C. Section 4600 medical treatment which is legal under the Medical Marijuana initiative and ratified by the AME as reasonable medical treatment."

RECOMMENDATION

It is recommended that the Petitions for Reconsideration be denied in their entirety.

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350 P.3d 849
Supreme Court of Colorado.

Brandon COATS, Petitioner
v.
DISH NETWORK, LLC, Respondent.

Supreme Court Case No. 13SC394
|
June 15, 2015

Synopsis
Background: Terminated employee brought employment discrimination action against employer, alleging that his termination based on his state-licensed use of medical marijuana violated the lawful activities statute, which made it an unfair and discriminatory labor practice to discharge an employee based on the employee's lawful outside-of-work activities. The District Court, Arapahoe County, Elizabeth B. Volz, J., dismissed the action for failure to state a claim. Employee appealed, and the Court of Appeals, Davidson, C.J., 303 P.3d 147, affirmed in relevant part. Employee petitioned for review.

Holdings: The Supreme Court, Eid, J., held that:

[1] an activity such as medical marijuana use that is unlawful under federal law is not a "lawful" activity under lawful activities statute, and

[2] employee could be terminated for his use of medical marijuana in accordance with the Medical Marijuana Amendment of state constitution.

Affirmed.

West Headnotes (4)

[1] **Labor and Employment**
Protected activities in general

An activity such as medical marijuana use that is unlawful under federal law is not a "lawful" activity under lawful activities statute, which makes it an unfair and discriminatory labor practice to discharge an employee based on the employee's lawful outside-of-work activities. Colo. Const. art. 18, § 14; Colo. Rev. Stat. Ann. § 24-34-402.5(1).

3 Cases that cite this headnote

[2] **Labor and Employment**
Protected activities in general

Lawful activity statute, which made it an unfair and discriminatory labor practice to discharge an employee based on the employee's "lawful" outside-of-work activities, was not limited to activities lawful under state law, and thus employee could be terminated for his use of medical marijuana in accordance with the Medical Marijuana Amendment of state constitution, which remained unlawful under federal law; statute did not restrict the term "lawful" to state law. Comprehensive Drug Abuse Prevention and Control Act of 1970 § 404, 21 U.S.C.A. § 844(a); Colo. Const. art. 18, § 14; Colo. Rev. Stat. Ann. § 24-34-402.5(1).

2 Cases that cite this headnote

[3] **Statutes**
Undefined terms

In construing undefined statutory terms, Supreme Court looks to the language of the statute itself with a view toward giving the statutory language its commonly accepted and understood meaning.

Cases that cite this headnote

[4] **Labor and Employment**
Protected activities in general

The commonly accepted meaning of the term "lawful," for purposes of the lawful activities statute that makes it an unfair and discriminatory labor practice to discharge an employee based on the employee's lawful outside-of-work activities, is that which is permitted by law or, conversely, that which is not contrary to, or forbidden by law. Colo. Rev. Stat. Ann. § 24-34-402.5(1).

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1 Cases that cite this headnote

Certiorari to the Colorado Court of Appeals, Colorado Court of Appeals Case Nos. 12CA595 & 12CA1704

Attorneys and Law Firms

Attorneys for Petitioner: The Evans Firm, LLC, Michael D. Evans, Denver, Colorado, Thomas K. Carberry, Thomas Karel Carberry, Denver, Colorado, Campbell Law, LLC, John E. Campbell, St. Louis, Missouri, Wolf Legal, PC, Adam B. Wolf, San Francisco, California

Attorneys for Respondent: Martinez Law Group, P.C., Meghan W. Martinez, Ann Christoff Purvis, Elizabeth Imhoff Mabey, Denver, Colorado

***850** Attorneys for Amicus Curiae State of Colorado: Colorado Department of Law, Cynthia H. Coffman, Attorney General, David C. Blake, Deputy Attorney General, Michael Francisco, Assistant Solicitor General, Michelle Brissette Miller, Assistant Attorney General, Denver, Colorado

Attorneys for Amicus Curiae Colorado Mining Association: Jackson Kelly PLLC, Laura E. Beverage, Meredith A. Kapushion, Denver, Colorado, Ryley Carlock & Applewhite, Michael D. Moberly, Charitie L. Hartsig, Phoenix, Arizona

Attorneys for Amicus Curiae Colorado Civil Justice League: Husch Blackwell LLP, Christopher L. Ottele, Mary H. Stuart, Carrie Claiborne, Denver, Colorado

Attorney for Amicus Curiae Colorado Defense Lawyers Association: Hall & Evans, L.L.C., Andrew D. Ringel, Denver, Colorado

Attorneys for Amicus Curiae Colorado Plaintiff Employment Lawyers Association: Ryan Law Firm, LLC, Kimberlie K. Ryan, Denver, Colorado

Attorney for Amicus Curiae Patient and Caregiver Rights Litigation Project: Springer and Steinberg, P.C., Andrew B. Reid, Denver, Colorado

En Banc

Opinion

JUSTICE EID delivered the Opinion of the Court.

¶ 1 This case requires us to determine whether the use of medical marijuana in compliance with Colorado's Medical Marijuana Amendment, Colo. Const. art. XVIII, § 14, but in violation of federal law, is a "lawful activity" under section 24–34–402.5, C.R.S. (2014), Colorado's "lawful activities statute." This statute generally makes it an unfair and discriminatory labor practice to discharge an employee based on the employee's "lawful" outside-of-work activities. § 24–34–402.5(1).

¶ 2 Here, petitioner Brandon Coats claims respondent Dish Network, LLC ("Dish") violated section 24–34–402.5 by discharging him due to his state-licensed use of medical marijuana at home during nonworking hours. He argues that the Medical Marijuana Amendment makes such use "lawful" for purposes of section 24–34–402.5, notwithstanding any federal laws prohibiting medical marijuana use. The trial court dismissed Coats's complaint for failure to state a claim after finding that medical marijuana use is not "lawful" under Colorado state law. Coats appealed, and the court of appeals affirmed.

¶ 3 In a split decision, the majority of the court of appeals held that Coats did not state a claim for relief because medical marijuana use, which is prohibited by federal law, is not a "lawful activity" for purposes of section 24–34–402.5. *Coats v. Dish Network, LLC,* 2013 COA 62, ¶ 23, 303 P.3d 147, 152. In dissent, Judge Webb would have held that section 24–34–402.5 does protect Coats's medical marijuana use, because the term "lawful" as used in the statute refers only to Colorado state law, under which medical marijuana use is "at least lawful." *Id.* at ¶ 56, 303 P.3d at 157 (Webb, J., dissenting).

¶ 4 We granted certiorari and now affirm. The term "lawful" as it is used in section 24–34–402.5 is not restricted in any way, and we decline to engraft a state law limitation onto the term. Therefore, an activity such as medical marijuana use that is unlawful under federal law is not a "lawful" activity under section 24–34–402.5. Accordingly, we affirm the opinion of the court of appeals.

I.

¶ 5 We take the following from the complaint. Brandon Coats is a quadriplegic and has been confined to a wheelchair since he was a teenager. In 2009, he registered for and obtained a state-issued license to use medical marijuana to treat painful muscle spasms caused by his quadriplegia. Coats consumes medical marijuana at home, after work, and in accordance with his license and Colorado state law.

¶ 6 Between 2007 and 2010, Coats worked for respondent Dish as a telephone customer service representative. In May 2010, Coats tested positive for tetrahydrocannabinol ("THC"), a component of medical marijuana, during a random drug test. Coats informed Dish that he was a registered medical marijuana patient and planned to continue using ***851** medical marijuana. On June 7, 2010, Dish fired Coats for violating the company's drug policy.

¶ 7 Coats then filed a wrongful termination claim against Dish under section 24–34–402.5, which generally prohibits employers from discharging an employee based on his engagement in "lawful activities" off the premises of the employer during nonworking hours. § 24–34–402.5(1). Coats contended that Dish violated the statute by terminating him based on his outside-of-work medical marijuana use, which he argued was "lawful" under the Medical Marijuana Amendment and its implementing legislation.

¶ 8 Dish filed a motion to dismiss, arguing that Coats's medical marijuana use was not "lawful" for purposes of the statute under either federal or state law.

¶ 9 The trial court dismissed Coats's claim. It rejected Coats's argument that the Medical Marijuana Amendment made his use a "lawful activity" for purposes of section 24–34–402.5. Instead the court found that the Amendment provided registered patients an affirmative defense to state criminal prosecution without making their use of medical marijuana a "lawful activity" within the meaning of section 24–34–402.5. As such, the trial court concluded that the statute afforded no protection to Coats and dismissed the claim without examining the federal law issue.

¶ 10 On appeal, Coats again argued that Dish wrongfully terminated him under section 24–34–402.5 because his use of medical marijuana was "lawful" under state law. Dish likewise reiterated that it did not violate section 24–34–402.5 because medical marijuana use remains prohibited under federal law.

¶ 11 In a split decision, the court of appeals affirmed based on the prohibition of marijuana use under the federal Controlled Substances Act, 21 U.S.C. § 844(a) (2012) (the "CSA"). Looking to the plain language of section 24–34–402.5, the majority found that the term "lawful" means "that which is 'permitted by law.' " *Coats*, ¶ 13, 303 P.3d at 150. Applying that plain meaning, the majority reasoned that to be "lawful" for purposes of section 24–34–402.5, activities that are governed by both state and federal law must "be permitted by, and not contrary to, both state and federal law." *Id.* at ¶ 14, 303 P.3d at 151. Given that the federal CSA prohibits all marijuana use, the majority concluded that Coats's conduct was not "lawful activity" protected by the statute. The majority therefore affirmed the trial court's decision on different grounds, not reaching the question of whether the state constitutional amendment created a constitutional right for registered patients to use medical marijuana or an affirmative defense to prosecution for such use. *Coats*, ¶ 23, 303 P.3d at 152.

¶ 12 In dissent, Judge Webb argued that the term "lawful" must be interpreted according to state, rather than federal, law. He argued that the majority's interpretation failed to effectuate the purpose of the statute by improperly narrowing the scope of the statute's protection. *Id.* at ¶ 47, 303 P.3d at 156 (Webb, J., dissenting). Finding that the Medical Marijuana Amendment made state-licensed medical marijuana use "at least lawful," Judge Webb concluded that Coats's use should be protected by the statute. *Id.* at ¶ 56, 303 P.3d at 157 (Webb, J., dissenting).

[1] ¶ 13 We granted review of the court of appeals' opinion [1] and now affirm. The term "lawful" as it is used in section 24–34–402.5 is not restricted in any way, and we decline to engraft a state law limitation onto the term. Therefore, an activity such as medical marijuana use that is unlawful under federal law is not a "lawful" activity under section 24–34–402.5. Accordingly, we affirm the opinion of the court of appeals.

*852 II.

¶ 14 We review de novo the question of whether medical marijuana use prohibited by federal law is a "lawful

activity" protected under section 24–34–402.5. *DuBois v. People,* 211 P.3d 41, 43 (Colo.2009).

¶ 15 The "lawful activities statute" provides that "[i]t shall be a discriminatory or unfair employment practice for an employer to terminate the employment of any employee due to that employee's engaging in any *lawful activity* off the premises of the employer during nonworking hours" unless certain exceptions apply. § 24–34–402.5(1) (emphasis added). An employee discharged in violation of this provision may bring a civil action for damages, including lost wages or benefits. § 24–34–402.5(2)(a).

[2] ¶ 16 By its terms the statute protects only "lawful" activities. However, the statute does not define the term "lawful." Coats contends that the term should be read as limited to activities lawful under state law. We disagree.

[3] **[4]** ¶ 17 In construing undefined statutory terms, we look to the language of the statute itself "with a view toward giving the statutory language its commonly accepted and understood meaning." *People v. Schuett,* 833 P.2d 44, 47 (Colo.1992). We have construed the term "lawful" once before and found that its "generally understood meaning" is "in accordance with the law or legitimate." *See id.* (citing *Webster's Third New International Dictionary* 1279 (1986)). Similarly, courts in other states have construed "lawful" to mean "authorized by law and not contrary to, nor forbidden by law." *Hougum v. Valley Memorial Homes,* 574 N.W.2d 812, 821 (N.D.1998) (defining "lawful" as used in similar lawful activities provision); *In re Adoption of B.C.H.,* 22 N.E.3d 580, 585 (Ind.2014) ("Upon our review of the plain and ordinary meaning of 'lawful custody,' ... 'lawful' means 'not contrary to law.' "). We therefore agree with the court of appeals that the commonly accepted meaning of the term "lawful" is "that which is 'permitted by law' or, conversely, that which is "not contrary to, or forbidden by law." *Coats,* ¶ 13, 303 P.3d at 150.

¶ 18 We still must determine, however, whether medical marijuana use that is licensed by the State of Colorado but prohibited under federal law is "lawful" for purposes of section 24–34–402.5. Coats contends that the General Assembly intended the term "lawful" here to mean "lawful under Colorado state law," which, he asserts, recognizes medical marijuana use as "lawful." *Coats,* ¶ 6, 303 P.3d at 149. We do not read the term "lawful" to be so restrictive. Nothing in the language of the statute limits the term "lawful" to state law. Instead, the term is used in its general, unrestricted sense, indicating that a "lawful" activity is that which complies with applicable "law," including state and federal law. We therefore decline Coats's invitation to engraft a state law limitation onto the statutory language. *See State Dep't of Revenue v. Adolph Coors Co.,* 724 P.2d 1341, 1345 (Colo.1986) (declining to read a restriction into unrestricted statutory language); *Turbyne v. People,* 151 P.3d 563, 567 (Colo.2007) (stating that "[w]e do not add words to the statute").

¶ 19 Coats does not dispute that the federal Controlled Substances Act prohibits medical marijuana use. *See* 21 U.S.C. § 844(a). The CSA lists marijuana as a Schedule I substance, meaning federal law designates it as having no medical accepted use, a high risk of abuse, and a lack of accepted safety for use under medical supervision. *Id.* at § 812(b)(1)(A)–(C). This makes the use, possession, or manufacture of marijuana a federal criminal offense, except where used for federally-approved research projects. *Id.* at § 844(a); *see also Gonzales v. Raich,* 545 U.S. 1, 14, 125 S.Ct. 2195, 162 L.Ed.2d 1 (2005). There is no exception for marijuana use for medicinal purposes, or for marijuana use conducted in accordance with state law. 21 U.S.C. § 844(a); *see also Gonzales,* 545 U.S. at 29, 125 S.Ct. 2195 (finding that "[t]he Supremacy Clause unambiguously provides that if there is any conflict between federal and state law, federal law shall prevail," including in the area of marijuana regulation).[2] ***853** Coats's use of medical marijuana was unlawful under federal law and thus not protected by section 24–34–402.5.

¶ 20 Echoing Judge Webb's dissent, Coats argues that because the General Assembly intended section 24–34–402.5 to broadly protect employees from discharge for outside-of-work activities, we must construe the term "lawful" to mean "lawful under Colorado law." *Coats,* ¶¶ 46–47, 303 P.3d at 156 (Webb, J., dissenting). In this case, however, we find nothing to indicate that the General Assembly intended to extend section 24–34–402.5's protection for "lawful" activities to activities that are unlawful under federal law. In sum, because Coats's marijuana use was unlawful under federal law, it does not fall within section 24–34–402.5's protection for "lawful" activities.

¶ 21 Having decided this case on the basis of the prohibition under federal law, we decline to address the issue of whether Colorado's Medical Marijuana

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Amendment deems medical marijuana use "lawful" by conferring a right to such use.

III.

¶ 22 For the reasons stated above, we affirm the decision of the court of appeals.

JUSTICE MÁRQUEZ does not participate.

All Citations

350 P.3d 849, 99 Empl. Prac. Dec. P 45,330, 165 Lab.Cas. P 61,600, 40 IER Cases 419, 31 A.D. Cases 1289, 2015 CO 44

Footnotes

1 We granted certiorari to review the following issues:

1. Whether the Lawful Activities Statute, section 24–34–402.5, protects employees from discretionary discharge for lawful use of medical marijuana outside the job where the use does not affect job performance.
2. Whether the Medical Marijuana Amendment makes the use of medical marijuana "lawful" and confers a right to use medical marijuana to persons lawfully registered with the state.

2 The Department of Justice has announced that it will not prosecute cancer patients or those with debilitating conditions who use medical marijuana in accordance with state law. Similarly, in December 2014, Congress passed the Consolidated and Further Continuing Appropriations Act that prohibited the Department of Justice from using funds made available through the Act to prevent Colorado and states with similar medical marijuana laws from "implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana." Consolidated and Further Continuing Appropriations Act, 2015, Pub. Law No. 113–235, § 538, 128 Stat. 2130, 2217 (2015). However, marijuana is still a Schedule I substance, and no medical marijuana exception yet exists in the CSA. As such, medical marijuana use remains prohibited under the CSA.

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